

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Drombanna
Centre ID:	OSV-0002652
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Lead inspector:	Mary Moore
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 02 November 2017 09:00 To: 02 November 2017 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This inspection was the fourth inspection of this centre by The Health Information and Quality Authority (HIQA). The first inspection was undertaken in September 2014; the last inspection was on 31 May and 1 June 2017. This current inspection was undertaken to establish the progress the provider had made in addressing the failings identified so as to inform a decision in relation to the registration of the centre.

How we gathered our evidence;

Prior to the inspection inspectors reviewed the information held by HIQA in relation to this service. This included the previous inspection findings and the provider's response to the action plan, and, any notifications submitted of adverse events and incidents that had occurred in the centre since the last inspection.

The inspection was facilitated by the person in charge and the team leader; inspectors also met with frontline staff on duty. The integrated services manager came to the centre to meet with inspectors and also attended verbal feedback on the inspection findings at the conclusion of the inspection.

Inspectors reviewed and discussed with staff records including resident and staff related records, fire, and health and safety related records, records of any complaints received and records of accidents, incidents and adverse events that had occurred in the designated centre since the last inspection.

The centre was home to five residents. Inspectors met with all five residents but engagement with residents was led by them, their needs and choices. Residents primarily engaged through observation, gesture and facial expression; residents shared with inspectors their preferred activities and sources of engagement.

Description of the service;

The centre consisted of a domestic style two storey premises in a small housing development on the outskirts of the city. Transport was provided and staff supported residents to access their day service and other amenities. Residential services were provided to a maximum of five residents, both male and female, with high support needs.

Overall judgment of our findings;

Overall the inspection findings were not satisfactory. Residents did not live compatibly with each other; this impacted on the safety and quality of life of residents living in the centre. The governance arrangements of the centre did not ensure that the provider adequately met its regulatory responsibilities or its own short and long-term objectives for the centre.

At the time of the last HIQA inspection the inspector concluded that some residents by virtue of their individual needs did not live compatibly with each other. This had resulted in safeguarding issues, restrictive practice and restriction of resident's routines and choices. This matter was fully accepted by the provider who has both a short-term and long-term plan to reduce the occupancy of the centre and provide residents with accommodation and supports suited to their needs. However, the matter was not resolved and while the provider had taken measures to safeguard residents ultimately resident's needs were not compatible. The design and layout of the environment limited the effect of behaviour management strategies and the provider's ability to ensure that residents were protected from harm and abuse at all times. While there was some improvement since June 2017, peer-to-peer physical interaction incidents continued in the centre.

The provider had a definitive management team in place and had devised an improvement plan for the centre; inspectors were advised that the implementation of the improvement plan was complete. However, these inspection findings did not support satisfactory improvement in the level of regulatory compliance achieved in the centre. While the occupancy and incompatibility of residents needs impacted on the compliance evidenced it was also evidenced that insufficient oversight also contributed to the non-compliance evidenced.

The provider failed to demonstrate that there were adequate arrangements in place for evacuating all residents in the event of a fire where residents by virtue of their disability did not and may not respond to the requirement to leave the house.

Staff had identified, recorded and reported peer-to-peer safeguarding incidents. However, the review of the incidents log by inspectors indicated that a significant number of safeguarding incidents had not been notified to HIQA.

Failings were identified and improvement was necessary to ensure that medicines management practices were safe and that residents received medicines as prescribed.

Complainant satisfaction at the action taken and outcome of the management of their complaint was not satisfactorily evidenced. The fact that complainants may not have been satisfied at the response to their complaint was reflected in the finding that matters of significance to a complainant had been complained of twice.

The provider had, over the course of three HIQA inspections failed to ensure that the review of each resident's personal plan was multidisciplinary.

Inspectors reviewed ten Outcomes; seven of these 10 Outcomes had also been reviewed at the time of the last inspection. The level of compliance across six Outcomes was static and improved compliance was not evidenced. The evidence to support these judgements is found in the body of the report in each respective Outcome. The regulations breached and the actions required of the provider are detailed in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors were not assured that complaints management procedures were effective. Behaviours of concern impacted negatively on resident choice, privacy, dignity and quality of life.

