Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Broadleas
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	08 February 2018
Centre ID:	OSV-0001983
Fieldwork ID:	MON-0021211

About the designated centre

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

Broadleas provides residential short breaks (respite) to adults with an intellectual disability. The ethos of Broadleas is to provide a 'home from home' while on a short break. The centre is located in Co. Kildare and is a dormer bungalow located in a rural setting. There are four bedrooms for the use by residents and two bedrooms for the use of staff. There is also two sitting rooms and a kitchen for use by residents. There is ample external grounds for residents to access throughout the year. Broadleas can provide a short break to 4 adults at any one time. Residents are supported by a minimum of two staff at any one time. Individuals staying in Broadleas for a short break may have a broad spectrum of support needs which range from requiring minimum support with daily activities/personal care to those requiring a high level of support with daily activities and personal/intimate care.

The following information outlines some additional data of this centre.

Current registration end date:	27/11/2018
Number of residents on the date of inspection:	4

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 and information submitted by the provider or person in charge 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 to 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 summarize our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions:

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:

Date	Times of Inspection	Inspector	Role
08 February 2018	16:00hrs to 20:30hrs	Jillian Connolly	Lead

Views of people who use the service

Residents were observed to be comfortable in the centre. The residents the inspector spoke with expressed that they were happy with the service provided to them and that they felt safe. They were familiar with the staff supporting them and said that they staff were good to them. Residents viewed the centre as a holiday experience in which they could spend their time as they wished.

Capacity and capability

The provider had established clear and effective governance and management systems for the oversight of the care and support provided to residents. This included a clear governance structure in which the person in charge was the front line manager of the centre and held the responsibilities for the day to day operation of the centre. They reported to the operations manager who held the responsibility for two designated centres and other services which do not fall within the remit of regulation.

The practices of the centre were governed by policies and procedures which outlined roles and responsibilities in areas such as risk management, safeguarding and the assessment and planning of individuals needs. Audits also occurred on a regular basis as an assurance mechanism. The provider had conducted unannounced visits and an annual review for the quality and safety of care provided to residents. The findings of each were documented and actions arising compiled in a team plan. It was the responsibility of the person in charge and the operations manager to implement the actions. The inspector found that this review was steering improvements in service delivery for residents.

The management team were also supported by additional departments such as human resources and the quality team. These resources assisted with developing and implementing robust systems to ensure a safe service was provided.

There was also a procedure in place for residents and their family members to make complaints, if needed. Residents were clear on the complaints procedure and told the inspector that they were comfortable telling staff if they were unhappy with the support that they received. The register of complaints demonstrated that complaints were responded to in a timely manner and all efforts were made to resolve a complaint and a positive resolution for the complainant.

Overall the inspector found that these systems promoted a safe and effective service and enabled the provider to identify areas for improvement to ensure that the

service provided was in line with and met the needs of residents.

While the inspector found that appropriate action occurred when an adverse event occurred in the centre, safeguarding concerns had occurred and not been reported to HIQA. The provider stated that this was due to the incidents occurring as a result of behaviours that challenge. However, the inspector found that there had been an impact on other residents in the centre and therefore met the criteria for an allegation or suspicion of abuse and required reporting to HIQA within 3 working days.

As of the day of this inspection, the person in charge had been absent for more than 28 days. The provider had notified HIQA of this as required by the regulations. The provider had ensured that their post was filled during this absence and that there was a person in the post of social care leader. The inspector met with this person during the inspection and found that they had adequate knowledge to ensure continuity of care in the absence of the person in charge.

Staff stated that they were supported within their role by the management team and received supervision regularly. They felt that this was a forum for professional development. The provider also had ensured that staff had received all mandatory training as required by the regulations and provided them with the knowledge and skills to meet the needs of residents accessing the services. On the day of inspection, there were two staff members on duty. Rosters demonstrated that this was the minimum staff members that were on duty at any one time. Residents and staff expressed satisfaction with the staffing levels. The provider had also demonstrated flexibility in adjusting staffing levels based on changes in need of residents.

Regulation 15: Staffing

There was sufficient staff on duty on the day of inspection, rosters demonstrated that this was a consistent practice.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received all of the mandatory training and were appropriately supervised.

Judgment: Compliant

Regulation 23: Governance and management

The provider had established governance and management arrangements in place which promoted a safe and effective service.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The practices in place for the admission of residents were effective and gave due consideration to the compatibility of residents.

Judgment: Compliant

Regulation 31: Notification of incidents

HIQA had not been notified on all allegations and/or suspicions of abuse which had occurred in the designated centre.

Judgment: Not compliant

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

HIQA had been notified that the person in charge was absent.

Judgment: Compliant

Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent

There were appropriate arrangements in place for the absence of the person in charge to ensure continuity of service delivery.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was implemented in practice.

