

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Killarney Residential Services
Centre ID:	OSV-0003428
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Kerry Parents and Friends Association
Lead inspector:	Mary Moore
Support inspector(s):	Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	1

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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 November 2017 09:00	20 November 2017 18:30
21 November 2017 08:30	21 November 2017 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA). The last inspection was undertaken in April 2016 and was the first inspection by HIQA of the service. This current inspection was undertaken to follow-up on the actions that had emanated from that inspection and to monitor on-going regulatory compliance so as to inform a registration decision.

The inspection was facilitated primarily by one of the persons participating in the management of the centre (PPIM). The PPIM had assumed the day-to-day

management of the centre since April 2017 while the person in charge was on planned leave. During the course of the inspection inspectors also met with the assistant director of services and the frontline staff on duty in each house. The assistant director of services also attended verbal feedback at the conclusion of the inspection on behalf of the provider.

How we gathered our evidence:

Prior to the inspection inspectors reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the application for registration of the centre, the previous inspection findings and action plan, all correspondence received in relation to that action plan and any notice received of incidents that had occurred in the centre. In the centre inspectors reviewed records including policies and procedures, fire and health and safety related records, records of complaints received and records pertaining to residents and staff.

There were 16 residents living in the designated centre one of whom was on home leave. As residents attended structured day services inspectors sought over the course of the two days to maximise the opportunities for meeting with residents. Inspectors met with 12 of the 15 residents living in the centre. This engagement with residents was guided by each resident and their choices and needs; the majority of the residents conversed freely with inspectors while others choose to observe and listen but not directly engage.

Inspectors found residents to be relaxed and confident in their engagement with inspectors. Residents invited inspectors to join them in refreshments in their homes and a natural conversation developed about daily routines, favoured staff and activities. For example some residents shared their enjoyment and anticipation of the festive season and their plans for it. Residents spoke of the importance of family and community engagement and how this was supported by staff.

Inspectors noted that residents were comfortable in asserting themselves and communicating in the presence of staff. Residents spoke positively of staff; staff spoke positively of residents and of their ability rather than disability; inspectors' observations of staff and resident interactions were positive.

Description of the service:

The centre comprised four houses located within the general environs of the busy local town and the provider's main day service and administration building. Three houses were in residential areas, the fourth was in a more rural location. Residential and respite services were provided to a maximum of 17 residents.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors found that the service to be provided was as described in that document.

Overall Findings:

Inspectors based on what they saw, read and heard from both residents and staff concluded that the service provided to residents was person-centred based on the assessed needs of each resident. There was consistent evidence of good practice in

the daily support and care provided to residents and improvement was noted on the previous HIQA inspection findings.

At the time of this inspection there was a clear management structure, a culture of, and systems for the review of the quality and safety of the care and services provided to residents. However, the requirement for consistent monitoring and oversight of the effectiveness of the governance arrangements is discussed in Outcome 14.

Residents had daily access to a structured programme of activity and engagement and a good balance was struck between what was facilitated within the provider's own resources and what was accessed in the local community.

Residents had access to regular medical review and staff maintained a high standard of documentation pertaining to residents needs and the care, supports and services provided to them. However, there was evidence that access to services to which residents had a statutory entitlement was not always facilitated by the Health Service Executive Community Services, though the provider had requested access on residents' behalf.

Residents did at times present with behaviours of concern or risk to themselves and others. The provider supported these residents well while acknowledging and managing the impact on their peers. Improvement was required however in ensuring that all residents had a plan for managing behaviours of concern particularly where there was an associated restrictive practice.

Notwithstanding the substantial good practice evidenced, and the commitment to the provision of safe, quality services to residents based on individual needs, failings were identified that impacted on the level of compliance evidenced and ultimately also the quality and safety of the services provided.

These failings included the failure to complete fire safety works, refurbishment of the premises and the provision of suitable premises, governance arrangements and staffing levels that had the capacity to meet residents' changing and increasing needs. The provider has in its engagement with HIQA advised HIQA that the provider does not have the resources to address these failings and has not been able to secure funding from the funding body, the Health Service Executive (HSE) despite having made repeat efforts to secure funding.

