Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Hillview
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	21 March 2018
Centre ID:	OSV-0005496
Fieldwork ID:	MON-0021514

About the designated centre

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

This designated centre provides full time residential services to four male residents. In addition to the supports and services provided in the centre, each resident attended a local day service; the provider aimed to ensure that residents were connected to, and integrated into, the local community and support networks. In line with the assessed needs of the residents there was one social care worker on duty at all times. The premises was a detached single storey house on its own spacious site; though the area was rural it was well populated and a short commute from the busy local town; transport was provided.

The following information outlines some additional data of this centre.

Current registration end date:	11/10/2019
Number of residents on the date of inspection:	3

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information and information submitted by the provider or person in charge since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk to staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre.
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarize our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
21 March 2018	09:45hrs to 16:45hrs	Mary Moore	Lead

Views of people who use the service

There were three residents living in the designated centre; one resident was on leave at home with family during the inspection. One of the resident's had expressed to staff their interest in meeting the inspector. This was conveyed to the inspector and after being granted permission from the provider the inspector went to see the residents in their day service. The inspector met with both residents who live in the centre.

The repeated phrase used by both residents to convey their views of the service was they were happy. In summary they told the inspector that they could not be happier with their life.

Residents said that they loved their house, had great staff supporting them and were satisfied with the range and quality of meaningful engagement that they had. It was clear that there was a particularly close bond between this particular group of residents.

When asked if they would say if there was something wrong or something that they were unhappy with residents replied that they would; they would tell the person in charge or their key-worker.

Capacity and capability

The inspection was carried out to monitor on-going compliance with regulatory requirements. Overall the inspector was satisfied that there was a clear management structure and appropriate persons appointed to manage the designated centre. However, there was some further scope for improvement to underpin and maintain consistent delivery and oversight of the safety and quality of the service.

The person in charge worked full-time, was suitably qualified in social care and healthcare studies and was currently undertaking a management qualification. The person in charge facilitated the inspection with ease and had sound knowledge of regulatory requirements and her responsibilities. One resident described the person in charge as a great manager.

Further to previous HIQA inspection findings the provider had made alterations to the governance structure to enhance capacity so as to provide effective governance

and administration of the designated centre. For example the person in charge previously had responsibility for two designated centres comprised of three houses one of which was a busy respite house. The person in charge was still responsible for two designated centres but these now comprising two houses with a similar statement of purpose. The person in charge was required to work some front-line shifts but the requirement for this had reduced and had stabilised at 12 hours each week.

The person in charge said that the positive benefit of these changes was evident and that there were advantages to working as a front-line staff; for example the opportunity to work directly alongside other staff and supervise the quality of the supports and services provided to residents. However, the person in charge said that particularly as a consequence of the front-line shifts, it was still a challenge to ensure that each designated centre was effectively governed and supervised so as to assure the consistent appropriateness, safety and quality of the services provided in each centre.

The person in charge had ready access to and support from her line manager and attended the monthly management team meetings chaired by the chief executive officer. In addition monthly quality and standards meetings were held where issues including medicines management, incident reporting and audits across services were discussed and shared for the purposes of learning and improvement.

The person in charge said that staff meetings and regular staff supervisions facilitated discussion on any issues arising in the centre; the person in charge also worked shifts that corresponded to times when there were residents and staff in the house.

The provider had established arrangements for the completion of the reviews required by Regulation 23 (2). The annual review sought and incorporated feedback from residents and families. The unannounced visits utilised comprehensive lines of inquiry, action plans, time-frames and responsible persons were identified. In addition there was a schedule of in-house audits to be completed in 2018 for example of medicines management, fire safety and food safety.

The inspector reviewed the reports of the annual review and the most recent unannounced review completed on 2 March 2018. Overall the latter found a substantive body of good practice particularly in relation to quality of life outcomes for residents. Eleven actions did issue however which would link to a requirement for enhanced, consistent oversight.

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

Ordinarily there was one social care staff on duty in the house; the night time staffing arrangement was a sleepover staff. The evidence available was that these staffing numbers and arrangements were suited to the assessed needs of the current residents. There was an established team of regular experienced staff

employed in the centre.

Residents were described as, and presented as very compatible with each other in terms of their interests and choices; this facilitated the one staff arrangement. Some residents required some staff assistance in relation to their activities of daily living but the inspector was advised that this presented no supervision issues for staff in relation to the other residents. The occupancy of the house also fluctuated as residents enjoyed regular home leave.

Centre-specific records were maintained of staff attendance at training; attendance was monitored to ensure that refresher training was attended within the required mandatory timeframe. These records indicated that all staff working in the centre had attended safeguarding training, training in responding to behaviours of concern including de-escalation and intervention techniques, fire safety, manual handling, medicines management and first-aid.