Judgment: Compliant

Quality and safety

The inspector found that the system in place for short term admissions was robust and ensured that the appropriate supports were in place for the duration of an individual stay in the centre. However, improvement was required to ensure that all aspects of the personal plan for longer term residents was reviewed and updated to ensure that the information contained related to the care and support they received in this centre.

The inspector was told by staff and residents that the centre aimed to enable residents to take part in activities that they enjoyed for the duration of their stay. This included going for drives, walks or going shopping. The personal plans in place identified the relevant information to ensure that residents' needs were met for the duration of their stay, such as the medication they received, supports required for intimate care, the food residents enjoyed and any associated risks which may be present. Family members and the day service team provided staff with the relevant information and were contacted prior to each individual stay to ensure that the information remained relevant. Residents were happy with the support that they received and were observed to be comfortable in their environment. The inspector was told that they liked the food and alternatives were available if they did not like the evening meal. The inspector also observed that residents were supported to go to the shop when they requested it or to go for a drive. The information contained in the personal plans was supported by recommendations from allied health professionals, if required.

The admissions process was conducted on quarterly basis by relevant members of the team and took into consideration special requests of residents and/or their families. It also gave, due consideration, to the compatibility of residents. However, on occasion, there had been instances of safeguarding concerns which had arisen in the centre. The inspector found, that the appropriate action was taken once the concern was reported and the procedures of the organisation were followed. Actions included ensuring that some residents would not stay together in the centre. However, the inspector identified one instance in which there was a delay of two days in reporting a safeguarding concern to the relevant members. As a result, there was a delay in initiating the procedures. This was in the process of being addressed as of the day of inspection. The inspector was informed that residents felt safe in the centre and staff present on the day of inspection were aware of what constitutes

an allegation or suspicion of abuse and the process to be followed.

The provider was in the process of developing their risk management system as of the day of inspection. The system was linked with the overall governance and management arrangements of the centre and identified risks associated with the day to day practices of the centre and risks associated with the support to be provided to individual residents. The inspector found that appropriate actions were taken when adverse events were reported.

The risk register of the centre identified pertinent risks such as the risk of a fire. To reduce the risk, the provider had implemented control measures such as a fire alarm, emergency lighting and fire extinguishers, which were serviced at appropriate intervals. Staff had received training in the prevention and response to fire and residents knew the procedure to be followed. Drills were also conducted and consideration was given in the admissions process of the supports residents may require.

Another risk identified was the risk associated with medication management practices. The provider had the appropriate policies and procedures in place to ensure that staff administering medication had received the appropriate training, medication was received and stored appropriately. A control measure in place was for staff to conduct regular stock checks to ensure that the medication in stock was correct in line with what had been received and administered. The inspector confirmed that the checks were accurate. There was also guidance in place for the circumstances in which prn (as required) medication should be administered.

Personal plans also identified the supports residents may require to ensure their healthcare needs were met. Residents had also been supported to attend their general practitioner, if required, during their stay.

Regulation 18: Food and nutrition

The food provided to residents was in line with their wishes. Alternatives were available if residents did not like the meal provided to them. Staff were aware of the individual dietary needs and preferences of residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place which promoted the health and safety of residents, visitors and staff.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had systems in place for the prevention and management of fire to protect residents, staff and visitors.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The medication management practices in the centre promoted that residents received the medication prescribed to them.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Not all aspects of a resident's personal plan had been reviewed within 28 days of their admission.

Judgment: Substantially compliant

Regulation 6: Health care

The health and well being of residents was promoted in the centre.

Judgment: Compliant

Regulation 8: Protection

There was a delay in reporting a safeguarding concern in the designated centre to

the designated officer.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Broadleas OSV-0001983

Inspection ID: MON-0021211

Date of inspection: 08/02/2018

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. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime 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:

Regulation Heading	**Judgment**
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The Person in Charge has revised the procedures for reviewing Safeguarding incidents to ensure timely reporting to HIQA by 12/2/2018.	
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: The Person in Charge has ensured that the planner has reviewed and updated the individual's plan to ensure it is up to date and includes all relevant information by 20/2/2018. The Person in Charge has ensured planner has completed a new assessment of need by 20/02/2018	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Person in Charge has ensured that the Safeguarding Reporting procedures were reviewed with the staff members on duty at time of incident and they were reminded of the importance of the timely reporting of incidents 6/2/2018 . The Person in Charge will ensure that the Safeguarding Reporting procedures were reviewed with the staff team and reminded them of the importance of the timely reporting of incidents 30/4/2018	

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).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Yellow	12/2/2018
Regulation 05(4)(a)	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).	Substantially Compliant	Yellow	20/2/2018
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Yellow	30/4/2018