Report of an inspection of a Designated Centre for Disabilities (Adults)

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Listowel Respite Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Kerry Parents and Friends Association</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Kerry</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>18 September 2018</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0005683</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0021524</td>
</tr>
</tbody>
</table>
About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This designated centre is comprised of two single storey houses in separate locations. Respite supports and services are provided in both houses; over 40 residents currently access the service and a maximum of seven residents can be accommodated at any one time. The service is open on a full time basis; both planned and emergency respite is facilitated and a broad range of needs including higher physical needs are accommodated. Each house is staffed by a team of social care staff and care assistants; the centre is managed and supervised by the person in charge who is a registered nurse. The person in charge also co-ordinates the respite service itself and the general operation of the centre reflects individual resident respite needs and requirements, for example occupancy and compatibility of needs.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>14/03/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
</tr>
</tbody>
</table>
How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. **Capacity and capability of the service:**
   
   This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and safety of the service:**
   
   This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 September 2018</td>
<td>09:45hrs to 17:30hrs</td>
<td>Mary Moore</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

Residents were not present as they had departed for their day service for the day and had a planned community activity in the evening. The inspector did review records and spoke with staff to form a sense of how residents and their families viewed the service, for example records of consultation with residents and complaint records; this review is referenced throughout the text of the report.

Capacity and capability

While still establishing itself the inspector concluded that the centre was effectively governed to ensure that each resident received a safe, quality service that was appropriate to their needs. The centre was resourced to ensure that this objective was met.

The inspection focused on one of the two houses that comprise this designated centre, the house that was not operational at the time of the last HIQA (Health Information and Quality Authority) inspection; the other house has been inspected twice previously.

The day to day operation of the centre was the responsibility of the person in charge. It was clear from observation, on speaking with her and from the records reviewed that the person in charge was consistently engaged in the general operation and administration of the centre. The person in charge told the inspector that she was supported in her role by staff and by the senior management team.

The inspector found that staffing levels and arrangements met the individual and collective needs of residents. Relief staff were sourced from within the providers own resources; staff spoken with confirmed that consistency of staffing was provided for; this ensured that residents were familiar with staff and staff were familiar with residents and their needs.

The provider facilitated training for staff; the person in charge monitored staff attendance at training. All staff employed had attended mandatory training including for example safeguarding and the management of actual and potential aggression (MAPA). Some recently recruited staff had completed training in their previous employment and were awaiting attendance at the providers own training programmes in these areas; this training was scheduled.

The person in charge had requested additional training to ensure that staff had the knowledge and skills to meet the needs of specific residents. Training in percutaneous endoscopic gastrostomy (PEG) nutrition was scheduled, however training requested in the management of insulin dependent diabetes was (based on
these inspection findings) required and outstanding.

The provider had arrangements to ensure that it met its obligations to complete an annual review and at a minimum, six-monthly unannounced reviews of the quality and safety of each of its designated centres. The person in charge was aware that the first six-monthly unannounced review of this centre was planned and imminent; the assistant director of services confirmed this.

In the interim the inspector found that there were other effective systems for monitoring and assuring the quality and safety of the service and supports provided to each resident. For example the inspector found that each accident and incident and its management was reviewed in a timely manner by the person in charge with corrective action taken if necessary to prevent a re-occurrence. The person in charge and staff spoken with confirmed that probationary reviews and formal staff supervisions were completed; regular staff meetings were scheduled in each house. There was an internal programme for auditing areas of practice such as medicines management, hand hygiene and food safety; again the inspector saw that the person in charge formulated an action plan if it was required.

Complaints were acknowledged and listened to. The actions taken in response, the reassurance provided and complainant satisfaction were clearly recorded. Two complaints had been received and satisfactorily resolved.

<table>
<thead>
<tr>
<th>Regulation 14: Persons in charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.</td>
</tr>
<tr>
<td>Judgment: Compliant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 15: Staffing</th>
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</thead>
<tbody>
<tr>
<td>Staffing levels and arrangements were appropriate to the assessed needs of the residents. Residents received continuity of care and supports from a team of regular staff.</td>
</tr>
<tr>
<td>Judgment: Compliant</td>
</tr>
</tbody>
</table>

| Regulation 16: Training and staff development |
Education and training for staff in the management of insulin dependent diabetes was required.

Judgment: Substantially compliant

**Regulation 21: Records**

The inspector found that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. Requested records were made available; the required information was retrieved from the records with ease; the records were well maintained.

Judgment: Compliant

**Regulation 23: Governance and management**

The centre was effectively and consistently governed and resourced so as to ensure and assure the delivery of safe, quality supports and services to residents. The first unannounced provider review was due to be completed; in the interim the provider had other systems of review and utilized the findings of reviews to inform and improve the safety and quality of the service.