The feedback received from residents on staff and the quality of their interactions and the supports that they delivered was positive and complimentary.

How to make a complaint was prominently displayed in plain English; a log of complaints received was maintained. The inspector saw that complainants were listened to; a record was maintained of the actions taken to provide reassurance and to seek a resolution. There was evidence that the management of complaints was overseen by responsible persons such as the complaints officer. However, while the inspector observed that matters complained of had been resolved; for example poor internet access; complaint records did not include a record of whether or not complainants were satisfied.

Regulation 14: Persons in charge

The person in charge met regulatory requirements in terms of knowledge, skills and experience. The person in charge facilitated the inspection with ease and had sound knowledge of regulatory requirements and her responsibilities

Judgment: Compliant

Regulation 15: Staffing

The evidence available was that staffing numbers and arrangements were suited to the assessed needs of the current residents; there was an established team of regular experienced staff employed in the centre

Judgment: Compliant

Regulation 16: Training and staff development

Centre-specific records of training completed were maintained. All staff employed had completed mandatory and required training.

Judgment: Compliant

Regulation 23: Governance and management

Overall the inspector was satisfied that there was a clear management structure and appropriate persons appointed to manage the designated centre. Changes had been made to enhance capacity. However, there was some further scope to improve upon capacity to underpin and maintain consistent delivery and oversight of the safety and quality of the service.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints records did not evidence whether complainants were satisfied or not.

Judgment: Substantially compliant

Quality and safety

The inspector found that the care, supports and services provided in the designated centre was focused on residents and their needs and preferences. Residents self-reported that they enjoyed a good quality of life.

The inspector saw that the provision of supports was informed by the comprehensive assessment of resident's needs.The personal support plan based on the assessment findings captured each resident, their strengths, needs, choices, visions and their required supports. Staff spoken with had sound knowledge of each resident and their personal plan.

There was evidence that residents were consulted with and participated in the development and review of their plan. The accessibility of the plan to the resident was promoted by personalised narrative and pictorial and photographic presentation. The person in charge confirmed that any stakeholder who had input into the residents' care and support was invited to the annual review of the personal plan; minutes seen of completed reviews confirmed this.

Overall the standard of assessment and planning was good, satisfied regulatory requirements and did provide assurance that residents received timely and appropriate support. However, at verbal feedback the inspector did advise that the plans would benefit further from an overall review as there was some duplication, the support plan did not always flow from the relevant assessment and there was some inconsistency in dating so as to robustly evidence regular review.

Each personal plan incorporated the plan for the progression of resident’s personal goals and objectives. Improvement was noted in this area with staff clearly tracking the actions taken to support residents in achieving their goals. There was an action plan for each agreed goal. Some goals evolved and continued as daily living skills, for example road safety awareness.

Residents themselves said that they had good opportunity to engage in meaningful activities and appropriate and constructive community engagement. The inspector saw that these activities and opportunities included music and musical events, sporting events, community based social events and work experience in local businesses. One resident described how he had achieved his goal of going on a helicopter ride but had yet to decide on what he wanted to achieve in 2018.

It was clear from residents’ personal plans that family and personal friendships were important to residents; they were supported by staff and family members to maintain these relationships. There was consistent evidence of strong resident inclusion in social events, family events, holidays and day trips.

From speaking with residents and from records reviewed the inspector concluded that resident choice and autonomy was respected and promoted. Both residents spoken with said that they could not be happier and that there was nothing they

would change about the centre. Residents had a clear sense of ownership of and took pride in the house; they spoke of each other as friends. The inspector saw plans that supported resident's to have control in areas such as their personal finances.

In addition to the day-to-day communication between staff and residents formal house meetings were convened; all of the residents engaged with this process. The minutes of these meetings demonstrated consultation, respect for individual choices and a forum for residents to raise items of importance to them; there was evidence that action was taken where improvement could be effected. For example residents had raised concerns in relation to poor television reception; this issue was addressed.

Staff had assessed and were familiar with residents' communication strengths and needs; further to this assessment residents were appropriately supported and assisted to communicate effectively. The inspector saw that residents had access to and utilised as they choose assistive technology and communication applications; staff also employed supports such as PECS (picture exchange communication systems); for example to facilitate engagement with the resident meeting referenced above. It was clear that where a resident communicated by a variety of means; that is verbal, gesture and assistive technology; each was respected and promoted in line with the residents wishes. Where a resident had specific communication needs the inspector observed easy, natural and effective communication between the resident and staff. The importance of effective and appropriate communication in understanding, preventing and responding to explicit behaviours was clearly referenced in plans of support.