On reviewing the report of the most recent provider unannounced visit to the centre in September 2017, inspectors noted that an expression of dissatisfaction had been received during the visit from a resident representative. The matters complained of substantially referred to the quality and safety of the supports and services received by residents given the impact of behaviours of concern. The matters complained of were reflected in the action plan of the visit and also formalised into a complaint to be addressed. There was a record of actions taken to resolve to matters complained of. However, on reviewing this record and the records of two further complaints received inspectors noted that complainant satisfaction was not evidenced. The fact that complainants may not have been satisfied at the response to their complaint was reflected in the finding that the matters complained of in September 2017 had previously been brought to the provider's attention as a complaint in March 2017.

At the time of the last inspection the inspector found that resident choice in relation to their routines and activities in the centre was restricted by the incompatibility of residents' needs. This had not been addressed and the plans as submitted to HIQA to address this issue had not materialised within the submitted timeframes. From the record of accidents and incidents reviewed and their own observations inspectors saw that residents did not have unlimited access to the kitchen, residents did not have free

movement and access to the main communal room and kitchen without risk of injury from their peers. The incompatibility of needs not only resulted in restricted choices and freedom of movement but also compromised resident privacy and dignity with resident's bedrooms entered by their peers, mealtimes were disturbed ; there was one recorded incident where a resident's privacy was compromised by a peer while their personal care was being attended to in a bathroom.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Deficits were identified in the process of personal planning with and for residents on inspection in 2016 and May 2017; these deficits have only been partially addressed.

One identified deficit was the failure to ensure that the review of the resident's personal plan, be that annual or more frequently as required, was multidisciplinary. The provider has, subsequent to each inspection committed to the multidisciplinary review of each resident's plan but this action has not been met within the timescales provided.

Inspectors were advised that reviews are now scheduled to commence the week of 13 November 2017.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working

order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The premises was a two-storey domestic type building that was suited to the provision of residential services; it was not however suited to the number and assessed needs of the current cohort of residents. This unsuitability and its impact are addressed in Outcome 8.

Each resident was provided with their own bedroom; rooms were seen to be of a suitable size and included provision for personal storage; bedroom accommodation was provided on both the ground and first floors.

Adequate sanitary facilities were provided. At ground floor level residents had access to a universally accessible bathroom with shower, toilet and wash-hand basin. At first floor level where three residents were accommodated there were two further sanitary facilities one with shower, toilet and wash-hand basin, the other with floor-level bath, toilet and wash-hand basin.

Overall the house was in acceptable condition but some general maintenance was required internally and externally. This was a busy house and there was general evidence of wear and tear particularly the walls and flooring of the main stairwell. The bathrooms presented as bleak and uninviting; there was a missing toilet seat. Externally the gutters were noted to be discoloured and contained vegetation.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

While efforts were being made to promote the health and safety of residents, staff and

visitors in the designated centre, the arrangements in place regarding evacuation did not demonstrate that all residents could be evacuated in the event of a fire.

Actions arising from the previous inspection were followed up where it had been found that no fire drills were carried out with minimum staff or to simulate night-time circumstances. Following that finding, a fire drill was carried out in June 2017 to address this issue with a further day time drill carried out in September. Records of these drills were maintained which included staff names and an evacuation time.

However, the provider failed to demonstrate that there were adequate arrangements in place for evacuating all residents in the event of a fire. On reviewing the record of the June 2017 fire drill, inspectors saw that while staff had recorded an evacuation time, they had failed to evacuate one resident who was recorded as remaining in bed. Inspectors reviewed the personal evacuations plans (PEEP) for all residents and it was noted that all contained a generic direction that if a resident refused to evacuate then staff were to leave the resident in the centre and rely on the presence of fire resistant doors to protect the safety of the resident until emergency services arrived.

Staff members spoken with indicated that they would follow this direction. However when speaking of the resident who had not evacuated during the June 2017 fire drill, staff members also expressed responsibility for resident life and safety and referred to certain prompts which could in their view be used to encourage the resident to evacuate. However these were not referred to in the resident's PEEP nor was there any indication that they had been attempted during the simulated drills.