Judgment: Compliant

**Regulation 24: Admissions and contract for the provision of services**

Contracts were in place that set out the provision of respite services, the support, care and welfare of the resident in the centre and the applicable fee.

Judgment: Compliant

**Regulation 31: Notification of incidents**

Based on the records seen in the designated centre there were effective arrangements for reviewing incidents and accidents and ensuring that the prescribed
Notifications were submitted to HIQA.

**Judgment:** Compliant

**Regulation 32: Notification of periods when the person in charge is absent**

The provider was aware of its responsibility to notify HIQA (Health Information and Quality Authority) of absence of the person in charge where that absence was of a continuous period of 28 days or more. The person in charge confirmed that there had been no such absence since her appointment.

**Judgment:** Compliant

**Regulation 34: Complaints procedure**

The provider had effective procedures for the receipt, management and review of complaints. How to complain and who to complain to was prominently displayed. A record of complaints received and their resolution was maintained.

**Judgment:** Compliant

**Quality and safety**

Areas for improvement were identified but overall the inspector found that residents currently accessing the centre were provided with safe, quality support and services that met their individual needs.

For residents accepted for admission the provider had arrangements for assessing resident's needs and preparing a plan of support. An assessment tool had been developed and information was sought prior to admission from families and other services such as the day service. Based on the information provided, the person in charge prepared a plan of support. The sample of plans reviewed by the inspector reflected the information received and provided good and sufficient guidance for staff on how to support resident’s needs. Staff spoken with had good knowledge of residents and described how that knowledge increased with each period of respite. However, procedures that were compliant with regulatory requirements for assessing needs and preparing a plan of support were not in place for all proposed admissions. This if not addressed had the potential to impact on access and equity of access. The details of this finding and the action required were discussed in detail.
with the person in charge and the assistant director of services.

There was evidence of good communication practice to support effective communication particularly where verbal communication was absent or limited; for example staff used pictorial systems of communication, a visual schedule and social stories (a learning tool that describes a social situation and how to respond to it).

The individualised nature of the service was informed by the assessments mentioned above but also by the meeting held between staff and each group of residents on admission. Records of these meetings indicated that residents were asked what meals they would like to have, what they would like to do and if there was something in particular that they wished to do during their respite stay. Staff confirmed that adequate transport was available and staffing levels facilitated choice, for example if some residents wished to remain in the house while the others wished to go out. Financial receipts seen corresponded to the activities requested by residents. Staff also however endeavoured to maintain established routines so that there was continuity of care between home and the centre, for example in relation to night-time routines.

The person in charge described measures for protecting residents from harm and abuse. These measures included training for staff, reporting procedures, ready access to the designated safeguarding officer and supervision of practice; the person in charge worked shifts that corresponded to times when both staff and residents were in the houses. How to stay safe and how to make a complaint were discussed with residents and easy-to-read information was available in each bedroom. The compatibility of residents needs was considered when planning respite; this reduced the risk for negative peer to peer incidents.

Resident safety was promoted by effective risk management practice but the inspector did find that the scope of the risk register required expansion. The approach to risk management was individualised and the person in charge maintained a comprehensive and extensive suite of resident specific risk assessments and the controls required to promote resident safety. There was evidence that incidents led to timely review, further risk assessment or additional controls. However, there were limited environmental or work-related risk assessments. Based on these inspection findings there were areas that required the support of a risk assessment to identify the level of risk, the adequacy of the controls in place or if additional controls were required to promote staff and resident safety. For example there were times when residents were not supervised if two staff were required to attend to other residents needs; there had been a recent needle-stick injury (managed appropriately). The size and overall security of the site was also an area that required review in relation to maximising resident safety particularly in relation to managing the risk of and the risk posed to residents leaving the centre and the site without staff knowledge. The site was large; the main gate was a distance from the house and required manual operation by staff.

Overall the provider had effective systems to protect residents and staff in the event of fire. The premises was equipped with a high standard of protective measures
such as fire resistant door-sets with self-closing devices and an integrated fire
detection system. Certificates were available confirming that fire safety measures
were inspected and tested at the prescribed intervals. Fire safety and the fire
evacuation procedures were discussed with residents on admission and regular
simulated drills were undertaken to maximise resident participation due to the
respite nature of the service. The person in charge discussed the measures that
were being taken to promote effective evacuation where a resident was reluctant or
choose not to evacuate. Staff utilised pictorial cues and social stories; a challenge
for staff was the infrequency of respite visits. Overall good evacuation times were
achieved during the simulated drills.

