



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

Name of designated centre:	Drombanna
Name of provider:	RehabCare
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	30 July 2018
Centre ID:	OSV-0002652
Fieldwork ID:	MON-0021513

## About the designated centre

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

The centre consists of a domestic style two storey detached premises in a small housing development on the outskirts of the city; transport is provided. Residential services are provided on a full-time basis to a maximum of five residents, both male and female. At the time of this inspection there were five male residents living in the centre, two of whom had recently transferred from another designated centre. Residents assessed needs are high and at times require one-to-one staff support. All residents have access to structured day services Monday to Friday; since January 2018 all of these day services are provided off-site. Residents are supported at all times by a team of social care staff. The provider has indicated its intent to reduce the capacity of the service to a maximum of four residents.

**The following information outlines some additional data on this centre.**

Current registration end date:	31/10/2018
Number of residents on the date of inspection:	5

## 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:**

Date	Times of Inspection	Inspector	Role
30 July 2018	09:15hrs to 16:45hrs	Mary Moore	Lead

## Views of people who use the service

All five residents living in this centre attend off-site day services; the inspector met briefly with residents prior to their departure in the morning. Residents engage through gesture, facial expression and some limited verbal communication. The inspector saw that the house was busy but relaxed as staff and residents prepared to leave the centre. Residents smiled or gestured a welcome but continued with their routine which is of importance to them in the context of their assessed needs. The inspector noted easy engagement between staff and residents.

## Capacity and capability

Overall the inspector found that the provider had implemented its remedial action plan within the timeframe committed to. This was a significant plan that involved the reconfiguration of three designated centres including the establishment of a new designated centre and the transfer of residents between centres based on their assessed needs. These actions had been identified by the provider as necessary to address non-compliance with the regulations and quality and safety issues that had arisen due to resident needs that were not compatible. These changes were recent but the inspector was satisfied that the desired objective would be met in relation to the appropriateness, safety and quality of the service provided for residents. However, the inspector also found that further action was necessary to ensure effective and consistent oversight of the service on an ongoing basis.

There had been inconsistency in the governance structures of this centre and further changes had occurred since the last inspection in line with the reconfiguration of centres. The management team consisted of the team leader, an additional interim team leader, the person in charge and the integrated services manager. While the team was new, each person participating in the management of the service was familiar with the residents and had worked successfully with each other prior to and during the reconfiguration process; this provided assurance regarding the effectiveness of the governance systems. The person in charge was currently responsible for two designated centres but this was shortly due to reduce to this centre only; this provided further reassurance. All persons participating in the management of the centre were clear on their respective roles, responsibilities and reporting relationships and articulated commitment to providing residents with a safe, quality service that was appropriate to their needs.

The provider had also established procedures that supported quality and safety such as the monthly review of incidents. Each individual incident and its management was reviewed; good practice and areas where improvement was required were identified

and fed back to management and staff.

The provider had completed a further unannounced provider review since the last HIQA (Health Information and Quality Authority) inspection (March 2018) and a medicines management specific audit.

With the reconfiguration of the centres the provider had established a core staff team that were familiar with residents' needs. There was still some reduced requirement for relief staff but these were sourced for the providers own staffing resources. Adjustments had been made to the rota to ensure that staff coming on duty had time to receive a handover prior to residents returning to the centre in the evening.

However, while acknowledging the significant body of work completed and the positive impact that this had on residents quality of life, the inspector concluded that further action was required of the provider to ensure that there were governance arrangements in the designated centre that ensured and assured the consistent provision of safe, quality support and services to residents. For example 14 actions issued from the internal provider audit of May 2018 ; one action was the development of one comprehensive service action plan with progress of actions monitored by operational management personnel; this was not in place and it did not provide for good oversight of areas where improvements were still needed.

There were reported recent alleged breaches by staff that if upheld compromised both quality and safety issues; these breaches while reported and managed reinforced the requirement for consistent supervision of practice. There was evidence on inspection of a practice that was not in line with the provider's own policies and procedures and was not appropriately supported by risk assessment and protocol. The provider had given a commitment that there would be a management presence on site each day to ensure direction and supervision of practice on a daily basis; the inspector was advised that this had lapsed in the two weeks prior to this inspection.

#### Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre.

Judgment: Compliant

#### Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs of the residents. The reconfiguration of a group of designated centres had supported the establishment of a team of regular, experienced staff that were familiar with residents and their needs.

Judgment: Compliant

### Regulation 21: Records

The inspector found improved records management. The required records were retrieved for the inspector with ease; the required information was retrieved from the records with ease; the records were well maintained.

