Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Listowel Respite Services
Centre ID:	OSV-0005683
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):	None
Type of inspection	Announced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	4

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 February 2018 09:15	20 February 2018 18:30

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This inspection was the first inspection of this centre by the Health Information and Quality Authority (HIQA) and was carried out to inform a decision to register the centre. However, the provider had in October 2017 reconfigured another designated centre and one of the two houses that comprise this new centre was previously inspected in August 2017.

How we gathered our evidence:
Prior to the inspection the inspector reviewed the documents submitted by the provider with the application for registration of the centre, the previous inspection findings and action plan response and any other correspondence received in the interim from the provider such as notice of any accident, incident or adverse event.

The inspection was facilitated by the person in charge and the assistant director of services. The assistant director of services represented the provider at the verbal feedback of the inspection findings at the conclusion of the inspection.

The inspector reviewed records such as fire and health and safety records, records of accidents and incidents, of complaints received, reports of audits and records as they pertained to residents and staff. The inspector discussed the review of these records with the person in charge.

One house was unoccupied; there were three residents availing of respite in the other house. The inspector met with the residents and the frontline staff on duty when they returned from the day service in the evening. This engagement was led by residents and their needs and choices. This particular group of residents had previously met with the inspector during the inspection in August 2017. Residents told the inspector that they had enjoyed their day and were seen to be anxious to proceed with their plans for the evening with staff while also anxious to observe the working of the inspector. Residents were observed to be comfortable engaging with staff and with the person in charge. Residents were seen to engage in individual activities of their choosing with staff.

Description of the service:
The designated centre consisted of two houses. Both houses were located in separate rural but populated areas approximately a ten minute drive from the busy local town and the day service. One house is and has been occupied by residents availing of respite services and was notified to HIQA as a designated centre; the other house is a new development and has never been used for the provision of supports and services to residents. It is the provider's intention to provide respite services in both of these houses to a maximum of seven residents. Respite is to be provided to residents with a diverse range of needs included high dependency needs.

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

Overall judgment of our findings:
The inspection findings were satisfactory. The inspector found that the provider had taken action to address failings that had emanated from the previous inspection. For example the centre had been reconfigured to ensure that both houses shared a common purpose; a person in charge had been appointed to support the effective governance of the designated centre.

Both premises were suited to their purpose and function. Funding had been secured to complete the necessary fire safety works. The funding for one house was sourced by the provider through a community initiative programme. The Health Service Executive funded the works required in the second house of which they were the owner.

Resident's needs were comprehensively assessed and a plan of support was devised based on the findings of the assessment. Resident's needs and plans were seen to be kept under review by staff. Staff described collaborative systems of working between residents, their families, day service staff, residential staff and the community outreach programme so that residents and their families experienced a continuum of

care.

There was a clear management structure and systems for the ongoing review of the safety and quality of the care, supports, and services provided to residents. The person in charge had the qualifications, skills and experience required for the role.

The inspector found that the current staffing numbers were adequate and there was explicit confirmation available to the inspector that funding to open the second house was sanctioned. Previous deficits in staff mandatory training were substantially addressed. Staff supervisions however, while they were current were not happening at the required frequency.

A review of policy and procedures for medicines management specifically where respite services were provided was required to ensure that practice was adequately supported.

There was evidence of good fire safety practice; however, oversight was required of simulated evacuation drills to ensure that all staff and residents participated in these.

Of the twelve Outcomes inspected the provider was judged to be complaint with eight Outcomes and in substantial compliance with the remaining four.The evidence to support these judgements is found in the body of the report in each respective Outcome; the regulations breached and the action required of the provider are detailed in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Findings:
There were policies and procedures governing admission, transfer and discharge to and from the designated centre. There was an existing admission, transfer and discharge forum. Both the assistant director of services and the person in charge advised that the format of the placement forum was under discussion to ensure that decisions made in relation to respite access were equitable and determined on the basis of transparent criteria.

Based on the sample of records reviewed the provider had explicitly agreed with residents and-or their representative the terms on which care, support and services were to be provided and the fees to be charged.

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:
The needs of each resident had been assessed; plans of support were in place informed by the findings of the assessment.

The inspector saw documentary evidence that residents needs had been assessed prior to admission and subsequently thereafter most recently in 2017. The assessment informed the development of the support plan and the plan was reviewed and updated regularly and as required. The support plan presented a clear picture of each resident, their strengths, needs, choices and required supports.