The provider supported residents to enjoy good health. Staff consistently monitored resident well-being and sought medical advice and review from the general practitioner (GP) when necessary; this was evidenced on inspection. Staff on behalf of residents liaised with four different GP practices as was their expressed choice and preference.

Staff monitored health indicators such as blood pressure and body weight on a regular basis.

Staff maintained comprehensive records of referrals, reviews, recommended treatments, investigations completed and their result, for example blood-profiling, x-rays and scans. Narrative notes evidenced the implementation of prescribed care, for example daily exercise programmes.

As appropriate to their needs inspectors saw that residents had access to other health care services. The inspector saw that residents had access to neurology, psychiatry, psychology, physiotherapy, occupational therapy and speech and language therapy; dental care, optical review and chiropody. Nursing assessment and care for residents and advice for staff was available as needed in the day service.

There was evidence of systems that supported good medicines management. All staff had completed medicines management training including the administration of

prescribed rescue medicines.

Medicines were supplied by a local community based pharmacist; medicines were checked on supply for accuracy by nursing staff in the day service; where medicines were administered in the day service a separate supply was provided by the pharmacist.

Medicines were seen to be securely stored and supplied on an individual resident basis.

The prescription records seen contained all of the required information and staff maintained a record of each medicine administered by them to residents; the administration record corresponded to the instructions of the prescription. The maximum daily dosage of PRN medicines (a medicine only taken as the need arises) was stated.

There were procedures for the reporting, monitoring and management of any medicines related errors; there was only one such reported error in the twelve months prior to this inspection; there was evidence of corrective actions taken to prevent reoccurrence.

There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, a designated person, and staff training. There were no reported safeguarding concerns.

There was evidence that staff sought to support residents to develop skills in self-protection; the safeguarding and complaints policy were available in an easy read format and both topics were discussed regularly with residents at the residents meetings. Residents said that everything in the house was good and that they had a very good team of staff working with them in the house. Residents said that if they had a concern that they would raise it; the person in charge said that residents would seek her out if there was something bothering them. The inspector noted that residents were comfortable in approaching the person in charge to discuss and seek reassurance on certain matters.

Residents did at times present with behaviours that had the potential to impact on their general well-being. The inspector saw that residents had access to and the support of both psychiatry and psychology; plans detailed the supports and interventions to be implemented by staff; the focus of the plans was therapeutic. Staff spoken with described those interventions including designated staff time and timely reassurance.

The inspector saw that residents were provided with an environment and routines with minimal restrictions. There was one medicine prescribed as an adjunct to the management of behaviours; the person in charge said and records seen indicated that this medicine was rarely utilised and its ongoing prescription was scheduled for review. There was one intervention identified as a restrictive practice as part of a seizure management plan. There was a clear rationale for its use and prescribed periods when it could be used; its use was discussed and agreed with the resident's

representative.

Since the last inspection the person in charge had compiled a risk register that on review contained a broad range of identified risks, their assessment, the controls to reduce and manage the risk and the estimate of residual risk. The assessed risks included the four risks as specifically required by Regulation 26, for example the unexpected absence of a resident. The sample of risks reviewed was resident and centre specific and detailed relevant controls. There was evidence that the process of risk assessment was dynamic, for example, the introduction of additional risk assessments following an incident. However, the inspector did note and advise at verbal feedback that the majority of residual risk ratings were medium orange risk; while this could be rationalised a review of likelihood of occurrence was recommended.

There was evidence of good fire safety awareness. For example the person in charge had a protocol for holding open fire doors in defined circumstances, for example if a resident requested this or if there was a requirement for supervision. When a difficulty had been encountered during a simulated evacuation drill, a further drill was completed and the relevant Personal Emergency Evacuation Plan (PEEP) was updated so as to prevent a reoccurrence. Drills to date indicated that residents were evacuated in a timely manner. Of the five drills recorded all four residents had participated in three of these drills; however only two staff names of four regularly employed were noted, indicating that all staff may not have participated in a simulated drill.

Certificates seen on inspection and submitted subsequent to the inspection did not evidence the inspection, testing, and maintenance of the fire detection system or the emergency lighting in accordance with the recommendations of the relevant standard. There were gaps in these records between November 2016 and August 2017; there was a gap of seven months between that August 2017 date and this HIQA inspection. The certificates seen in the centre and submitted stated that quarterly inspection was required. The provider was requested to submit evidence that timely arrangements had been made to have these systems inspected; this was submitted.