Judgment: Compliant

### Regulation 23: Governance and management

The actions taken by the provider in response to previous regulatory breaches and the positive impact of this was evidenced and acknowledged. However, based on these inspection findings and in the context of the history of regulatory non-compliance, further action was required of the provider to ensure and assure the consistent delivery and oversight of safe, quality support and services to residents.

Judgment: Not compliant

### Regulation 31: Notification of incidents

Based on the incident records seen by the inspector the person in charge fulfilled her legal responsibility to submit prescribed notifications to HIQA, for example an injury requiring medical attention and the use of any restrictive practice.

Judgment: Compliant

### Regulation 34: Complaints procedure

The inspector found improved practice in relation to the management of complaints.

The log of complaints received (three since the last inspection) detailed the complaint, the action taken to resolve the matter, the feedback provided to the complainant and their satisfaction.

Judgment: Compliant

## Quality and safety

Previous HIQA inspection findings and the providers own reviews had established that residents needs were not compatible and that the design and layout of the premises limited the effect of behaviour management strategies; this resulted in a consistent pattern of peer to peer incidents that impacted negatively on the quality and safety of the service. The provider had implemented its plan to address this and while the changes were relatively recent, overall the evidence was that the desired outcome of improved quality and safety would be achieved.

The inspector found that while five residents still lived in the centre this was a different cohort of residents whose needs and the compatibility of those needs had both been assessed prior to transition. While each resident presented with individual needs that required support, they were a compatible group known to each other in the day service with no reported pattern of negative peer to peer interaction.

The inspector reviewed a compatibility assessment completed by the behaviour therapist that clearly set out each resident's requirements and the arrangements required to maximise compatibility and reduce the possibility of peer to peer incidents. Overall the inspector was satisfied that the arrangements were in place in the designated centre to meet these requirements, for example exclusive access to a recreational space and exclusive access to a quiet space if required. This helped ensure a quiet calm environment. The provider confirmed however that it still intended to proceed to reduce the occupancy of the centre so as to maximise the capacity to best meet residents' needs. Staff reported that since admission residents had respected each other's personal space and shared without difficulty the communal and dining spaces if they choose to do so.

The inspector saw that discharge from and admission to the designated centre in addition to the compatibility review was supported by detailed transition plans informed by residents' needs and consultation with families and the behaviour therapist. To maximise resident participation in the transition process communication tools such as social stories had been developed.

The person in charge confirmed that the behaviour therapist provided active and consistent input into the service and into each resident's behaviour management guidelines to ensure that behaviour management strategies were evidenced based and person centred and that both staff interactions and responses were in line with the guidelines. There was clarity on approved restrictive practices and a reported reduction in restrictive practices such as the unplanned locking of doors and



restricted access to the communal and dining room to prevent injury from peer to peer as they were no longer required.

All staff had completed safeguarding training and additional refresher training had been provided to staff in May 2018. Evidence was made available to the inspector that staff did report to management concerns they had in relation to resident safety; the provider had taken action to ensure that residents were protected.

Further to previous concerning findings in relation to the incidence of medicine errors additional controls had been implemented including better stock management and a pre and post administration stock balance count for one specific medicine. The inspector reviewed the records of medicines management incidents and found that there was a reduced incidence of staff related administration errors. However it was of concern to the inspector to find that staff had transcribed medicine prescriptions ( transferring a medication order from the prescriber's prescription to a medication administration record/prescription sheet). This was done in the absence of provider policy and procedure sanctioning this practice and stipulating the safeguards required in order to minimise the risk of error. Best practice would indicate that the responsibility for generating the prescription was with the medical practitioner or the registered prescriber; this was the principle underpinning the provider's medicines management policy dated March 2017 and as reflected in other records such as the provider's report of the medicines audit completed in May 2018.

The provider had put arrangements in place to ensure that residents could be evacuated from the centre in the event of fire where residents were reluctant to evacuate. Staff were familiar with residents personal emergency evacuation plans, tested their adequacy during simulated evacuation drills and reported their use and effectiveness.

### Regulation 25: Temporary absence, transition and discharge of residents

The inspector saw that the transition of residents between services was supported by detailed plans of transition that relevant stakeholders were consulted about and had inputted into. The provider considered the needs and best interest of all residents and the requirement to protect residents from harm including abuse from their peers.

