



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

Name of designated centre:	Graifin House
Name of provider:	RehabCare
Address of centre:	Leopardstown Road, Foxrock, Dublin 18
Type of inspection:	Announced
Date of inspection:	07 February 2018
Centre ID:	OSV-0002636
Fieldwork ID:	MON-0020813

About the designated centre

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

This community based residential centre provides a high support residential service for adults with Prader-Willi Syndrome (PWS). This service was established in 2002. Each individual has complex needs in relation to their PWS, pertaining to food, behaviour that challenges, and mental and physical difficulties. The house is a two storey, six bed roomed building located on a main road in a suburban area. Residents can also access the building from a side entrance. A large garden area is available to the front and side of the premises. Each resident has their own single room with one located on the ground floor and four on the second floor. The house is close to a broad range of services and amenities, with a public transport system also locally available. There is capacity for five residents and at the time of inspection it was home to two gentlemen and three ladies over 18 years of age. Residents are supported over the 24 hour period by care support workers, two team leaders and the person in charge.

The following information outlines some additional data of this centre.

Current registration end date:	03/06/2018
Number of residents on the date of inspection:	5

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
07 February 2018	09:15hrs to 17:45hrs	Helen Thompson	Lead
07 February 2018	09:15hrs to 17:45hrs	Marie Byrne	Support

Views of people who use the service

On the day of inspection, the inspectors met, and had conversations with three of the five residents that utilise this service. Feedback on the quality and safety of the service provided was also taken from a review of four completed questionnaires received from the residents and their representatives. During the inspection process, inspectors also met with a resident's family member.

Overall, residents expressed their satisfaction with the service that they received in this centre and that they were happy living there. This included positive comments with regard to having their own bedroom, the quality of the food provided, the meeting of their care and support needs, available activity options and the promotion of their rights. Residents were also complimentary of the staff team and reported that their experience, where required of making a complaint had been positive.

The main aspect that residents highlighted as requiring improvement related to the centre's premises. This included the provision of a private room to meet with their visitors and the completion of planned work to further promote the residents accessibility of the premises.

Inspectors observed on the day of inspection, that residents were facilitated to participate in a meaningful day of their choice which included attendance at day service and community based activity options.

Capacity and capability

Inspectors observed that overall the governance, management and oversight of the delivery of the service was good, but some improvements were required to consistently ensure the quality of service provision for residents.

There was, at the time of inspection, a clearly defined governance structure with distinct lines of authority and accountability. Since the previous inspection in March 2017, the provider had completed an unannounced visit and an annual review for the centre.

Residents and staff could raise any concerns regarding the quality and safety of care delivered.

The service being delivered to residents was observed to be in keeping with the centre's current statement of purpose.

There were enough staff available, who were familiar with residents' needs and whom also had appropriate qualifications. Staff engaged with residents in a person centred and respectful manner.

Staff were provided with training in line with the residents' needs. However, to ensure that the residents' needs were appropriately and continuously met, some gaps in training needed to be addressed. For example, staff needed training and refresher training in safeguarding vulnerable people, the safe administration of medication, manual handling and food safety. This regulatory breach had also been identified on the previous inspection of the centre. Staff had also not been receiving formal supervision however since the person in charge returned from leave, this issue had been identified and there was now a plan to address it. This included a scheduling process for each staff and a review of the supervision template.

Other identified areas that required improvement included, a tightening of the centre's existing overarching monitoring systems to ensure that any possible deficits with the quality and safety of the care delivered to residents were promptly identified, and addressed in a timely manner.

Residents reported that in general their experience of raising issues was positive. However, the provider needed to more effectively monitor the complaints process to ensure that complaints were appropriately closed out for each resident and their representative, and that feedback from this data set contributed to increasing the quality of service provision to residents. The voice and views of residents, and their representatives also needed to be formally incorporated into the centre's annual review process.

The required policies to inform and guide staff practices when supporting residents and their needs were available. However, a small number required review as they had been developed over three years ago. This included the policy for the handling of complaints, and for the use of restrictive procedures and physical, chemical and environmental restraint.

Regulation 15: Staffing

There was an appropriate number and skill mix of staff to support the residents' need and wishes over the 24 hour period.

Staff were familiar with the residents' needs, and due consideration was given to ensuring that the centre recruited staff that could comprehensively support residents' particular needs.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required in the area of staff training and with the staff supervision process.

Judgment: Substantially compliant

Regulation 23: Governance and management

Aspects of the governance and management systems required improvements including usage of information taken from the centre's complaints data, the follow up and completion of actions from the previous HIQA inspection and from the centre's own monitoring systems.

The recent annual review dated December 2017 did not demonstrate that there had been consultation with the residents and their representatives.

It was observed that there were opportunities for staff to raise concerns with regard to the quality and safety of care provided to the residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Inspectors reviewed the centre's statement of purpose (November 2017) and found that it contained the information as outlined in Schedule 1 of the regulations. There was also evidence of review of this document.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvement was required with regard to the recording of the outcome of the complaint, actions taken, follow up and the complainant's level of satisfaction.