Of the eighteen Outcomes inspected the provider was judged to be compliant with ten, in substantial compliance with four and in moderate non-compliance with three. One Outcome Health and Safety and Risk management was judged to be in major non compliance due to the outstanding fire safety works. The findings to support these judgements are discussed in the body 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:

Residents were consulted in relation to the running of the centre and the opportunities for residents to engage in activities and social engagement had improved.

At the time of the last inspection inspectors were concerned at the arrangements in place for the provision of respite; the arrangements did not ensure each resident's privacy and dignity in relation to but not limited to, his or her personal space. The provider had reviewed these arrangements and there was now a specific bedroom designated for respite use in one house. However, there was one residual arrangement in one house specific to two residents. Staff advised that the resident who normally utilised the bedroom had raised no complaints and neither had their representatives who staff advised were aware of the arrangement. While mindful of the challenges described by staff in relation to this particular arrangement, there was no explicit evidence to support the suitability of this arrangement to both residents; an explicit protocol was required in relation to the use of the room outlining how choice, privacy, personal space and belongings and infection prevention and control were all assured.

The procedure for complaints was observed to be on display in each unit of the designated centre. A complaints policy and a complaints officer were in place. However from reviewing this policy and talking with management it was unclear who the registered provider had nominated to ensure that all complaints were responded to appropriately and that a record of all complaints was maintained.

The complaints log that was maintained within the designated centre was reviewed by

inspectors. This log included details of complaints made, actions taken by the provider and whether the complainant was satisfied with the outcome. However during the course of reviewing other records and from speaking to one resident, inspectors became aware of two complaints which were not recorded in the complaints log. Inspectors reviewed the subjects of these complaints and found that the issues raised had been addressed.

Residents were supported to make complaints and consultation with residents was also provided for through resident meetings. Such meetings took place on a weekly basis in each unit of the designated centre. Residents spoken with confirmed that these took place and inspectors reviewed minutes of these meetings. During these meetings issues such as safeguarding, meals, fire safety and activities were discussed.

Since the previous inspection the ability of residents to engage in meaningful activities of their choice had improved. This was helped greatly by the provision of additional transport to the centre. Various activities were referred to in the minutes of resident meetings while residents spoken with indicated that they engaged in activities such as going swimming, shopping trips, going for nature walks and attending mass.

Inspectors saw that residents' spiritual, religious choices and preferences were detailed in their individual plan. Staff supported these choices in line with each resident's overall needs, for example choosing a quiet location in the church near an exit if residents wished to attend mass but disliked large crowds.

Residents were supported to manage their finances and records of any transactions were kept within the designated centre along with corresponding receipts. A sample of such records was reviewed by inspectors. As required by the regulations, a policy in relation to this area was in place. However from reviewing the policy and talking to staff it was apparent that the frequency of review of residents' personal finances was not being carried out as often as required under this policy. This is addressed under Outcome 18.

Judgment:

Substantially Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Staff had assessed each resident's communication ability and needs; in completing the assessments staff applied a broad understanding of communication including comprehension and communication through facial expressions, gestures and manual signing. From the assessment a plan for supporting communication was developed. Inspectors saw supporting communication tools including communication dictionaries, PECS (picture exchange communication systems), visual prompts including a visual staff schedule, a visual menu and the use of social stories. Inspectors saw staff to implement these tools with effect.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

On speaking with residents it was evident that their quality of life and their achievements, their relationship with staff and family and community engagement were extremely important to them. Residents spoke of planned visits home and the relationships they enjoyed with peers and staff. It was clear to the inspector that residents were satisfied that they lived fulfilling lives, enjoyed a strong sense of self and were supported and facilitated by staff to maintain family, personal and community relationships.

For example inspectors saw that residents continued to enjoy visits home supported by their family, staff supported residents to visit more dependent relatives or to visit a family grave where residents had experienced a family bereavement.

As appropriate family were invited to attend and did attend personal plan reviews; there was evidence of ongoing consultation and communication between staff and families in relation to resident well-being and welfare.

