Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Listowel Residential Services
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Short Notice Announced
Date of inspection:	07 February 2019
Centre ID:	OSV-0003429
Fieldwork ID:	MON-0024167

About the designated centre

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

This centre was established in 2004 to provide residential and respite services to persons with a disability in their own community. The centre is open and staffed on a 24 hour full-time basis. A maximum of six residents can be accommodated; five residents live in the centre on a full-time basis and approximately five additional residents currently access the respite service. The model of care is social and the staff team is comprised of social care staff and care assistants led by the person in charge. Nursing advice and support is available from within the providers own resources and staff support residents to access any other required healthcare service. The provider aims to provide a person-centred service and the support provided is informed by the process of individual assessment and consultation with residents and their families. The provider values and promotes community inclusion and supports residents to avail of the services and facilities of the busy local town (including its own day-service) and the surrounding areas. The premises is located on the outskirts of the busy local town a short commute from any required or desired services; transport is provided.

The following information outlines some additional data on this centre.

Current registration end date:	31/05/2021
Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as 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
07 February 2019	09:45hrs to 18:00hrs	Mary Moore	Lead

Views of people who use the service

There were five residents living in the centre at this time and one vacant bed. The inspector engaged with residents and staff as they went about their normal daily routine. Residents and staff spent some time out of the house as they attended their day service or went to planned social events including the hairdresser and lunch. The inspector noted that residents looked well. Residents communicated using a variety of means. Two residents communicated verbally while other residents observed with interest and communicated by facial expression or physically demonstrated their comfort with staff and with the inspector.

Residents spoke about their day in the day service and were clearly familiar with staff and members of the management team; the atmosphere particularly in the evening was relaxed and light hearted. One resident, the most recently admitted said that she liked the house and invited the inspector to view her room and personal items such as family photographs. Another resident was looking forward to a planned trip home to family. The trip to the hairdresser and for a manicure had clearly been enjoyed and in line with the residents wishes. Other residents simply observed and listened and smiled at the discussions.

Practice observed by the inspector was dignified and respectful.

Capacity and capability

Overall the inspector was satisfied that the provider sought to provide each resident with safe, quality supports and services that were appropriate to their needs; the provider had management systems designed to achieve that objective. However, some actions from the last HIQA (Health Information and Quality Authority) inspection had not been completed including fire safety works. The inspector also found that while improvement was noted at the time of this inspection, quality tended to fluctuate as improvement was not sustained.

The provider did have good governance structures that were as advised in the statement of purpose and function (a record required by the regulations that stipulates for example information such as the purpose, aims and objectives of the service). For example the person in charge worked full-time and had the qualifications and experience necessary to manage the designated centre. The person in charge was supported by the assistant director of services, who was accessible and responsive and called regularly to the centre. The provider convened monthly quality and standards meetings and management meetings; the latter were attended by the Chief Executive Officer and the meetings were described as open

and transparent with staff free and supported to raise suggestions or concerns.

The area of responsibility for the person in charge had been reduced to two designated centres with a common purpose and function and her requirement to work frontline shifts was limited to approximately 14 hours per month; this allowed the person in charge to spend the remainder of her time on the operational management of the designated centre.

The provider had systems of review for self-identifying both good practice and areas that required improvement such as the quality and standards meeting mentioned above, centre based audits, and the annual review and unannounced reviews that the provider was required to undertake at a minimum of six-monthly intervals.

The inspector reviewed the 2018 annual review and saw that feedback had been sought from residents representatives; the feedback was positive. The inspector reviewed the findings of the most recent unannounced provider review undertaken in November 2018. The lines of enquiry were comprehensive; the reviewer focussed on the provider's processes and the quality, safety and individualised nature of the service. While no concerns were raised for resident safety or welfare the overall findings of the review were not satisfactory and 39 individual actions issued. The provider responded appropriately to the findings; for example the inspector reviewed minutes of a senior management meeting convened in response and a meeting convened with staff; there was evidence of accountability and responsibility for the findings and commitment to improvement. This inspector did find improvement in common areas of review such as medicines management and resident's personal plans.