Inspectors reviewed training records for staff working in the centre and noted that the majority had undergone fire safety training within the previous 12 months. However it was noted that two agency members of staff were not listed as having undergone fire safety training while another member of staff spoken to indicated that they had not participated in a fire drill despite working in the centre for a year. During the previous inspection it had been found that some staff had not received up-to-date fire safety training.

A centre-specific risk register was in place along with risk assessments relating to individual residents. These were noted to have been recently reviewed. However in a risk assessment for one resident, it was noted that the control measures outlined had not been updated to reflect additional measures that had been taken to address the risk in question.

The previous inspection had found that some of the specific risks named in the regulations were not suitably addressed. At this inspection it was found that individual risk assessments had recently been put in place in relation to the risks of self harm and the unexplained absence for all residents. It was also observed that the safety statement for the centre had been updated since the previous inspection.

A system was in place for recording accidents and incidents in the centre. Inspectors saw evidence that adverse incidents were discussed during staff team meetings and there was an organisational quarterly review meeting for such incidents. However, it was noted that some medicines related incidents had not been signed off or risk rated

by the person in charge in line with the system in place. It was also not demonstrated what learning had been achieved following such incidents as indicated by the ongoing incidence of such events. Issues relating to medicines will be discussed in greater detail under Outcome 12.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The needs of all residents living in the designated centre were not compatible; the design and layout of the designated centre did not support the number and the assessed needs of the current cohort of residents. This impacted on staff's ability to support residents in the management of behaviours of concern and to prevent in so far as is reasonably possible, incidents of peer-to-peer physical interactions. This also resulted in a requirement for environmental restrictive practice for the safety of residents.

Over the course of HIQA inspections the cohort of residents living in this designated centre has altered and prior to the inspection of May 2017 there was an increased incidence noted in the notification to HIQA of peer-to-peer physical interactions. It was evidenced at the time of that May 2017 inspection that some resident's needs were not compatible and that this was impacting on the quality and safety of residents lives.

It was evident that the provider accepted this failing and had implemented strategies to reduce the risk of peer-to-peer incidents. The provider also had both a short-term and long-term plan to reduce the occupancy of the centre and to provide some residents with accommodation better suited to their assessed needs. However, it was confirmed to inspectors that the short-term plan had not and would not be implemented within the timeframes indicated to HIQA. An acceptable rationale was provided to inspectors for this.

In the interim inspectors were assured that both residents and staff had access to and support from the behaviour therapist. Each resident had behaviour management guidelines and focussed training had been provided to staff on the implementation of management strategies. Staff continued to explore other management strategies such as a recent speech and language referral and recommendations to support effective communication. Inspectors were advised that staff responded positively to any training and guidance provided; the implementation of the behaviour management guidelines was monitored by the team leader. The busy morning transition time had been identified as a possible trigger to behaviours and additional staff support had been provided in response. Staff had created a separate recreational area for one resident to reduce the risk of peer to peer interactions.

However, while some reduced incidence was reported and evident from behaviour related records reviewed by inspectors, ultimately resident's needs were not compatible; the design and layout of the environment limited the effect of behaviour management strategies and consequently the provider's ability to ensure that residents were protected from harm and abuse. The communal room was the main thoroughfare by which all residents and staff accessed the combined kitchen-dining room; residents accessed the secure garden from the kitchen. The communal room and kitchen were therefore a high risk area for potential and actual peer to peer interactions and had resulted in the introduction of a restrictive practice (double thumb-turn device on the kitchen door) so as to restrict access at times and provide residents with the personal space that they required at mealtimes.

A professional review completed on behalf of the provider clearly concluded that reduced occupancy and alternative accommodation for some residents were required to ensure the safety and quality of life of all residents.

There were policies and procedures for the implementation of planned and unplanned restrictive practices required for the safety of residents and others. Inspectors saw current records of the approval and sanction of planned interventions such as monitors to detect seizure activity, devices to ensure safety while travelling or chemical intervention when therapeutic interventions may not be successful in managing behaviours of concern. However, based on these inspection findings the process for reporting, sanctioning and reviewing unplanned restrictive practices including physical intervention was not sufficiently evidenced to ensure that when implemented they were warranted and were implemented only as a last resort.