As discussed later in Outcome 10 residents were seen to engage in a broad range of activities many of which were based in the local community.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed a sample of contracts for the provision of services which were found to contain the required information such as the services to be provided. In the sample of contracts reviewed it was noted that the contracts were signed by the resident or their representative.

The provider had policies and procedures in place to guide the admissions process. In questionnaires reviewed during the course of the inspection, family members indicated that they had the opportunity to visit the designated centre before their relatives began to live there.

Judgment:

Compliant

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):

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

Findings:

Inspectors saw current comprehensive assessments of residents' needs that clearly identified any area where support was required to maintain resident welfare and well-being. Where a requirement for support was identified the required plan of support was

in place. The support plans seen offered clear and sufficient guidance to staff. The plans were seen to be updated and amended as necessary in line with changing needs, for example further to a professional review. The plans seen were presented in a very person centred manner and maintained to a high standard.

Residents had appointed keyworkers who on speaking with, had sound knowledge of residents and their required supports. Inspectors triangulated specific supports such as dietary requirements and falls prevention strategies and found that these were in place.

The PPIM told inspectors that she monitored the exchange of communication between the residential and day services to ensure that residents received continuity of supports. A sub-committee of the quality and standards committee had also been formed to review how information was transferred between services.

The personal plan incorporated the process for identifying, agreeing and progressing residents personal goals and priorities. The reports of the provider's own reviews indicated that this was an area that required improvement. However, the records seen by inspectors indicated that this process was multidisciplinary in nature, residents and their families attended, agreed goals were recorded as were responsible persons and achievement timeframes. The goals were individual to each resident, their wishes and general development needs. There was evidence of goals achieved and actions taken in relation to goals in progression.

Judgment:

Compliant

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):

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

Findings:

This designated centre consisted of four separate domestic type houses in separate geographical locations. Elements of the design and layout of the premises were not suited to the needs of residents; refurbishment work was required to ensure that the premises were appropriately maintained.

Some works had been completed since the last inspection. For example repairs had

been completed to a chimney and works had been completed to a bathroom to maximise its accessibility for residents. Alterations such as the removal of door saddles to promote accessibility and reduce falls risk had been completed.

However, there was no definitive utility space in one house. The inspector saw laundry equipment including the tumble dryer stored and utilised in the corner of one communal room. The inspector did see a risk assessment where a required control was the removal of the tumble dryer from the kitchen as the noise level was disruptive to residents. The main entrance of this house was not universally accessible and was not ramped. Residents did have an alternative entrance to the rear of the house that they did use but the completion of the ramp based on records seen including risk assessments and reviews by healthcare professionals was an outstanding matter.

Two houses were of earlier construction and both were showing evident signs of age and a requirement for maintenance and upgrade. There were evident areas of damp, defective paintwork, cracks, poor or damaged plasterwork and joinery, and broken floor tiles in one house.

One resident's bedroom was accessed directly off the utility room and this bedroom is referenced again in Outcome 7 in the context of fire safety. Another bedroom in this house (there was a short corridor leading off it and there was an external door from the en-suite), was also routinely accessed through the kitchen and the utility room. Inspectors saw that staff had in June 2017 formally raised their concerns with the provider as to the unsuitability of this bedroom to the resident's needs. Staff had raised concerns in relation to the location of the bedroom, the available space and the unsuitability of the en-suite sanitary facilities. The person in charge had, further to the concerns raised, completed a suite of associated risk assessments for risk of falls, risk of lack of sleep and risk of poor infection prevention and control.

Inspectors saw that the general design, layout and presentation of this section of the house was not of a high standard though staff sought to make the bedroom as comfortable and as suited to the resident's needs as possible. Inspectors saw that the resident spent a considerable amount of time in their bedroom, insufficient space was afforded, the only source of natural light was a ceiling based skylight. Personal storage was provided but there was no space available for a wardrobe. There was no natural ventilation unless the main door or the door to the en-suite (which had a window) was left open.

Otherwise generally residents' bedrooms were well presented, welcoming and personalised.

Judgment:

Non Compliant - Moderate

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:

There were deficits in the provision of fire safety systems across the designated centre.