The accessibility of the plan was enhanced through the use of pictorial and photographic supports; the language used was person centred and respectful. Some residents had signed their plans to indicate that they were consulted with and participated in the development and review of their plan.

Each support plan incorporated the plan for progressing the residents' personal goals and objectives. The person in charge described how this could be specific to respite or a collaborative process between the day service and the designated centre; this was reflected in the records seen by the inspector.

Each personal plan was the subject of an annual review to which the resident, their representatives and members of the multi-disciplinary team were invited. There was an action plan for each agreed goal. There was a theme of ongoing learning and development in the identified goals such as learning telephone and computer skills. Where an agreed goal did not progress staff documented the actions that were taken and the reasons why the goal was not achieved, for example a residents altered preferences.

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):
No actions were required from the previous inspection.

Findings:
The designated centre consisted of two domestic type properties; both houses were of relatively recent construction; each was located on its own spacious site; all facilities were at ground floor level. The design and layout of both houses was suited to their purpose and function.

The accommodation provided to residents was of a high standard. Both houses were in a good state of repair and decoration; recent refurbishment works had been completed in both.

Ramps and handrails had been provided to promote accessibility.

Each resident was provided with their own bedroom, bedrooms offered sufficient space including personal storage space. Where it was envisioned that residents with higher physical needs were to be accommodated this was reflected in the design and layout.

Adequate sanitary facilities were provided including facilities that were universally accessible. Handrails and grab-rails were fitted.

Adequate communal/recreational space was provided; there was a choice of space in one house and this was seen to support resident's individual needs.

Both kitchens were appropriately equipped and incorporated the dining area; these offered sufficient space for the number of residents to be accommodated.

Adequate facilities were provided for completing personal laundry if this was required.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
There were measures in place to protect and promote the health and safety of residents, staff and others. However, oversight was required of simulated evacuation drills.

The inspector viewed a current health and safety statement and a plan for responding to

emergencies; the plan included the provision of alternative accommodation for residents if required.

Records seen demonstrated that the assessment and management of risk informed the provision of supports and services to residents. Risk assessments were seen to be kept under review and that the controls identified reduced the level of assessed risk.

The provider had sought and secured the funding required to complete the necessary fire safety works for one of the two houses that comprised the designated centre. The funding was sourced through a community initiative programme.The Health Service Executive had funded the fire safety works in the other house of which they were the owner.

The inspector saw that each house was fitted with emergency lighting and automated systems for detecting smoke and fire. Fire resistant doors had been inserted to protect escape routes; doors were fitted with self-closing devices and smoke seals. Certificates were available stating that these works had been completed to the specification of the relevant standard.

Final exits were clearly indicated; doors were fitted with easily released thumb-turn devices; where there was a requirement for a key-locking device, keys were readily accessible in propriety key-boxes.

One bedroom was accessed through the kitchen and the utility area. The inspector saw that a designated, externally ramped exit was provided from the utility area and this area which was an escape route was protected by the provision of a fire resistant door with self-closing devices on each of the three routes leading off it. At verbal feedback the importance of maintaining the safety and integrity of this area was discussed, for example no unsafe storage or the placement of high risk electrical equipment.

There was evidence of good fire safety practice. For example the person in charge had risk assessed and devised a protocol for the management of fire resistant doors for occasions where staff may be required to provide direct observation and supervision of residents; this arrangement required the door to be open. The person in charge had taken corrective action following difficulties that had been encountered by staff when evacuating a resident during a simulated drill. The inspector saw that the residents PEEP (Personal Emergency Evacuation Plan) had been reviewed and amended and a further drill had been scheduled to test the adequacy of the corrective actions.

However, collectively the records of these drills did not demonstrate how they were scheduled to ensure that they maximised the attendance of all staff and all residents so that both were familiar with and aware of the procedure to be followed in the event of fire.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
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. The contact details of the designated person were prominently displayed and residents had ready access to her on a daily basis. Easy-read versions of safeguarding procedures were available to residents.

Training records seen indicated that all staff including staff employed on a relief basis had completed safeguarding training.

There was evidence available to the inspector that the provider did respond appropriately to any concerns raised about the quality and safety of the supports and services provided to residents; the response was multidisciplinary; safeguarding measures were implemented as appropriate.

Plans were in place for the provision of personal intimate care to residents. However, the sample reviewed did not adequately address specific needs as outlined in other areas of the personal plan or known specific preferences. Consequently the plan did not offer sufficient guidance as to how personal intimate care was to be provided in the context of individual requirements or requests.