Training records reviewed indicated that all staff members had received training in intervention and de-escalation including physical intervention. However it was noted in training records reviewed that one agency staff member was not listed as having undergone any safeguarding training; this is addressed in Outcome 17.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

During the course of the inspection accidents and incidents logs in the centre were reviewed by inspectors. In addition to the safeguarding incidents that had been notified to HIQA, it was observed by inspectors that there were ten further incidents of a safeguarding nature since the previous inspection that had not been notified to HIQA.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Some failings identified at the time of the last inspection had been addressed and the provider had implemented measures aimed at improving the safety of medicines management practice. However, despite these measures further failings were identified and improvement was necessary to ensure that medicines management practices were safe and that residents received medicines as prescribed.

Inspectors were advised that a revised and amended medicines management policy that detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines had been made available. The inspector spoke with staff who demonstrated an understanding of medicines management and adherence to policy and procedure.

Medicines for residents were supplied on an individualised basis by a local community pharmacy. The inspector noted that medicines were stored securely.

Medication prescription and administration records were reviewed. Medication prescription records were current and contained the information required by legislation. Medical authorisation was in place for medicines required to be administered in an altered format; that is, crushed. Discontinued medicines were signed and dated as such by the relevant prescriber. The maximum daily dose of as required medicines (PRN medicines) was stated. Medication administration records identified the medications on the prescription and allowed space for staff to record comments such as withholding or refusing of medications.

The provider had introduced a tool for the weekly audit of medicines practice. Records indicated that the audit did identify deficits such as labelling issues, the non-recording of the opening dates of products requiring use within a specified timeframe and one occasion of the non-recording of medicines administered by staff.

However, issues identified on this inspection and not highlighted by the weekly audit included;

- The use of obliterating fluid on two prescriptions
- The use of medicines identifiers that were not evidenced based and would not support staff to accurately identify and confirm a medicine supplied if required to do so
- A medicines supply error noted by staff but not included in the log of medicines incidents
- Lack of clarity and inconsistency between a prescription for an emergency medicine and the associated plan. There was inconsistency in relation to the dose to be administered, when it was to be administered and the maximum dosage to be administered
- Poor stock control with duplicate supplies of some medicines in stock leading to busy and complex medicines storage areas. For example duplicate supplies of a seizure management medicine were seen and there were seven identical inhalers in one resident's medicines storage area
- The practice by staff in the centre of affixing post-it notes with adhesive tape to medicines supplied that obliterated some of the information including the pharmacy label on the box.

Medication related incidents were identified and reported on an incident form; medication related incidents were reviewed by the team leader. However, the provider's annual review had noted that in the period from October 2016 and March 2017 there were 15 recorded medicine related incidents. Records seen by inspectors indicated that since 3 June 2017 to 1 November 2017 there were 12 recorded medicines related incidents. In particular three of these incidents were the failure by staff on three separate occasions to administer medicines as prescribed to residents; a fourth incident was the administration of the wrong medicine at the wrong time to the wrong resident. Each incident was reviewed and action was taken to ensure the residents wellbeing, for example seeking medical advice. However, the ongoing nature of the incidents did not reflect adequate learning and improved safer medicines management practice as a consequence. The review of these incidents did not satisfactorily explore all possible causal factors for repeat failings such as the systems of stock supply and management referenced above. Following this inspection, the provider advised that it had sought support from the pharmacy to assist in the review of medications management processes.

Judgment: Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A statement of purpose was in place which had been reviewed in the 12 months prior to this inspection; the statement contained most of the information required by the regulations. However, some of this information required updating to reflect the current arrangements in the centre. For example the organisational structure was not accurate, the total staffing complement was not stated in full-time equivalents; the arrangements for dealing with complaints required updating.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was a clear management structure and systems for the monitoring of the quality

and safety of the care, support and services provided to residents. However, these governance systems did not ensure improved regulatory compliance or the consistent delivery of high quality, safe, support and service to residents.