The provider had carried out a fire safety review for all four houses in April 2016. Various recommendations were made including the upgrading of the fire alarm system, improvements in fire containment and the need for alternations in two units to address concerns with the use of inner rooms as bedrooms. Inspectors were informed at the outset of this inspection that this situation remained unchanged as the provider had requested but failed to secure the funding required to complete the required works. Only two of the four houses were serviced by an automated fire detection system and emergency lighting. The other two houses had limited fire detection coverage by either battery or mains connected detectors. In addition these two houses were not serviced by emergency lighting.

The fire evacuation procedure was on display in all units of the centre while maintenance checks on the fire alarm system, where there was one in place, and fire extinguishers had been carried out by external contractors. However inspectors were not provided with any record of such checks on the emergency lighting that was present in some units of the centre. This was also a failing of the previous inspection.

The effectiveness of fire drills, the evacuation procedures and residents' personal evacuation plans (PEEPs) were highlighted as an area for concern previously by inspectors. During this inspection inspectors found that regular fire drills were taking place in each unit while the evacuation times recorded had reduced and more clarity had been introduced to the evacuation procedures. PEEPs had also been reviewed by an external body in the month before this inspection as requested by staff to ensure the adequacy of the evacuation plan.

Internal staff checks were being carried out on a daily and weekly basis. Staff members spoken with demonstrated a good knowledge of what to do in the event of a fire and the contents of residents' PEEPs. Training records reviewed indicated that all staff members had received training in the areas of fire safety and manual handling.

A risk register was in place which was maintained in an electronic format. This system was also used to record accidents, incidents and near misses. This system was reviewed by inspectors and it was noted that all risk assessments were in date and clearly stated existing control measures and any other actions which were required to address an identified risk. Staff members spoken with were aware of the risks in the centre while risks and adverse incidents were noted to have been discussed during staff team meetings. Inspectors noted good consistency between risk assessments, controls and residents personal plans.

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:

Overall there was good practice in relation to protecting residents from harm and abuse including harm from their peers. However, a review was required of one restrictive practice.

There were measures in place to protect residents from harm and abuse; these included organisational and national safeguarding policies and procedures, designated persons, risk assessments and staff training. The inspector saw that the contact details of relevant persons such as the complaints officer and the designated officer were displayed in each house.

The PPIM said that she was assured as to the safety of the care and supports that residents received as she herself worked frontline duties, she had worked as a peer with many of the staff employed, staff were formally supervised and she called unannounced on a regular basis to each house. The PPIM said that some residents in each house had to capacity to raise concerns with her, staff or the designated officer who they had almost daily contact with in the day service.

Training records indicated that staff had received training in safeguarding and in responding to behaviours of concern including de-escalation and intervention techniques.

Inspectors saw that residents were supported to develop their own safeguarding knowledge and skills. For example safeguarding was discussed at the resident meetings and inspectors saw the use of safeguarding social stories by staff with residents (short simple stories to describe a situation and the appropriate responses to it). Staff recorded how residents demonstrated their understanding of what was discussed.

Residents did at times present with behaviours of concern and risk to themselves and others. The provider supported each resident and staff to understand, prevent and manage these behaviours; guidance strategies were outlined in behaviour management guidelines supported by regular review and input from psychology. Where appropriate, residents also had access to regular support from psychiatry. Staff spoken with had a good understanding of residents, the behaviours and the management guidelines and the importance of consistent implementation.

The provider also acknowledged however, that behaviours also impacted negatively at times on fellow housemates; safeguarding plans were in place as required. Staff spoken with said that knowledge of the triggers for behaviour was very important to preventing incidents as was good supervision. Based on the feedback from staff, records seen on inspection and notifications submitted to HIQA the behaviour management strategies were effective; the views of staff and peers were sought and informed the review of the effectiveness of the management strategies. At the time of this inspection the provider had further plans to modify one environment to further reduce the triggers for such incidents.

There was some limited requirement for practices deemed restrictive for the safety of the resident themselves or others. There was a process for the identification, sanction and review of a restrictive practice. There was a particular environmental restrictive practice, restricted access to the main kitchen of one house; there was a rationale for this practice. However, in the absence of a specific behaviour management plan for the behaviours of concern, it was difficult to be assured that restricted access was the least restrictive procedure that could be applied. Staff did not maintain a record of the frequency or the duration of the restrictive practice.