Regulation 10: Communication

Staff had assessed and were familiar with resident's communication strengths and needs; further to this assessment residents were appropriately supported and assisted to communicate effectively

Judgment: Compliant

Regulation 13: General welfare and development

Residents had good opportunity to engage in meaningful activities and appropriate and constructive community engagement. These opportunities were led by individual resident choices, wishes, interests and abilities; disability however did not limit these opportunities.It was clear from residents' personal plans that family and personal friendships were important to residents; they were supported by staff and family members to maintain these relationships.

Judgment: Compliant

Regulation 26: Risk management procedures

Since the last inspection the person in charge had compiled a risk register that on review contained a broad range of identified risks, their assessment, the controls to reduce and manage the risk and the estimate of residual risk. The assessed risks included the four risks as specifically required by Regulation 26. The sample of risks reviewed was resident and centre specific and detailed relevant controls. There was evidence that the process of risk assessment was dynamic.

Judgment: Compliant

Regulation 28: Fire precautions

Only two staff names of four regularly employed were noted in the records maintained of simulated fire drills indicating that all staff may not have participated in a simulated drill.

Certificates seen on inspection and submitted subsequent to the inspection did not evidence the inspection, testing, and maintenance of the fire detection system or the emergency lighting in accordance with the recommendations of the relevant standard.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was evidence of systems that supported good medicines management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector saw that the completed assessment of residents' needs was comprehensive and looked at the health, personal and social care needs of each resident. The personal support plan captured each resident, their strengths, needs, choices, visions and their required supports. Staff spoken with had sound knowledge of each resident and their personal plan.There was evidence that residents and their representatives were consulted with and participated in the development and review of the plan.

Judgment: Compliant

Regulation 6: Health care

The assessment of residents' needs included the assessment of their healthcare needs. In addition to this baseline assessment records seen demonstrated that staff consistently monitored resident well-being and sought medical advice and review as needed.

Residents had access to neurology, psychiatry, psychology, physiotherapy, occupational therapy and speech and language therapy; dental care, optical review and chiropody. Nursing assessment and care for residents and advice for staff was available as needed in the day service.Staff maintained comprehensive records.

Judgment: Compliant

Regulation 7: Positive behavioural support

In relation to supporting any behaviours of concern residents had access to and the support of both psychiatry and psychology; plans detailed the supports and interventions to be implemented by staff; the focus of the plans was therapeutic. Staff spoken with described those interventions including designated staff time and timely reassurance.

The inspector saw that residents were provided with an environment and routines

with minimal restrictions.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, a designated person, and staff training. There were no reported safeguarding concerns.

There was evidence that staff sought to support residents to develop skills in self-protection.Residents said that everything in the house was good but if they did have a concern they would raise it

Judgment: Compliant

Regulation 9: Residents' rights

From speaking with residents and from records reviewed the inspector concluded that resident choice and autonomy was respected and promoted. Both residents spoken with said that they could not be happier and that there was nothing they would change about the centre. Residents had a clear sense of ownership of and took pride in the house; they spoke of each other as friends. Formal house meetings were convened; all of the residents engaged with this process. The minutes of these meetings demonstrated consultation, respect for individual choices and a forum for residents to raise items of importance to them; there was evidence that action was taken where improvement could be effected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hillview OSV-0005496

Inspection ID: MON-0021514

Date of inspection: 21/03/2018

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider will continue to ensure that the designated center is resourced to ensure effective delivery of care and support. The management structure for the center had been changed immediately prior to this inspection and the designated provider will support the manager to manage her performance by increasing supervision and support in the transition period from having responsibility for 3 houses to 2 houses Supervision of all staff will take place as per schedule to support staff to reflect on their professional responsibility for the quality and safety of the services they are providing The registered provider has recruited further relief staff to ensure the service is safe and appropriate to residents needs Recruitment remains ongoing	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: All residents are provided with easy read complaints procedure. Complaints procedure is an item on the resident meeting agenda. Complaints procedure and adherence to the KPFA complaints policy will be discussed at future team meetings. Inputting of complaint on the KPFA electronic recording system XYEA and following all steps completely will also be discussed	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The registered provider has put a system is in place for regular servicing of fire panel and lighting. The fire panel and lighting were serviced in the following week, the next service for July has been pre-booked. This is also now logged and monitored in the house communication book.

Close monitoring of compliance by staff to complete statutory number of drill annually. Fire safety management is in place such as fire training, regular fire checks, PEEPs and evacuation procedures are displayed.
Fire safety is discussed under health and safety at resident meetings.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	03/09/2018
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	Completed
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably	Substantially Compliant	Yellow	31/05/2018

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/05/2018