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:	Carrow House
Name of provider:	RehabCare
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	25 June 2019
Centre ID:	OSV-0002654
Fieldwork ID:	MON-0022929

About the designated centre

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

Carrow House is a designated centre providing respite services for individuals with an intellectual disability. The centre is a two story house located near a busy town in Co.Tipperary. The local town has a variety of shops, pubs, clubs and parks available. Carrow House provides a respite service for adults with an Intellectual Disability, Autism and mental health issues. The service provides respite to those individuals with low support requirements and individuals that have the physical ability to access all areas of the property required to meet their physical needs. The service is focused on providing support in all areas that may impact on a service user's well-being. It is a five bedroom house with four bedrooms for service users and a fifth for staff to sleepover. The house has a shared kitchen and living areas. The Respite Service is open for 144 nights per year. Carrow House respite provides additional residential and respite service outside the 144 nights should an individual require further support, this is always done in consultation with the individual, their families and the Health Service Executive. Each individual receives a respite weekend every 7/8weeks. This time frame is changeable due to various factors such as service users moving into residential settings/supported accommodation and also based on the demand for the service. Carrow House is staffed by care workers, a team leader and respite services manager.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
25 June 2019	10:00hrs to 17:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

Two residents were staying in the respite house on the day of inspection. The inspector had the opportunity to meet and speak with both residents. There were forty one residents availing of the respite service altogether.

Overall the residents appeared at ease staying in the respite house. One resident said they liked the staff and liked coming into respite to stay for a break. This individual was being supported and encouraged to attend a concert where their favourite band will be playing. The inspector observed familiar interactions between staff and residents. Jokes were made about GAA rivalry and the different teams that were supported and it was evident that staff and residents had a friendly relationship.

Residents were facilitated to attend their normal daily activities during their respite stay. These included attending day services, work and various individualised activities. A system was in place to assess how the residents stay in respite had gone. This highlighted any areas in need of improvements for future stays. Complaints and feedback regarding respite stays were seriously reviewed and considered when planning future respite stays.

Staff and residents sat down to dinner together in the evening, at the close of the inspection day, and this was a relaxed experience with the kitchen patio doors open to the garden and different food choices being offered to residents. Staff had planted flowers and some vegetables in the garden surrounding the house and these were well maintained.

Capacity and capability

In general, the provider was demonstrating the ability to provide an effective service to residents availing of respite. Systems were in place to promote a person centred service and continuity of care for residents during their respite stay. The majority of actions had been addressed following the previous inspection, however the inspector found that some improvements were still needed to ensure effective risk management at times.

Effective governance and management was observed in the designated centre. There was a person in charge (PIC) who had a shared post and attended the centre two days per week or more regularly if needed. There was also a team leader in place who was involved in the management of the centre and reported to the PIC on a regular basis. Staff spoken with were familiar with reporting systems and lines of accountability.There was an auditing system in place that was identifying areas in

need of improvement in the centre. Six monthly unannounced audits had been completed by a person nominated by the provider. An action place was devised following this audit which outlined clear timelines and persons responsible for completing actions. The inspector found that issues identified in the audit were similar to findings on the day of inspection and an action plan was in place to address these issues. However, overall findings on the day of inspection indicated that some improvements were needed to promote compliance with the regulations. Issues were identified in areas including fire safety, risk management, notification of incidents and safeguarding. Concerns in relation to risk management had been identified during the centres previous inspection and these had not been adequately addressed.

There were appropriate staffing levels in place to meet the assessed needs of the residents. The staffing levels and the staff rota were regularly reviewed to ensure the staffing was appropriate for the different residents availing of respite. A handover document was implemented to promote continuity of care. This outlined clear instructions regarding the responsibilities and duties of staff during each shift. This included checking the centres environment, checking the menu, reading the daily notes, cleaning duties and the petty cash check. An internal relief system was used to cover sick leave and annual leave and there was an on call system for management that staff could ring outside of regular hours, should the need arise. A system was in place for staff supervision and performance management. This was completed three monthly and a template was utilised by staff and their line manager that reviewed different issues that may arise including health and safety, key working duties, external relations, performance, personal development and service policies. The inspector did not have the opportunity to review staff Schedule 2 documents as these were in a different location on the day of inspection.

Training was provided to all staff to ensure the assessed needs of the residents were being met. Training provided appeared to be guiding staff practice. Training was provided in areas including fire safety, manual handling, medication management, first aid, epilepsy management, safe guarding, food safety, hand hygiene, autism management, and boundary management. Some staff had also received training in areas including diabetes management and data protection. A regular analysis was completed to ensure that all staff were up to date on mandatory training. Refresher training was then scheduled for staff should the need arise. The team leader had completed a medication assessor course and was responsible for the supervision of staff administering medication.