Since the last inspection the person in charge had implemented centre specific
medicines management procedures; the objective of these procedures was to
ensure that medicines management practice was safe and protected both resident
well-being and staff practice. A record was maintained of medicines management
incidents and these reflected staff vigilance in relation to the implementation of
these procedures; for example the accuracy of the prescription and medicines
supplied on each admission. The medicines in stock were seen to be supplied
as stipulated by the medicines management procedure.

**Regulation 10: Communication**

There was evidence of a broad understanding and a multi-faceted approach to
communication. Staff and residents used assistive tools to support effective
communication. Residents and their families were consulted with.

Judgment: Compliant

**Regulation 26: Risk management procedures**

The scope of the risk register required expansion. There were further areas that
required the support of a risk assessment to identify the level of risk, the adequacy
of the controls in place or if additional controls were required to promote staff and
resident safety.

The size and overall security of the site was an area that required review in relation
to maximising resident safety.

Judgment: Substantially compliant

**Regulation 28: Fire precautions**
The provider ensured that there were effective fire safety management systems in place including arrangements for the safe evacuation of residents. Where a challenge had arisen, staff in the day service were using tools such as pictorial cues and social stories to maximise resident understanding and co-operation with the evacuation procedures in preparation for the next respite admission.

**Judgment:** Compliant

### Regulation 29: Medicines and pharmaceutical services

The provider had medicines management policies and procedures that informed practice; staff had completed the relevant training. Based on the records seen on inspection staff adhered to the procedures for the safe management of medicines. Records were kept to account for the management of medicines including their receipt, administration and disposal. The provider was in the process of reviewing its policy on self-administration of medicines by residents. The person in charge confirmed that suitable residents had been identified and self-administration of medicines would be facilitated once there was policy to support practice.

**Judgment:** Compliant

### Regulation 5: Individual assessment and personal plan

Suitable arrangements for the completion of a comprehensive assessment and the preparation of a personal plan were not in place for some proposed admissions.

**Judgment:** Substantially compliant

### Regulation 6: Health care

Prior to admission and on each subsequent admission information was sought and obtained on residents general health and well-being; a plan of care was in place as necessary. For example the inspector saw plans guiding personal care, diet and nutrition and mobility. Medical review was facilitated if required during the period of respite.

**Judgment:** Compliant
**Regulation 7: Positive behavioural support**

Staff practice was guided by plans that detailed how behaviour presented, what the resident was expressing through these behaviours, how staff should respond and actions that may inadvertently trigger behaviours. There was no reported peer to peer issues that impacted on the quality of the respite experience in this house. Compatibility of needs was considered prior to admission and provision was made in the other house for supporting behaviours that may be challenging or of risk to others. This was reflected in the statement of purpose and function.

A log was maintained of the use of potentially restrictive practices such as restricted access to sharp items or the administration of PRN (as required) medicines. The practice described to the inspector and the review of the log reflected the principle of the least restrictive procedure for the shortest duration possible.

Judgment: Compliant

**Regulation 8: Protection**

There are policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Staff described the person in charge as approachable and supportive; staff could raise any concerns they had about the quality and safety of the care and support provided.

Judgment: Compliant

**Regulation 9: Residents' rights**

Residents were supported to safely exercise independence, choice and control in their daily routine while in the centre. There was an individualised approach to establishing and facilitating resident choice and preference. Staff were aware of and respected resident capacity to make decisions about their stay.

Judgment: Compliant
### Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 24: Admissions and contract for the provision of services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Compliant</td>
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<tr>
<td>Regulation 32: Notification of periods when the person in charge is absent</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 10: Communication</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
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</table>
Compliance Plan for Listowel Respite Services
OSV-0005683

Inspection ID: MON-0021524

Date of inspection: 18/09/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action within a reasonable timeframe to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be SMART in nature. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

A schedule for supervision of staff is completed. Regular staff meetings are scheduled for the designated Centre and regulations and standards are part of the agenda. Training in the management of insulin dependent diabetes has been sourced & a date has been scheduled for December 2018.

| Regulation 26: Risk management procedures  | Substantially Compliant        |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Ensure all incidents that occur are risk assessed appropriately. Both as a specific individualised risk and centre specific risk which include appropriate controls and actions. All risk assessments will be monitored and reviewed as appropriate by the PIC. The PIC will ensure that all Transport is road worthy and have systems in place to support this.

| Regulation 5: Individual assessment and personal plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

All assessment of need are completed on admission to the designated Centre and individual care plans are completed with all stakeholders. New procedures for admission of individuals to respite service has been developed in conjunction with senior management.
Section 2: Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>10/11/2018</td>
</tr>
<tr>
<td>Regulation 05(1)(a)</td>
<td>The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2018</td>
</tr>
<tr>
<td>Regulation 05(4)(a)</td>
<td>The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident’s needs, as assessed in accordance with paragraph (1).</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/11/2018</td>
</tr>
</tbody>
</table>