Some residents experienced behaviours of concern and risk. All staff had completed required and relevant training including de-escalation and intervention techniques; however one staff was overdue refresher training. Residents had access to their required supports including mental health professionals and psychology. The latter was available from within the providers own resources; residents, staff and families were seen to ready access and input from the psychologist. Behaviour management guidelines were in place and were seen to be kept under review in line with residents changing needs.

There were policies and procedures for identifying, agreeing and reviewing any practice deemed to be restrictive. Residents were seen to enjoy minimal restrictions, for example while medicines as required (PRN) were included in the behaviour management guidelines, records seen indicated that they were rarely utilised; the person in charge

confirmed this. The restrictive practice committee was seen to maintain oversight and not sanction any restrictive intervention where it was deemed that there were alternatives to be considered.

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 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:
The inspector found that arrangements were in place for supporting residents to maintain their health and well-being.

The assessment of residents' needs included the assessment of their health and physical needs. Where a need was identified there was a corresponding plan of support.

Residents were not in receipt of full-time residential services and attended the centre on

a respite basis; therefore there was a collaborative approach to meeting healthcare needs between residential and day care staff and residents representatives. Staff maintained relevant records; the inspector was satisfied that residents had timely access to their GP (general practitioner) and to other healthcare services including psychiatry, psychology, neurology, dental care and chiropody.

There was evidence of regular monitoring and assessment of resident health and wellbeing. Residents' body weight was measured regularly to identify any loss or gain that may require intervention. Regular monitoring of blood pressure and pulse where appropriate was undertaken in line with each resident's assessed needs and healthcare plan. Where a resident declined care this was documented and monitored.

The person in charge was a registered nurse and participated in ongoing professional development. The person in charge had the knowledge required to ensure that the care and support provided to residents was evidenced based.

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

Findings:
There were measures that promoted safe medicines practice; however, review of both policy and procedure was required to consolidate practice, specifically as it pertained to respite provision.

Training records indicated that all staff had completed safe administration of medicines training including the administration of emergency medicines. Staff were seen to implement measures that enhanced the safety of medicines management practice such as medicines handover records and daily counts of residents' medicines.

There were procedures for the reporting and monitoring of any medicines related errors; there were only two such reported errors in the twelve months prior to this inspection.

The inspector saw that further to the last inspection findings plans for the administration of medicines required in an emergency to manage seizure activity have been revised and amended. The plan now outlined clear guidance to staff on the administration of emergency medicine, recovery times, repeat administration, possible side effects and

when and why the assistance of emergency services may be required.

The centre did not liaise with any specific pharmacist; each resident brought their supply of medicines with them when availing of respite. Secure storage for medicines was available in the centre. Both the prescription and the medicines supplied were checked for accuracy in the day service. Staff maintained a record of each medicine that they administered. However, the person in charge advised that she had recently identified as unsafe and had corrected the manner in which some medicines had been supplied to the centre. The inspector noted that one medicine accepted had a largely illegible label attached to it.

A small stock of analgesia prescribed as required (PRN) was retained; however no stock balance of these was completed.

There were policies and procedures on facilitating residents to manage their own medicines if they had the capacity and desire to do so. However, assessments had not been completed to determine if there were residents who may wish to manage aspects of their medicines and if it was safe for them to do so.

Judgment:
Substantially 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:
A revised statement of purpose was submitted to HIQA prior to this inspection. The statement of purpose contained all of information prescribed by Regulation 3 and Schedule 1; the statement accurately described the centre and the supports and services to be provided.

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

Findings:
The inspector found that the centre was effectively governed and that there were systems for monitoring on a consistent basis the quality and safety of the care, support and services provided to residents.

There was a definitive management team consisting of the person in charge and the assistant director of services. There was clarity on roles, responsibilities and reporting relationships.

The person in charge was recently appointed to this centre as part of the reconfiguration plan. The person in charge worked full-time, was suitably qualified and experienced and engaged in ongoing professional development. The person in charge was actively registered as a nurse in intellectual disability, had completed postgraduate management studies and had more than the required experience in a supervisory role.

On a day-to-day basis the person in charge was supported by the social care worker in each house and had ready access to the assistant director of services. The person in charge worked shifts that corresponded to times when there were residents and staff in the house; there was no requirement for the person in charge to work frontline duty; these working arrangements supported supervision and the capacity to ensure effective governance. The person in charge had a solid body of experience of regulatory requirements and inspection.

There was an out-of-hours on call support system for staff operated by the senior managers.

Monthly management team meetings were held, the chief executive officer chaired these meetings, the persons in charge attended and the minutes were disseminated to all staff. 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.