There was an appropriate policy and procedure in place for the management of complaints. This appeared to be guiding practice. There was a designated person nominated to manage any complaints or concerns received. Residents were assisted to understand the complaints procedure. Complaints and feedback regarding respite stays were seriously reviewed and considered when planning future respite stays. Residents meetings were held regularly and this was an opportunity for residents to discuss any preferences regarding meal times/activities during their stay. A template was utilised by staff at the end of each respite stay to assess if there was anything the resident would like to change about their respite stay.

Regulation 15: Staffing

There were appropriate staffing levels in place to meet the assessed needs of the residents. Staffing levels and the staff rota was regularly being reviewed to ensure the staffing was appropriate for the different residents availing of respite

Judgment: Compliant

Regulation 23: Governance and management

There was a person in charge and a team leader. There was an auditing system in place that was identifying areas in need of improvement in the centre. Six monthly unannounced audits had been completed by a person nominated by the provider. However, improvements were needed to promote a higher level of compliance in areas including fire safety, risk management, safeguarding and notification of incidents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place that contained all items set out in Schedule 1 and accurately described the service being provided.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents required to be notified to the Office of the Chief Inspector had been notified.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an appropriate policy and procedure in place for the management of complaints. Complaints and feedback regarding respite stays were seriously reviewed and considered when planning future respite stays.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had completed mandatory training in areas including manual handling, fire safety, the safeguarding and protection of vulnerable adults,. Additional training was provided to some staff in areas including food safety, epilepsy management, medication management, autism, hand hygiene, and diabetes awareness.

Judgment: Compliant

Quality and safety

Overall, the registered provider was endeavouring to provide a quality service to the resident availing of respite. Residents appeared to enjoy their stays and this was evidenced through speaking with the residents, observing feedback submitted by residents and observing support being provided on the day of inspection. The inspector noted that on the day of inspection, some improvements were needed in areas including risk management, fire safety, premises and safe guarding to ensure the service being provided was safe at all times.

The premises was designed and laid out to meet the assessed needs of the residents availing of the respite service. The registered provider had ensured the provision of all matters set out in Schedule 6. The centre was a five bedroom house with four bedrooms for service users and a fifth for staff to sleepover. The house had one downstairs bedroom for service users who required it secondary to mobility needs. There was a shared kitchen area and living areas. The centre also had a large surrounding front and rear garden. While the centre was generally in a good state of repair, some outstanding paintwork required was observed around the building and there was a rusting radiator in an upstairs bathroom on the day of inspection.

There was a staff key working system in place that ensured all assessments and personal plans were in place for all residents and were subject to regular review. These were guiding the support being provided. Key working sessions were held

when possible, in accordance with the residents respite schedules. Social goals were devised with residents during these sessions by key workers. Residents were being supported to attend social activities during their respite stays and one resident was supported by staff to attend a concert with their family.

Residents were supported appropriately with any healthcare concerns and needs during their respite stays. There were assessments of need and personal plans in place that comprehensively assessed the needs of the residents and guided care being provided. The inspector observed a care plan in place that was guiding the care of a resident with a specific healthcare concern. This was comprehensive, guiding practice and subject to regular review. All staff working in the centre received training in first aid and residents were supported to attend their multi-disciplinary services during their respite stay, if the need arose.

There was a system in place to assess, manage and review potential and actual risks in the designated centre. However, measures in place to reduce the risk of injury to staff and residents secondary to behaviours that challenge associated with one resident were in need of further review. This was evidenced through the high volume of incidents recorded in the centres accident and incident log. Actions following one particular incident of concern, directed staff to read a residents positive behavioural support plan. However, this plan did not guide staff to reduce the risk of re-occurrence as this plan was being followed when the incident occurred. Accident and incident logs did not accurately record all adverse incidents that occurred. This was observed through reading a sample of residents daily notes. This was an issue raised during the centres last inspection and had not been appropriately addressed. In general, the residents availing of respite had a low level of behaviours of concern and positive behavioural support plans were in place where appropriate. There were no restrictive practices in place on the day of inspection.

Overall, the registered provider had ensured there were effective fire management systems in place. The inspector observed clear evacuation procedures situated around the centre. Fire fighting equipment was situated around the centre and was serviced annually by a fire specialist. An assembly point was clearly identified out. However, the inspector found that there was no system in place to ensure that all staff and all residents availing of respite had taken part in a fire drill. On the day of inspection a number of staff and residents had never taken part in a fire drill since the centre had been registered. Weekly checks were being completed to check the centres escape routes, alarms, fire panel, emergency lighting, and fire fighting equipment. However, the inspector noted numerous checks that had either not been completed or had not been signed as completed by staff on duty on dates when the respite service was open. This posed the possibility of faults or risks occurring in the areas that were not checked or observed by staff.