Judgment:

Substantially Compliant

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:

A system was in place for the recording of any adverse incident within the designated centre while adequate arrangements were in place for the required notifications to be submitted to HIQA.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Having spoken with residents and staff and having reviewed relevant records, inspectors were satisfied that residents had good opportunity to participate in meaningful activity and engagement. This engagement was based on each resident's assessed needs and wishes.

All of the residents attended day service Monday and Friday and their ability to attend and the benefit from it was reviewed in line with residents changing needs. For example some residents who required a slower pace of life or a less challenging environment were facilitated with a programme of engagement from their own house. In the evening and weekends inspectors saw that residents were supported by staff to attend a variety of activities such as dining out, swimming, attending mass, visiting family and various exercise programmes.

There was a theme of learning and development both in resident's personal objectives and in the general routines of the house. For example residents had been supported to successfully complete fire safety training; where a resident had expressed an interest in animal welfare they had completed a programme in farm safety awareness. Residents completed social skills training and supported staff in activities such as the weekly shop.

Residents were supported by staff to enjoy holidays away from the designated centre; feedback on what was enjoyed and not enjoyed by residents was ascertained so as to inform the next holiday.

Residents spoken with described the quality of the service that they received in the local community in particular the individual attention that they received in their favourite restaurants and from the barber.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Based on their observations, staff spoken with and records seen, inspectors were satisfied that the provider had arrangements in place to support and maintain resident health and well-being and overall there was evidence of good care and practice. However, while the provider had sought healthcare services to which residents had a statutory entitlement there was evidence that all of these referrals had not been facilitated.

The assessment of residents' needs included the assessment of their healthcare needs. In addition to this baseline assessment records seen indicated that staff consistently monitored resident well-being and sought medical advice and review from the general practitioner (GP) when necessary. Staff on behalf of residents liaised with three different GP practices.

Where a healthcare need was identified there was a corresponding plan of care, for example where residents required dietary modifications in response to a risk of choking or aspiration or where residents were at risk of falling.

As part of these plans of care measures implemented by staff to assess general well-being included regular monitoring of body weight and vital signs (pulse and blood pressure) and the use of recognised assessment tools, for example to assess the risk of falls; residents also received annual seasonal influenza vaccination.

Staff maintained comprehensive records of referrals, reviews, recommended treatments and the care delivered to residents. Records were updated as needs and treatments changed.

Overall as appropriate to their needs inspectors saw that residents had access to other health care services such as speech and language (SLT), neurology, psychiatry, physiotherapy, dental care, optical care and chiropody. Psychology review and support was available from within the providers own resources. However, records seen stated, staff spoken with said and it was confirmed at verbal feedback that all referrals sent for services to which residents had a statutory entitlement had not been facilitated by the HSE Community Services.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

There were policies and procedures in place to guide safe medicines management practice.

Staff were required to successfully complete safe administration of medicines training prior to undertaking medicines administration to residents; training included the administration of emergency rescue medicines.

Medicines were supplied to all residents by a community pharmacy in a medicines compliance aid; on delivery medicines were checked by staff. Medicines were seen to be supplied on an individual resident basis.

The inspector saw that medicines were securely stored; a refrigerator for medicines was also available.

A sample of prescription records were reviewed in each house. The sample seen by the inspector was current and legible, the maximum daily dosage of medicines prescribed on a p.r.n basis (as required) was stated; discontinued medicines were signed as dated as such. Staff maintained a record of medicines administered; the sample of administration records seen reflected the instructions of the prescription.

There were procedures including verified records of the return to the pharmacy of any unused and unwanted medicines.

Medicines requiring use within a specified timeframes were signed and dated by staff when opened.

The pharmacist had audited medicines management practice in the centre in June 2017. The pharmacist acknowledged that they were facilitated to meet their obligations to the residents under the relevant legislation and guidance. Medicines management audit brought about improvement in practice.