However, there were similar findings in the 2017 HIQA inspection. At that time (2017) the inspector again found that a substantive action plan had issued from the providers internal review of February 2017 but improvement was found when the next provider review was completed. These similar 2017 and 2018 findings indicate that while improvement occurs as a result of audit it is not sustained and therefore the quality and safety of the service is not consistent. The provider itself acknowledged in its 2018 review that action plans did not bring about the changes required. A further example of this inconsistency were the fluctuating findings found in medicines management systems between a pharmacy audit in August 2018 (satisfactory), the provider review of November 2018 (not satisfactory) and these HIQA inspection findings (improved).

In addition to this the inspector found that some but not all of the previous HIQA actions had been implemented, for example in relation to training for staff in restrictive practice and specifically in relation to the completion of fire safety works.

The provider had given a commitment to undertake and to complete required fire safety works by 31 December 2018; the centre was registered on that basis. These works had not commenced and the provider had failed to advise HIQA of the delay in the commencement of the works. The provider acknowledged this failure and breach and articulated their commitment to the works and to regulatory compliance.

The provider had addressed the staffing deficits found at the time of the last inspection and while not fully resolved there was significantly less reliance on relief staff to maintain the agreed staffing levels. The person in charge confirmed that she no longer covered shifts and that staffing had been particularly stable since December 2018. The person in charge was completing staff supervisions and convening regular team meetings.

The inspector reviewed staff training records and was satisfied that there were no gaps in staff attendance at mandatory training such as fire safety and safeguarding training. Other training records seen indicated that staff had qualifications relevant to their role including social care, healthcare and disability studies.

Registration Regulation 8 (1)

The provider had failed to notify and apply to the Chief Inspector for a variation to a condition attached to the registration of the centre.

Because the provider took the action necessary to address this in the days following this inspection, the level of non-compliance is adjusted accordingly.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs, of her role and associated responsibilities, and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, skill-mix and arrangements were appropriate to and reflected the

number and assessed needs of the residents. The inspector found that the provider assessed the adequacy of staffing and sought to ensure that residents received continuity of care and supports.

A sample of staff files was made available to establish their compliance with regulatory requirements. The inspector found there was a good level of compliance and systems were in place to manage the staff files.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframes. Staff had also completed training that supported them to safely meet resident's needs.

Judgment: Compliant

Regulation 23: Governance and management

While there were many indicators of good governance a review of governance and its effectiveness was required. Inspection findings indicated that while improvement occurred as a result of audit it is was not sustained and therefore the quality and safety of the service was not consistent.

Judgment: Substantially compliant

Quality and safety

Notwithstanding the inconsistency discussed in the first section of this report, this inspection did not find any concerning deficits in the care and support provided to residents. Staff spoken with were knowledgeable of residents and their required supports, the practice seen was respectful; the records reviewed were adequate to inform the care and support provided to residents on a daily basis. Sufficient improvement had been achieved at the time of this HIQA inspection to impact positively on the level of compliance evidenced.

The inspector found that the provider itself had effective systems for auditing the standard of the assessment of and the plan for supporting resident's needs; the last

audit had found deficits in these processes such as a lack of review and update. Again the inspector found that action had been taken in the interim to address much of these. The assessments seen were current and the findings were reflected in the support plan that issued. The plans were detailed and reflected in practice, for example in relation to dietary requirements or falls prevention practice.

Two residents attended the provider's day service; a programme of activity and community engagement was delivered from the centre for three residents. Residents were to a degree at a stage where they required a slower pace of life but still required access to meaningful activity and engagement. Residents had enjoyed day trips to Dublin and more local amenities and accessed local services on a regular basis with staff such as shops and restaurants. The provider itself had identified a requirement for improvement in this area to support individuality, resident satisfaction, the developmental of and the maintenance of existing and new interests and skills. It was agreed at verbal feedback that these improvements were necessary to drive quality and develop the existing good practice in the centre.

Residents were supported to maintain contact with peers and family, for example residents said that they enjoyed visits home and visits from family, particularly those family members living abroad. Representatives were invited to attend the review of the residents' personal plan and to provide feedback on the service. However, the policy on visiting the centre required review to ensure that controls and restrictions (such as phoning in advance) were not the norm but specified only on the basis of actual objective risk or resident preferences as outlined in the relevant regulation.