There were safe and appropriate systems in place for the administration and management of medication. A secure storage unit was in place where residents medicines were stored during their respite stay. A movable picture system was used to identify different residents storage shelves. A count of residents medication was completed by staff on every admission to the respite service. Medication prescriptions were reviewed regularly by residents general practitioners and were in

line with medication being administered. All staff were suitably trained to administer medication and assessments had been completed for all residents to review the suitability of self administering medication.

All staff had received training in the safeguarding and protection of vulnerable adults. Staff spoken with were knowledgeable regarding national safeguarding policy and procedures to follow in the event of a safeguarding concern. There was a designated officer in place to deal with safeguarding concerns. However, the inspector observed some peer to peer incidents recorded as complaints that had not appropriately been treated at safeguarding concerns. Furthermore, not all incidents required to be notified to the Office of the Chief Inspector had been notified, or had not been addressed in line with national policy.The inspector acknowledges that due to the nature of the respite service, there was no future risk to the residents concerned.

Regulation 26: Risk management procedures

There was a system in place to assess, manage and review potential and actual risks in the designated centre. However, measures in place to reduce the risk of injury to staff and residents secondary to behaviours that challenge were in need of further review. This was evidenced through the high volume of incidents. Accident and incident logs did not accurately record all adverse incidents that had occurred.

Judgment: Not compliant

Regulation 28: Fire precautions

In general, there were adequate precautions in place against the risk of fire. However, the inspector found that there was no system in place to ensure that all staff and all residents had taken part in a fire drill.

There were checking systems in place to review fire precautions, however gaps were noted on various date in these checks where staff had either not completed or not signed the checks.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were safe and appropriate systems in place for the administration and

management of medication in the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were assessments of need and personal plans in place that comprehensively assessed the needs of the residents and guided care being provided during residents respite stay. There was a key working system in place and regular key working sessions were held with residents.

Judgment: Compliant

Regulation 6: Health care

Residents were supported appropriately with any healthcare concerns and needs during their respite stays.

Judgment: Compliant

Regulation 8: Protection

Overall, the residents were being safeguarded. However, the inspector observed some peer to peer incidents recorded that had not been appropriately been treated at safeguarding concerns. The inspector acknowledges that due to the nature of the respite service, there was no future risk to the residents concerned. All incidents of concern had not been notified to the Office of the Chief Inspector.

Judgment: Not compliant

Regulation 17: Premises

While the premises was designed and laid out to meet the assessed needs of the residents availing of the service, some outstanding paintwork was observed and there was a rusting radiator in an upstairs bathroom on the day of inspection.

Judgment: Substantially 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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 16: Training and staff development	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 17: Premises	Substantially compliant

Compliance Plan for Carrow House OSV-0002654

Inspection ID: MON-0022929

Date of inspection: 25/06/2019

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**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Fire checks are signed off by staff on fire safety documentation – they have been removed from handover document, duplication of which was causing confusion amongst staff. Team leader now reviewing fire safety checks ensuring they are completed on a weekly basis. Completed by 30/06/2019. • All risk assessments and behavior management guidelines, relating to 1 service user, are reviewed at every team meeting following any behavioral incidents to ensure learning from reviews is used to inform practice. Completed by 30/06/2019.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • NF06 was not submitted for incident in 2018 although Safeguarding process had been followed correctly. Recent NF06 was submitted by PIC for incident in June 2019. HIQA notification process being adhered to. Completed by 30/06/2019.	

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All risk assessments and behavior management guidelines, relating to 1 service user, are reviewed at every team meeting following any behavioral incidents to ensure learning from reviews is used to inform practice. Completed by 30/06/2019.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire checks are signed off by staff on fire safety documentation – they have been removed from handover document, duplication of which was causing confusion amongst staff. Team leader now reviewing fire safety checks ensuring they are completed on a weekly basis. Completed by 30/06/2019. • Spreadsheet capturing all fire drills attended by staff and service users in place since end of June 19 to ensure that all personnel are involved in fire drills at appropriate intervals.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • Recent Peer on Peer incident was notified to Safeguarding Team and HIQA on 25 June 2019. • In order to prevent any future incidents going forward Service Users involved in peer-to-peer concern will not be scheduled to come into service and avail of respite breaks at the same time. This was completed by 30/06/2019.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Radiator observed to be rusty has been painted with radiator paint. Completed by	

30/09/2019.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2019
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	30/06/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	03/07/2019

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/06/2019
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 practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/06/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/06/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in	Not Compliant	Orange	30/06/2019

	relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			