Incomplete records were noted for three complaints that were reviewed on the day of inspection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Five of the required Schedule 5 policies were not reviewed within the required time frame. This regulatory breach was identified during the previous inspection.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors observed that the quality and safety of the service received by residents was good. In keeping with their individual profile, each resident's particular physical and mental health needs were supported. Their specialised support requirements especially in the area of food and nutrition were central to daily planning, staff engagement and interactions with the resident.

Any situation or matter that could cause harm for the resident was identified and addressed, with the resident's complex condition considered in this process. Also, to further ensure the resident's safety, any possible abusive type matter or situation was identified and appropriately responded to. In addition, there were robust procedures and practices to ensure that the resident could safely evacuate the building in the event of a fire.

The service provided was flexible and adaptive to times of change and altered needs for the resident, for example, admission to hospital.

Overall, the centre had an established medicines management system to support the residents' needs. Residents were facilitated to access a pharmacist of their choice. There was evidence of review of residents' medical and medicines needs. Staff that administered medicines to residents were trained in its' safe administration. There was evidence of review and learning from medication errors with improvement measures taken.

Residents were well supported with taking their medicines and with having them reviewed. Though in line with best practice one resident's medicines needed to be individually labelled, and audits of the resident's medication system completed.

Each resident was also supported to spend their day in a manner that was meaningful and purposeful for them. This included availing of many community

facilities and amenities.

Residents were involved in food shopping and in preparing meals and snacks. Residents reported that they were happy with the food, drinks and snacks that were available to them. Each resident was facilitated to access a dietician and had their own individualised plans to inform and guide staff practices. Education with regard to the resident's particular condition was promoted.

Each resident had their own room, access to shared spaces and an indoor exercise room.

There was evidence that any incidents and allegations of abuse were reported, screened, investigated and responded to. This included reporting of the matter to the local community safeguarding team. Over the course of the inspection, staff engagement and interactions with residents were observed to be person centred and positive in nature.

Residents reported that they were happy living in the centre. However, some parts of the residents' home needed to be cleaner and maintained to a higher standard. From a walk around of the premises and feedback from residents and their representatives, the inspectors observed that a number of improvements were required to ensure that the premises supported the residents' needs in a homely and comfortable manner. For example, it was noted that some rooms required painting, the floor covering in the kitchen was unsightly and the counter top cracked in places. Additionally, residents did not have the option of an appropriate private area to entertain their visitors.

Inspectors acknowledged that plans were in progress with regard to improving the accessibility of the premises with the addition of a ramped area. The person in charge reported that this work was reviewed recently by an architect and they were awaiting a date of completion. The inspectors were also informed that some new furniture items were currently on order. Additionally, it was noted that since the previous inspection work had been carried out on the garden which included the upgrading of the garden pathway.

Regulation 17: Premises

Inspectors observed that areas of the resident's home were not maintained to an appropriate standard of cleanliness and general decoration. Other premises matters needing to be addressed included the provision of a private area for residents to meet their visitors, and the facilitation of adequate ventilation and heating in all areas of the premises.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents' specialised food and nutritional needs were assessed, planned for, supported and reviewed in the centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

During the course of the inspection process, it was observed that residents' needs at times of change and transition in their lives were considered and supported. This included in reach support when residents' altered needs required admission to a hospital facility.

Judgment: Compliant

Regulation 26: Risk management procedures

Inspectors observed that the centre had an established risk management system. This included the required policies and the assessment of risks that could cause harm for the residents, staff or visitors which were subsequently documented appropriately on a risk register.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had a robust fire management system in place. This included suitable fire equipment and a procedure for the safe evacuation of residents and staff. Since the previous inspection, the required fire containment works had been completed by the provider.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

A number of areas required attention to further improve medication practices. These included the individual labelling of all medicines that the resident was prescribed and the completion of medication audits.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors found that residents' health care needs were recognised, assessed, supported and reviewed through a care planning system. Each resident had access to a general practitioner of their choice and were supported to access allied health professionals. These included a physiotherapist, occupational therapist, behaviour specialist and members of a mental health team.

Judgment: Compliant

Regulation 8: Protection

Inspectors observed that there were systems and measures in operation in the centre to protect the residents from possible abuse.