The inspector was satisfied that the provider did have the arrangements necessary to ensure that residents enjoyed the best possible health. The inspector found that staff monitored resident well-being and sought timely access to the relevant supportive General Practitioner (GP); residents individually attended their GP of choice. There was no reported obstacle to residents accessing allied health professionals and nursing advice and support was available from within the providers own resources. Where regular monitoring was required, for example of weight, pulse or blood pressure these were seen to be completed and recorded. There was evidence of staff knowledge and competency, for example SALT (speech and language therapy) review was sought in response to a recurring respiratory tract infection that may have indicated deteriorating swallow.

The provider had measures to protect residents from harm and abuse such as staff training, unannounced visits, discussion with residents using easy read material on how to stay safe, access to advocacy, and consultation with families. The person in charge described how she assured herself that residents were safe in the service, for example feedback from residents or their representatives, supervision of practice and monitoring of residents general demeanour. Residents both those living in the centre and those accessing the respite service were described as compatible and known to each other for a long time, therefore there was no identified risk of harm from a peer. The provider responded appropriately and in line with local and national safeguarding guidance to any concerns raised about the service.

At the time of the last inspection the provider had committed to providing staff with

training on restrictive practice; while this had not been provided overall the inspector found increased awareness of and minimal use of restrictive practice. For example while bedrails were in use they did not impede a resident from getting out of bed if it was safe for them to do so and alternatives such as a bed vacating alarm and impact reducing floor mat were in use.

There was discussion on a recently introduced chemical intervention; the inspector was advised that this intervention was a last resort. The provider did demonstrate that possible causes had been explored, alternative interventions had been trialled and that these had not worked. The consequences for the resident both positive and negative of intervening or not intervening were acknowledged and there was evidence of multi-disciplinary clinical decision making. Further clinical review by psychiatry was awaited and the inspector was of the view that this review was required to further advise on the evidence base of the intervention.

As stated in the first section of this report the provider audit of November 2018 had found numerous deficits in the management of medicines particularly in relation to storage and record keeping. The inspector found improvement in that medicines were appropriately stored, no out of date medicines were noted, the date of opening was largely recorded by staff and staff maintained records of medicines administered by them including medicines administered on a PRN (as needed) basis. There was a low reported incidence of medicines errors. Transcribing practice had been introduced; there was a supporting policy that including most of the risk control measures required for this practice. However there was scope to further improve the safety of medicines practice by;

- records that clearly distinguished between medicines received and medicines returned to the pharmacy
- objective assessment of resident capacity to participate in their medicines programme or not
- administration clarity in PRN protocols where the same medicines were also prescribed on a regular basis and staff had a choice of medicines to administer in response to the same presenting symptoms
- transcribing policy required further review to ensure that accuracy was checked against the original prescription by both the transcriber and the second nurse. Guidance was required (based on one transcribed record seen by the inspector) on the use of decimal points, leading and trailing zeros when transcribing dosage strengths.

As mentioned in the first section of this report the provider had failed to complete fire safety works. The inspector was advised that the delay was due to the requirement to seek planning permission for some works; this was recently granted. The centre did have existing fire safety measures such as a fire detection system and emergency lighting but remedial works required to these were some of the works not completed.

The inspector found that the existing fire safety measures were inspected and tested at the required intervals and most recently in November 2018. Proprietary key-boxes had been provided at final exits, staff and residents participated in

regular evacuation drills; there were no reported or recorded challenges to evacuation and adequate evacuation times were achieved. However, the inspector found that the garage attached to the main house and that housed laundry facilities, gas and electrical appliances was still not serviced with fire detection equipment; the provider was requested to address this as a matter of priority. This was done prior to the conclusion of the inspection; assurance as to the integrity of the attic space was confirmed by a competent person in fire safety and a temporary system of smoke detection was installed by staff.

Regulation 11: Visits

A review of the relevant policy was required to ensure that residents received visitors in line with their choices and preferences and restrictions were applied only on the basis of actual, objective risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not completed the works required to ensure that they had effective fire safety systems.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall there was evidence of good practice and improvement in the management of medicines. However, improvement was required as follows;

- records that clearly distinguished medicines received and medicines returned to the pharmacy
- objective assessment of resident capacity to participate in their medicines programme
- administration clarity in PRN protocols where the same medicines were also prescribed on a regular basis and staff had a choice of medicines in response to the same presenting systems
- transcribing policy required further review to ensure that accuracy of

transcription was checked against the original prescription by both the transcriber and the second nurse. Guidance was required (based on one transcribed record seen by the inspector) on the use of decimal points, leading and trailing zeros for dosage strengths.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was scope for improving and driving excellence in identifying and facilitating for residents personal objectives and initiatives for meaningful activity and engagement.