Judgment: Compliant

### Regulation 26: Risk management procedures

The person in charge had reviewed and updated risk assessments to reflect the

changes that had occurred in the designated centre. The provider had implemented a structured regular process for the review of accidents and incidents; where learning was identified the person in charge confirmed that this was fed back to staff.

Judgment: Compliant

### Regulation 28: Fire precautions

The provider had put arrangements in place to ensure that residents, in particular those that were reluctant to evacuate, could be evacuated in the event of fire or other such emergency.

Judgment: Compliant

### Regulation 29: Medicines and pharmaceutical services

There was evidence of transcribing practice that was not supported by policy and procedure that sanctioned this practice and stipulated the required systems to minimise the risk of error.

Judgment: Not compliant

### Regulation 7: Positive behavioural support

Residents required support to prevent and manage behaviours of concern or risk. Plans that detailed how therapeutic and reactive interventions were implemented were there to guide staff practice; the plan was tailored to individual needs and informed by input from the behaviour therapist. The review of incidents monitored adherence to and the effectiveness of behaviour management guidelines.

There was a reduction in the level of restrictive practice used to manage or in response to behaviours.

Judgment: Compliant

## Regulation 8: Protection

There are policies and supporting procedures for ensuring that residents were protected from all forms of abuse. The inspector was advised that there was clarity on reporting procedures, for example where staff were employed on a relief basis. There was evidence that staff did exercise their responsibility to report any concerns they had and that the provider did take action to protect residents from harm. The provider had also reduced the risk of abuse by peers in the centre and observed its responsibility to protect residents from peer to peer abuse when transitioning residents between centres.

Judgment: Compliant

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

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Drombanna OSV-0002652

Inspection ID: MON-0021513

Date of inspection: 30/07/2018

## 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 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p><b>Background</b></p> <p>There is an operational line management structure in place to oversee the management of the service, this structure supports service delivery from local level to national level across the organization. The organization is committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service. The Quality and Governance Directorate with subject matter experts are actively supporting the service on an ongoing basis in terms of risk management, medication, safeguarding etc.</p> <p><b>Actions</b></p> <ul style="list-style-type: none"> <li>• The service now has a full time PIC. A full time Team Leader supports the PIC with supervision of staff team and service delivery. A Care worker has been assigned additional responsibilities to support PIC and Team Leader. This arrangement has been effective 12/08/2018. RehabCare behavior therapist will work closely with the staff team to ensure the implementation of all recommendations for forward planning. Monthly meetings will be held between PPIM and PIC.</li> <li>• Formal supervisions will be held in line with company policy, these can be more frequent if required/requested. This will be fully operational by 30/09/2018.</li> <li>• PIC developed a comprehensive service action plan to monitor progress of actions from previous internal and external audits. This action plan will be completed by 31/12/2018.</li> <li>• Annual service review was completed by ISM on the 17/07/2018. Actions to be completed by 31/12/2018.</li> <li>• Team Leader and Manager will be carrying out weekly and monthly audits. Any issues will be discussed at monthly Team meetings and supervisions and action plans will be developed with timeframes and person responsible if necessary. These audits commenced 01/09/2018.</li> </ul>	

Regulation 29: Medicines and pharmaceutical services	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <p><b>Background</b></p> <ul style="list-style-type: none"> <li>• The organisation's Medication Management Policy governs the management and administration of medication within services. The policy has been developed and is regularly reviewed to ensure it is in line with international best practice. Within the policy there is guidance on the completion of regular medication audits at service level.</li> <li>• All incidents and near misses are reported and monitored on the organisation's incident management system. The PIC monitors incidents and ensures corrective actions are taken. These incidents are reviewed at team meetings in order to share learning amongst the staff team.</li> <li>• Within the Quality and Governance Directorate responsibility for developing the organisation's medication policies and procedures in line with best practice is led by the Quality and Practice Officer, who holds a nursing qualification. The Quality and Practice Officer is available to support the service to ensure the policy is implemented effectively at local level.</li> </ul> <p><b>Actions</b></p> <p>Going forward the following actions will be implemented to ensure the organizational policy on safe administration of medication is complied with:</p> <ul style="list-style-type: none"> <li>• Internal medication audit took place on the 01/05/2018. All recommendations have been implemented. Completion date 03/08/2018.</li> <li>• Use of labels on all DARs to ensure there is no transcribing practice. This was completed on 01/08/2018.</li> <li>• Team Leader/PIC to complete weekly audit to ensure full adherence to policy.</li> </ul>	

## 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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as	Not Compliant	Orange	03/08/2018



	prescribed to the resident for whom it is prescribed and to no other resident.			
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