The PPIM and staff spoken with confirmed that strict systems and protocols were in place for medicines related incidents; these were logged on the incident reporting system, reviewed and remedial actions if necessary were identified. The reported and

recorded incidence and type of such incidents based on the records seen was not concerning.

Judgment:

Compliant

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:

The statement of purpose contained all of the information required by the regulations, for example, the aims and objectives of the service, the specific care needs to be met and the criteria for admission to the centre.

Judgment:

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:

These inspection findings reflected management that ensured effective oversight of the supports, services and care provided to residents to ensure that the service provided

was safe, appropriate to residents' needs, consistent and effectively monitored. However, of concern to inspectors were the poor findings of an internal review undertaken in early 2017 and the sustainability of the working arrangements of the person in charge.

There was a clearly defined management structure that identified the lines of authority and accountability in the centre; staff spoken with clear on their respective roles, responsibilities and reporting relationships.

The person in charge or person fulfilling that role was employed fulltime and was suitably qualified and experienced. The person in charge or person fulfilling that role worked a seven day rota and continued to work four shifts per month as a frontline member of staff. This was a reduction in frontline duties when compared to the last inspection findings as the provider had increased the administration time available to the person in charge as committed to in the action plan response. However, this was a busy centre, comprising four separate houses that could accommodate a maximum of 17 residents, respite services were provided to an additional 13 residents, residents presented with a diverse range of needs and these needs were increasing.

The operational management and administration of the centre was described as challenging given the working arrangements of the person in charge. The provider confirmed that the working arrangements of the person in charge were an ongoing concern to it and had been discussed with the funding body, the HSE, as late as the week prior to this inspection.

There was a system of audit and review within the centre itself, for example the review and learning from incidents and accidents and medicines management audits. Arrangements were also in place for the completion of the annual review of the quality and safety of the care and supports provided and the six monthly unannounced visits as required by Regulation 23. The annual review incorporated feedback from residents and their representatives. Unannounced provider reviews were undertaken in March-April 2017 and in August 2017 as required by Regulation 23. The lines of enquiry were comprehensive and good practice and areas requiring improvement were reported on.

Of concern were the findings of the March-April 2017 review as a significant body of non-compliance was identified by the provider across all of the outcomes inspected against. Sixty five individual actions emanated from that review 20 of which were given an immediate timescale for implementation. The provider stated that the findings did not provide it with assurance that required actions from audits were acted upon so as to effect improvement.

The most recent unannounced provider review demonstrated significant improvement between April and August 2017 and the substantive implementation of the previous action plan. While acknowledging this improvement and these satisfactory HIQA inspection findings, the poor and unsatisfactory findings of the review of March-April 2017 did not support adequate oversight of the service or management systems that consistently supported and promoted the delivery of safe, quality supports and services to residents.

Arrangements were in place to ensure staff exercised their personal and professional responsibility for the quality and safety of the services that they were delivering. Inspectors saw evidence of this in minutes of meetings, in the complaints logs and in the review of residents' personal plans where staff were seen to advocate on behalf of residents.

Evidence of planning compliance for the premises has not been submitted with the application for registration. The provider had advised HIQA that it was not in a position to provide evidence until the fire safety upgrading works were complete.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The provider was clear on its requirement to notify HIQA and had submitted notification to the Chief Inspector of any expected or unexpected absence of the person in charge. The provider had appointed a suitable person for the management of the centre in the absence of the person in charge.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

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

Findings:

At the time of the last inspection inspectors were not satisfied that the centre was sufficiently resourced to ensure the delivery of safe, quality supports and services to residents. Since that inspection inspectors saw that the transport deficits seen at that time were satisfactorily addressed; the provider confirmed that this was addressed through a fundraising initiative rather than funding received from the funding body, the HSE. A resident had relocated to more suitable accommodation within the service and this relocation had been funded by the funding body.

However, the provider confirmed that failings in relation to fire safety works, refurbishment of the premises and the provision of suitable premise, governance arrangements and staffing levels that had the capacity to meet residents changing and increasing needs were all funding dependent. The provider has in its engagement with HIQA advised HIQA that the provider does not have the resources to address these failings and has not been able to secure funding from the HSE having made every effort to secure funding.