The provider had arrangements in place for the completion at the prescribed intervals 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, timeframes and responsible persons were identified. In

addition the person in charge had since her appointment, identified areas of change so as to improve the quality of the service, for example the scheduling of residents meetings so as to maximise the number of residents that participated in these.

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:
The inspector found that staffing numbers and skill-mix were appropriate to the number and assessed needs of the residents; residents were in receipt of continuity of supports from a regular staff team that had access to a programme of education and training.

There was two staff on duty when residents were present and the night-time arrangement was one sleepover staff and one waking staff. It was confirmed to the inspector that it was planned to replicate these staffing numbers and arrangements in the second house and that the necessary funding for this was available. Some residents had specific staffing arrangements based on their assessed needs; this was evidenced as facilitated on inspection.

A planned and actual staff rota was maintained; this reflected the staffing arrangements described to the inspector. There was some limited requirement for relief staff but the inspector saw from the rota that a core group of regular relief staff was employed to ensure that residents received continuity of care.

Staff files were made available for review. The sample reviewed was well presented and contained all of the records required by Schedule 2, for example complete employment histories and references from previous employers. Specific transport duties were completed by a volunteer once a week. Arrangements were also in place to ensure that the requirements of Regulation 30 with regards to vetting, support and supervision for volunteers were met.

Staff training records were maintained and staff attendance at training including

refresher training was monitored. The inspector reviewed these records and saw that all staff working in the centre including those employed on a relief basis had completed the required mandatory training. Deficits identified at the time of the last inspection had been substantially addressed; as discussed in Outcome 8 one staff was overdue refresher training in de-escalation and intervention techniques.

Staff had also completed training that supported them to meet resident's needs including the administration of regular medicines and emergency medicines, first-aid, infection prevention and control, autism-specific training, report-writing and food hygiene.

The provider operated a formal system of staff supervision. All staff had had a formal supervision and those on file were current; however, formal supervisions had not been completed at the minimum six-monthly frequency required by the provider's own policy.

Judgment:
Substantially Compliant

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:
The inspector was 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. The required records were retrieved for the inspector with ease; the records were well maintained. The inspector saw that the provider reviewed its policies as required and at a minimum at intervals of three years. For example the inspector saw that the policy on the management of complaints had been reviewed and amended based on recent HIQA inspection findings.

Judgment:
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 report[1]

Centre name:	A designated centre for people with disabilities operated by Kerry Parents and Friends Association
Centre ID:	OSV-0005683
Date of Inspection:	20 February 2018
Date of response:	06 March 2018

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 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:
Simulated evacuation drills did not demonstrate how they were scheduled to ensure that they maximised the attendance of all staff and all residents so that both were familiar with and aware of the procedure to be followed in the event of fire.

1. Action Required:

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

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Person in charge has scheduled monthly fire drills to maximise attendance of all staff and residents. Person in charge will provide oversight of same.

Proposed Timescale: 31/03/2018

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:
One staff was overdue refresher training.

2. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
This individual has been booked for training in Tralee

Proposed Timescale: 30/06/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal intimate care plans did not offer sufficient guidance as to how personal intimate care was to be provided in the context of individual requirements or requests.

3. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
Person in charge will liaise with designated officer and keyworker to complete risk assessments and reflect same in intimate care plans. Reviews have been scheduled for this week

Proposed Timescale: 30/04/2018

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Review of both policy and procedure was required to consolidate practice, specifically as it pertained to respite provision. The person in charge advised that she had recently identified as unsafe and had corrected the manner in which some medicines had been supplied to the centre; the inspector noted that one medicine accepted had a largely illegible label attached to it.

A small stock of analgesia prescribed on a PRN basis was retained; however no stock balance of these was completed.

4. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Stock balance check has been established. Draft centre specific has been completed by person in charge and sent to medication review committee. Planned contact to be made with all families re medication practices.

Proposed Timescale: 30/04/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments had not been completed to determine if there were residents who may wish to manage aspects of their medicines and if it was safe for them to do so.

5. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
Person in charge will liaise with clinical nurse specialist and individual's keyworkers to complete assessments and subsequent risk assessments if necessary.

Proposed Timescale: 30/05/2018

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Staff supervisions had not been completed at the minimum six-monthly frequency required by the provider's own policy. **6. Action Required:** Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised. **Please state the actions you have taken or are planning to take:** Person in charge has devised a schedule which will ensure all supervisions going forward are completed in line with KPFA policy.

Proposed Timescale: 31/03/2018