There was evidence that the provider sought to ensure that residents did receive safe, quality supports that were suited to their needs. For example the provider had in 2016 formulated an improvement plan for the service; the provider had a plan to reduce the occupancy of the service; staffing arrangements were adjusted to suit residents needs and regular reviews of medicines management practice had been introduced. However, ultimately satisfactory improvement and an acceptable level of regulatory compliance have not been achieved over the course of three HIQA inspections between May 2016 and November 2017.

Between the inspections of May 2017 and November 2017 compliance has remained both static while also demonstrating increased non-compliance. This pattern of increased non-compliance was also reflected in the provider's own reviews of the service. For example the annual review of May 2017 had concluded that compliance had deteriorated between the May 2016 and May 2017 inspections.

The unannounced provider review of September 2017 had found regular reliance on agency staff to fill vacant posts, deficits in the review and updating of personal plans, limitations on residents' choice and deficits in medicines management practice; 18 individual actions issued from the review. Areas of repeat non-compliance over the course of HIQA inspections have been the multidisciplinary review of the personal plan, behaviours of concern, medicines management practice, restrictive practice, staff training and governance arrangements that ensured and assured the quality and safety of the supports and services delivered to residents. Failings identified by inspection do not support adequate and effective oversight of the quality and safety of the supports and services provided to residents in the centre.

While staff meetings were convened and there was a formal system of staff supervision, it was unclear how staff were effectively supported to exercise their personal and professional responsibility for the quality and safety of the service they were delivering. For example staff spoken with described strategies that may have supported the successful evacuation of residents and factors that may have contributed to medicines incidents. However, these opinions-suggestions had not informed the review of service delivery so as to potentially improve both the quality and safety of the services delivered to residents.

In summary governance arrangements that facilitated the provider to fulfil its regulatory responsibilities and its' objectives for the centre in both the short-term and the long-term were required.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Appropriate levels of staff were provided in the centre; however there were some staff vacancies and ongoing reliance on relief and agency staff to maintain these staffing levels. Gaps were identified in staff training.

Inspectors reviewed the staff rosters since the previous inspection. While there were appropriate staffing numbers in place to meet the needs of residents, there were some staffing vacancies which were being filled by relief and agency staff. While rosters indicated and the team leader confirmed that consideration was given to continuity of staff, these vacancies had persisted over a number of months as shown in the rosters and told to inspectors by the person in charge. The unannounced provider review of September 2017 had also highlighted the regular use of relief and agency staff and the demands that this placed on regular staff in relation to allocated responsibilities; this was also reflected in the minutes of a staff meeting convened in August 2017.

Inspectors were informed that a recruitment process had been completed and some new staff were due to commence work in the centre in the weeks following this inspection.

In relation to staff training, the previous inspection found that some staff had not received up-to-date manual handling training. Training records were reviewed by inspectors and indicated that all staff had received such training. However as highlighted under Outcomes 7 and 8 there were some gaps in relation to fire safety and safeguarding training for some members of staff.

Staff spoken with told inspectors that medicines were administered only by staff with training in this area. Some residents did have a prescribed emergency medicine and staff spoken with again advised that there was always at least one staff on duty suitably qualified to administer this medicine. However, not all of staff working in the centre had completed medicines administration training at the time of inspection. Inspectors were informed by the person in charge that staff members were booked in to receive this training in the weeks following this inspection. However, as discussed under Outcome 12, improvement was required in relation to medicines management practice.

Staff files were reviewed on the previous inspection and so were not reviewed during this inspection. Inspectors were informed that there were no volunteers involved with the centre at the time of the inspection.

Judgment: Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002652
Date of Inspection:	02 November 2017
Date of response:	12 December 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Residents did not have unlimited access to the kitchen, residents did not have free movement and access to the main communal room and kitchen without risk of injury from their peers.

1. Action Required:

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:

- Following a review of restrictive practices with service manager, team leader, regional operations manager and behaviour therapist (06/12/17) the restrictive practice of using a thumb turn lock on the kitchen door has been removed.
- Individual incidents are continually reviewed and Behaviour Support Plans amended where identified triggers can be identified.
- The plan to both reduce number and change the mix of residents by 31/07/2018 and additional staffing from January 2018 will reduce such incidents recurring in future.