As the provider prioritised and supported residents to achieve their individual person plans, these funding non-compliances are addressed in the respective Outcomes in the body of the report.

Judgment:

Compliant

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):

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

Findings:

Based on the information available to inspectors previous issues relating to weekend staffing levels had been addressed. However, adequate staffing levels were not available within the provider's allocated resources to meet the changing needs of all residents.

During the course of the inspection staff members were observed to interact with residents in a caring and warm manner. It was clear that there were good relationships

between residents and staff. Residents who met with inspectors spoke very positively of the staff members who supported them. From speaking to staff and reviewing rosters, inspectors were satisfied that a continuity of staff was provided for.

The previous inspection had found that the weekend staffing arrangements in one unit of this centre were not based on residents' needs or occupancy levels. This issue had been addressed by the time of this inspection. However, while in general adequate staffing levels were in place, the provider had failed to provide for sufficient staffing levels for one resident at all times of the week in response to their changing needs. This was highlighted as a high risk in the centre's risk register and acknowledged by those participating in management of the centre. Concerns had also been raised at the review of the resident's personal plan as to the appropriateness of the arrangement that was in place to meet the resident's staffing needs. The details of this arrangement were discussed at verbal feedback; HIQA would concur with the concerns raised.

A system of supervision was in place in the designated centre; meetings were held every six months for individual staff members. Staff were given the opportunity to discuss issues including matters relating to the running of centre and training. Staff team meetings were also held on a regular basis in each unit of the centre.

Training records for staff were reviewed by inspectors and it was noted that all staff had undergone training in areas such as de-escalation, safeguarding, manual handling and fire safety. It was noted however that some staff members were overdue refresher training in the area of medicines management.

A sample of staff files were reviewed by inspectors. While the files reviewed contained most of the information required such as Garda vetting and employment histories, it was noted that some files did not have evidence of staff members' identity that included a recent photograph. In addition one file did not include a reference from a staff member's most recent employer. A similar finding had also been found during the previous inspection.

Files, which included Garda vetting, were also maintained in relation to volunteers involved with the centre and adequate provision was made for the supervision of volunteers.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)

Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place, retrieved and made available to inspectors as requested.

However as highlighted under Outcome 1, the frequency of review of residents' personal finances was not being carried out as often as required under the provider's own policy in this area.

Judgment:

Substantially Compliant

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 Kerry Parents and Friends Association
Centre ID:	OSV-0003428
Date of Inspection:	20 & 21 November 2017
Date of response:	21 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:

There was no explicit evidence that supported the suitability of the shared bedroom arrangement to all residents; an explicit protocol was required in relation to the use of the room outlining how choice, privacy, personal space and belongings and infection prevention and control were all assured.

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

1. 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:

A protocol will be drawn up for the shared care arrangement to ensure that each residents privacy and dignity will be respected.

Proposed Timescale: 30/01/2018

Theme: Individualised Supports and Care

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

Two complaints were not recorded in the complaints log.

2. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

The complaints policy will be an agenda item on all staff meetings to raise awareness of the processes involved and complaints will be logged in the Xyea system with follow up record of the residents' satisfaction or not with the outcome.

Proposed Timescale: 30/03/2018

Theme: Individualised Supports and Care

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

It was unclear who the provider had nominated to ensure that all complaints were responded to appropriately and that a record of all complaints was maintained.

3. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

The Complaints policy will be reviewed and revised to ensure compliance with regulation 34(3).

Proposed Timescale: 28/02/2018

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:

Inspectors saw that the general design, layout and presentation of this section of the house was not of a high standard. One residents bedroom was accessed directly from the utility room. Inspectors saw that in the other bedroom insufficient space was afforded, the only source of natural light was a ceiling based skylight. There was no natural ventilation unless the door to the en-suite (which had a window) was left open.

4. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

An urgent application for funding has been submitted to the HSE to renovate the premises to meet the needs of the residents.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

There were signs of age and a requirement for maintenance and upgrade. There were evident areas of damp, defective paintwork, cracks, poor or damaged plasterwork and joinery, and broken floor tiles.