Staff were facilitated with training in the safeguarding of vulnerable persons.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Graifin House OSV-0002636

Inspection ID: MON-0020813

Date of inspection: 07/02/2018

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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Background</p> <ul style="list-style-type: none"> RehabCare's Training Team co-ordinate and deliver a suite of training courses which meet regulatory requirements and assessed Resident's needs. The PIC liaises regularly with RehabCare's Training Team to schedule staff on relevant training courses. The Training Team update individual staff training records once training has been scheduled and completed. The PIC has access to these records via an internal platform. <p>Action</p> <ul style="list-style-type: none"> Two staff are due to complete outstanding adult safeguarding training on 22/5/18. Safe administration of medication refresher took place for three staff who required it on 27/4/18. Other staff are scheduled to complete this training on 9/5/18 Food safety training was completed on 9/3/18 and further training is scheduled to take place on 15/6/18 and 13/9/18 for remaining staff who require it. PIC to ensure up to date training records are maintained in the service and reviewed on 6 monthly basis. Staff training needs will continue to be identified during staff supervisions. All staff have now received supervision with PIC/PPIM, this was completed by 28/4/18. A Supervision schedule in place to ensure quarterly supervision of all staff takes place in line with revised organizational policy. 	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Background

- The provider has systems in place to ensure an annual review and unannounced six monthly visits take place in the service. This process includes provisions for consultation with residents and their families. The PPIM will ensure this is implemented in annual reviews going forward.

Action

- 2017 complaints were reviewed with updated 27/04/2018, all are closed with exception of one, there is a plan in place that may involve some building work in respect of this complaint with a view to close off by 30/6/18.
- A revised organizational complaints policy came into effect on 28/03/2018. Implementation of this policy will ensure that future complaints will be closed out in timely manner. The Manager will be have responsibility to ensure that all complaints are concluded to the satisfaction of the complainant with evidence of same recorded on the Complaint Management Database.
- The Service annual review completed in December 2017 will be updated to include feedback from families, this will be complete by May 10th.
- Completion of outstanding actions from 2017 HIQA inspection by 1/5/18.
- The PIC and PPIM will review this compliance plan to ensure actions have been completed on a regular basis. In addition reports arising from unannounced visits and other reviews will be regularly reviewed to ensure actions are complete. This will be done through the supervision process.

Regulation 34: Complaints procedure

Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Background

- A revised organizational complaints policy came into effect on 28/03/2018. Implementation of this policy will ensure that future complaints will be closed out in timely manner. The Manager will be have responsibility to ensure that all complaints are concluded to the satisfaction of the complainant with evidence of same recorded on the Complaint Management Database.

Action

- 2017 complaints were reviewed with updated 27/04/2018, all are closed with exception of one, there is a plan in place that may involve some building work in respect of this complaint with a view to close off by 30/6/18.
- All active complaints to be reviewed on monthly basis to ensure actions are completed and complaints closed out in timely manner.

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:	
<p>Background</p> <ul style="list-style-type: none"> • The organisation's Policy on Policies requires that all organizational policies are reviewed at minimum every 3 years. A plan is in place to ensure all Schedule 5 policies are reviewed in line organizational guidance and on three yearly basis or more frequently as required thereafter. <p>Action</p> <p>The policy on Restrictive Practices was disseminated on 30/04/2018. The remaining 4 policies will be disseminated for implementation as follows:</p> <ul style="list-style-type: none"> • Staff Learning & Development – Before 15/06/2018 • Service User Finances – Before 30/06/2018 • Data Protection & CCTV Policies – Before 31/05/2018 	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	
<ul style="list-style-type: none"> • Since the inspection a number of improvements have been made: <ul style="list-style-type: none"> ○ New cleaning schedule has been implemented since 1/3/18. ○ Professional carpet cleaning was completed on 15/3/18. ○ Ventilation of gym room was added to health and safety checklist 12/2/18. ○ Upgrade to outdoor pathway completed 28/4/18. ○ New floor covering in kitchen on 26/4/2018 ○ Painting of interior walls is scheduled 20/5/18. • The exiting relaxation room will be developed into multifunctional room/ visitor's room this has been discussed and agreed with residents. A clear out and cleaning of this room was completed on 8/2/18. There is daily/ weekly cleaning schedule in place to include ventilation/ heating of room, this has been in place since the 1/3/18. New furniture has been ordered for indoor and multifunction room, this was delivered on 19/4/18. • A system is in place whereby the Manager or the Team Leader will complete spot checks on cleaning. A checklist is used to record evidence of spot checks, this has been in use since 1/3/18. • All maintenance requirements to be added to maintenance log and completed on quarterly basis. 	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and	

pharmaceutical services:

Background

- The organisation's Medication Management Policy governs the management and administration of medication within services. The policy has been developed and is regularly reviewed to ensure it is in line with international best practice. Within the policy there is guidance on the labelling of medication and on the completion of medication audit.
- Service user medication counts are completed on daily basis, as a mechanism to monitor for errors in administration (weekly for 1 service user who self-administers in line with risk assessment). All incidents and near misses are reported and monitored on the organisation's incident management system.

Action

- All service user medication is now individually labelled, this was complete on **12/2/18**.
- A Service medication audit is scheduled to take place on **18/5/18**. Thereafter, this will be repeated regularly in order to assure the management and administration of medication practices in the service are compliant with organizational policy.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	15/06/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	18/04/2018
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.	Not Compliant	Orange	20/05/2018
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/04/2018
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	19/04/2018
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	Substantially Compliant	Yellow	10/05/2018

	residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	10/05/2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	10/05/2017
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	30/06/2018
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2018