Proposed Timescale: 31/07/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Residents needs were incompatible; resident's bedrooms had been entered by their peers, mealtimes were disturbed ; there was one recorded incident where a resident's privacy was compromised by a peer while their personal care was being attended to in a bathroom.

2. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:

- The service acknowledges that the needs of the residents are not compatible and a full reconfiguration plan of a number of services in the region has been developed with a view to facilitating some residents to transition to more suitable placements.
- This plan will be implemented by the end of July 2018.
- As part of this plan the number of residents residing in this service will reduce from 5 to 4.
- Compatibility of residents has been specifically addressed and assured as part of this plan.
- Regular relief and agency staff are currently being used to increase staffing in order to address the immediate safeguarding issues. Additional staffing has been allocated to the centre from January 2018. This is in addition to the additional PPIM that will be allocated to the service in order to ensure support effective governance within the service.

Proposed Timescale: 31/07/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Complainant satisfaction at the management and outcome of their complaint was not evidenced. The fact that complainants may not have been satisfied at the response to their complaint was reflected in the finding that there were repeat matters complained of.

3. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:

- All complaints referred to will be fully reviewed at review meeting to be held on 22/12/17 with the person who raised the complaints. Support plans will be amended as necessary to reflect the outcome of this meeting.

Proposed Timescale: 22/12/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The provider has failed to ensure that the review of the resident's personal plan, be that annual or more frequently as required, was multidisciplinary.

4. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

- All support plans are developed with input from the multidisciplinary team as required. Behaviour support plans are developed in conjunction with the family, behaviour therapist, staff team and psychiatrist. Health plans are developed in conjunction with the relevant health specialist. These specialists are involved in the review process.
- Relevant health specialists external to the organisation are invited to formal annual review meetings but unfortunately they usually decline to attend.
- Going forward each member of the multidisciplinary team will be asked to prepare a report if they are unable to attend annual review meetings.

Proposed Timescale: 22/12/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Some general maintenance was required to the house both internally and externally.

5. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:

- Schedule of works has been drawn up in conjunction with a maintenance company, the works will commence from 01/01/18.
- This company will be contracted to provide ongoing maintenance on a monthly basis to address both statutory and general maintenance requirements.
- Initial work planned is redecoration of 1st floor bathrooms and hallway/stairs. Roof, gutters and paths will be cleaned weather permitting by 28/02/18.

Proposed Timescale: 28/02/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Learning and improved service delivery further to the review of incidents and adverse events was not robustly evidenced.

6. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:

- A new process including documentation has been introduced to ensure recording, investigation and evaluation of all incidents are fully completed in a timely manner.
- This documentation will give an overview of the incident, reporting procedures followed and evaluation summary. Meetings will be held once a month with the Behaviour Therapist to review learning from serious incidents.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

A risk assessment had not been updated to reflect additional control measures put in

place.

7. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

- All risk assessment will be reviewed by year end, this review will ensure reflect additional control measures put in place are documented and implemented in practice.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The arrangements in place regarding evacuation did not demonstrate that all residents could be evacuated in the event of a fire.

8. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

- Personal emergency evacuation plans have been reviewed following consultation with a Fire officer from Limerick Fire Service and are awaiting final approval.
- Revised Plans will discussed with staff teams, this will inform practice going forward.

Proposed Timescale: 05/01/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Two agency staff were not listed as having undergone any fire safety training while another staff member had not participated in any fire drill while working in the centre.

9. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:

- All regular staff have received fire training with refresher training planned for January 2018. All staff have now participated in at least one fire evacuation drill in the past

twelve months (last drill 06/12/17).

- There is an agreement with the agency who provide staff, that the staff provided must have a minimum level of training undertaken. In both cases the staff have not worked in the service since it was identified that they had not received appropriate training.
- The agency has been made aware that staff cannot work in the service without the required training and have agreed to send training records to the service prior to their commencement.