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:

An urgent application for funding has been submitted to the HSE to renovate the premises to meet the needs of the residents.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

The main entrance used by staff and residents was not universally accessible and was not ramped. The completion of the ramp based on records seen including risk assessments and reviews by healthcare professionals was an outstanding matter.

6. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

A regular review will occur to ensure that centres adhere to best practice in achieving and promoting accessibility. The installation of a ramp will be completed at the entrance identified.

Proposed Timescale: 30/03/2018

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:

There were inconsistent fire safety measures across the four units of the designated centre.

7. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

An urgent application for funding for fire doors and fire systems has been submitted to the HSE. All remaining fire doors will be installed on receipt of funding.

The current fire safety features and procedures that has been developed by our fire consultant and previously submitted to HIQA are in effect and audited regularly.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

There was no certificate of inspection and testing by a competent person of the emergency lighting,

8. Action Required:

Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

An inspection certificate will be obtained for the emergency lighting.

Proposed Timescale: 31/01/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

In the absence of a specific behaviour management plan for the resident and the behaviours of the concern, it was difficult to be assured that restricted access was the least restrictive procedure that could be applied. Staff did not maintain a record of the frequency or the duration of the restrictive practice.

9. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

A referral has been sent to the Senior Clinical Psychologist to review the behaviours of concern and to ensure the least restrictive practice is used.

Proposed Timescale: 30/03/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Records seen stated, staff spoken with said and it was confirmed at verbal feedback that all referrals sent for services to which residents had a statutory entitlement had not been facilitated.

10. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

Representations have been made by the Association to the HSE to highlight the inequity in the provision of therapy services to the people we support from the HSE community services. They have a statutory right to these services and should not be denied access. We are continuing to pursue this issue with the HSE Disability Manager and will be meeting with her on 21/12/2017, when this issue will be raised again for action by the HSE.

Proposed Timescale: 31/03/2018

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:

Evidence of planning compliance for the premises has not been submitted with the application for registration.

11. Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

An urgent application for funding has been submitted to renovate the premises to meet the fire safety regulations in order to submit the planning compliance required. The Planning Compliance Form cannot be completed until this action is completed.

Proposed Timescale: 30/08/2018

Theme: Leadership, Governance and Management

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

The operational management and administration of the centre was described as challenging given the working arrangements of the person in charge. The provider confirmed that the working arrangements of the person in charge were an ongoing concern to it.

The poor and unsatisfactory findings of the internal review of March-April 2017 did not support adequate oversight of the service or management systems that consistently supported and promoted the delivery of safe, quality supports and services to residents.

12. 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:

More robust monitoring will be undertaken when the findings of the provider 6 monthly audit reports indicate causes for concern. Further follow up unannounced audits will be scheduled and appropriate remedial action will taken.

Proposed Timescale: 31/03/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider had failed to provide for sufficient staffing levels for one resident at all times of the week in response to their changing needs. This was highlighted as a high risk in the centre's risk register and acknowledged by those participating in management of the centre. Concerns had also been raised at the review of the resident's personal plan as to the appropriateness of the arrangement that was in place to meet the resident's staffing needs; HIQA would concur with the concerns raised.

13. 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:

A review of staffing levels will be undertaken. Redeployment of staff will be reviewed and more appropriate day service is being developed to meet the changing needs of the individual.

Proposed Timescale: 30/03/2018

Theme: Responsive Workforce

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

Some staff files did not have evidence of staff members' identity that included a recent photograph. In addition one file did not include a reference from a staff member's most recent employer.

14. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

All staff files have had photo ID included. Reference has been requested for the outstanding staff member's most recent employer.

Proposed Timescale: 30/01/2018

Theme: Responsive Workforce

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

Refresher training in the area of medicines management was required for some staff members.

15. 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:

Staff training has been scheduled in medication management for all staff who require a refresher course.

Proposed Timescale: 31/01/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

The frequency of review of residents' personal finances was not being carried out in line with the provider's own policy in this area.

16. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

The review of the residents' personal finances will be audited to ensure compliance with our policy.

Proposed Timescale: 30/01/2018