Judgment: Substantially compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Each resident had access to the range of healthcare services that they required. Staff had worked with residents, for example using social stories (presenting information in a way that supports the residents understanding of a difficult situation or activity), to develop and achieve resident compliance with medical interventions.

The provider was collating information on residents' access to national health screening programmes.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of a positive evidence based approach to the management of behaviour and plans that detailed how therapeutic or more restrictive interventions were implemented. The plan was tailored to individual needs. The plan was seen to

be informed by multi-disciplinary input.

There was policy and procedure on the use of restrictive practices and meaningful oversight by the restrictive practice committee.

Judgment: Compliant

Regulation 8: Protection

There were policies and supporting procedures for ensuring that residents were protected from all forms of abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Registration Regulation 8 (1)	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Listowel Residential Services OSV-0003429

Inspection ID: MON-0024167

Date of inspection: 07/02/2019

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**
Registration Regulation 8 (1)	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 8 (1): An application to vary has been submitted to HIQA with a deadline of completion of fireworks set for 21/06/2019. A process has been put in place in relation to the monitoring of all action plans submitted to HIQA which will be reviewed monthly by 2 members of the senior team.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC has developed an action plan to sustain compliance in this designated centre. This includes a performance improvement plan for staff which will be agreed and signed off by all staff and will be reviewed on a monthly basis by the PIC. A review took place of all duties and the PIC identified and assigned duties and responsibilities to each individual staff. A schedule of supervision is in place for all staff and increased supervision is scheduled for the PIC (every 2 months) to address any support needed and also to review performance by all staff in the designated area. A scheduled provider inspection is due in May 2019, however the PIC will carry out a self-assessment of the designated centre to be completed by April 12th. The PIC and the ADOS will review the outcome of this self-assessment to determine if any further action is required, A schedule of training will be developed for the staff to include training on restrictive practices, goal development and report writing.	

The CNS will commit to supporting staff in relation to care plans and also for overseeing any medical support that is required in the centre.

Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: The visitor's Protocol has been reviewed and updated for the designated centre, there are no restrictions for visitors at present. Visitors are requested to ring before visits so that outings for residents can be facilitated, however it is clear that this is not essential.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: An Application to vary was submitted to HIQA, the deadline for completion of fireworks in the designated centre is 21/06/2019. A monitoring system to detect smoke and fire and alert staff has been put in place for the garage area of the designated centre, the garage area is included for a fire alarm system also. Risk assessments are completed in relation to fire safety and are reviewed on a weekly basis.	

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Pharmacy hand over sheet has been reviewed, they now clearly identify the medication returned to the pharmacy. The self-assessment tool for self-administration has been completed for all residents in the centre, going forward people availing of respite in the designated centre will also be assessed re self-administration of medication. Prn protocols have been reviewed by the GP. They now clearly identify which medications are to be administered first with a clear time line to follow when administering PRN. The PRN medication was also reduced and going forward the CNS will offer support and guidance in relation to protocols and supporting care plans. The medication committee met on 11/03/2019 and reviewed the nurse transcribing	

section of the policy, clear guidelines will be added to the policy on the use of decimal points, leading and trailing zeros when transcribing dosage strengths.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Staff will be facilitated to attend goal training. The PIC will monitor the goals in place and discuss at team meetings with staff how they can be achieved and that are meaningful for individuals. Records will be kept of all progress made and of the residents satisfaction with same.
Monthly checks will take place by the PIC to ensure keyworkers are engaging in meetings with residents about activities/goals they wish to achieve that are individual to them.

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
Registration Regulation 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Substantially Compliant	Yellow	21/06/2019
Regulation 11(2)(a)	The person in charge shall ensure that, as far as reasonably practicable, residents are free to receive visitors without restriction, unless in the opinion of the person in charge, a visit would pose a risk to the resident concerned or to	Substantially Compliant	Yellow	14/02/2019

	another resident.			
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.	Substantially Compliant	Yellow	30/04/2019
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	21/06/2019
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 prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	14/02/2019
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to	Substantially Compliant	Yellow	30/04/2019

	paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.			