Proposed Timescale: 02/11/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The process for reporting, sanctioning and reviewing unplanned restrictive practices including physical intervention was not sufficiently evidenced.

10. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

- All restrictive practices were reviewed on 05/12/17. At team meeting held on 06/12/17 procedure regarding reporting of restrictive practices including appropriate timescales was reviewed.
- All unplanned restrictive practices will be formally reviewed within 10 working days of being reported.

Proposed Timescale: 06/12/2017

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The needs of all residents living in the designated centre were not compatible; the design and layout of the designated centre did not support the number and the assessed needs of the current cohort of residents. This impacted on staff's ability to support residents in the management of behaviours of concern and to prevent in so far as is reasonably possible, incidents of peer-to-peer physical interactions

11. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

- The service acknowledges that the needs of the residents are not compatible and a full reconfiguration plan of a number of services in the region has been developed with a view to facilitating some residents to transition to suitable placements.
- This plan will be implemented by the end of July 2018.
- As part of this plan the number of residents residing in this service will reduce from 5 to 4.
- Compatibility of residents has been specifically addressed and assured as part of this plan.
- Regular relief and agency staff are currently being used to increase staffing in order to address the immediate safeguarding issues. Additional staffing has been allocated to the centre from January 2018. This is in addition to the additional PPIM that will be allocated to the service in order to ensure support effective governance within the service.

Proposed Timescale: 31/07/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

All incidents of a safeguarding nature had not been notified to HIQA.

12. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:

- The process for reporting notifications especially during periods of leave by the PIC has been reviewed and procedures put in place to ensure future compliance.

Proposed Timescale: 30/11/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Failings were identified and improvement was necessary to ensure that medicines management practices were safe and that residents received medicines as prescribed.

13. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and

administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:

- Following this inspection, both an audit from the supplying Pharmacy and an internal medication audit have taken place. All recommendations are currently being addressed including those in respect of ordering, supply and storage of medication.
- RehabCare's new medication policy will be fully implemented from 01/01/18 which includes revised procedures. All new and refresher training will be in accordance with the new policy.

Proposed Timescale: 01/01/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Some of the information in the statement of purpose required updating to accurately reflect the current arrangements in the centre.

14. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

- Statement of purpose and function has been reviewed and all required amendments have been made.

Proposed Timescale: 30/11/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Governance systems did not ensure improved regulatory compliance or the consistent delivery of high quality, safe, support and service to residents. Failings identified by inspection do not support adequate and effective oversight of the quality and safety of the supports and services provided to residents in the centre.

15. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in

the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

- Senior management have reviewed the governance systems in place and additional PPIM support will be provided from 04/01/2018 to ensure compliance with the regulations.
- A full review of governance arrangements is being conducted throughout the region, the outcomes of this review will ensure effective oversight of the quality and safety of the supports and services provided to the residents in the centre.

Proposed Timescale: 31/03/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

While staff meetings were convened and there was a formal system of staff supervision, it was unclear how staff were effectively supported to exercise their personal and professional responsibility for the quality and safety of the service they were delivering.

16. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:

- Personal and professional responsibility for the quality and safety of the service staff are delivering is now an agenda item on both supervision sessions and team meetings.
- The PIC is participating in a training review of residential services within the region and will recommend that quality and safety be covered as a training objective.

Proposed Timescale: 28/02/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

There were some staff vacancies in the centre which had persisted over a number of months.

17. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

- There has been an ongoing recruitment drive during 2017 where a substantial number of vacancies have been filled. This recruitment drive will continue until all vacancies have been filled.
- Vacancies will be re-advertised and interviews will take place in the early 2018.
- Until these vacancies are filled, the centre will continue to use the same agency or relief staff to maintain as much consistency in service delivery as possible.

Proposed Timescale: 28/02/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Gaps were identified in staff attendance at training for safeguarding, fire safety and medicines management.

18. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

- All staff have received safeguarding and fire safety training and training records have been updated to reflect this.
- There are some staff awaiting medication training and until such time as it is completed along with two medication assessments, the staff will not participate in any administration of medication.
- Medication training is planned to take place within the first two months of 2018.

Proposed Timescale: 28/02/2018