

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Glen
Centre ID:	OSV-0002648
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Grainne Fogarty
Lead inspector:	Mary Moore
Support inspector(s):	Julie Hennessy
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day.

The inspection took place over the following dates and times

From:	To:
30 May 2017 08:30	30 May 2017 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This inspection was the third inspection of this centre by the Health Information and Quality Authority (HIQA); the last inspection was undertaken in February 2016. This current inspection was undertaken to follow-up on the actions that had emanated from the last inspection and to monitor on-going regulatory compliance so as to inform a registration decision.

How we gathered our evidence:

The inspection was predominantly facilitated by the person in charge and the team leader. The regional manager who was the provider's representative and the integrated services manager also met with inspectors; the regional manager (the provider's representative) attended verbal feedback at the conclusion of the inspection.

Prior to the inspection the inspector reviewed the information held by HIQA in relation to this centre. This included documents submitted by the provider with the application for registration of the centre, the previous inspection findings and action plans, any notice received of any incidents that had occurred in the centre and all correspondence received from the provider in relation to them. In the centre,

inspectors reviewed records including fire and health and safety related records, records of complaints received and records pertaining to residents, their assessed needs and required supports.

Inspectors met with all of the residents living in the centre; this engagement with residents was guided by each resident and their choices and needs.

Description of the service:

The centre comprised a domestic style two-storey building located on a spacious site in a rural location; transport was available. Residential services were provided to a maximum of 4 residents who required a high level of staff support to meet their assessed needs.

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. Inspectors were not satisfied that the document was an accurate reflection of the services and supports provided.

Overall Findings:

Given the longstanding complexities and challenges within this service, which the provider accepts and acknowledges, governance that demonstrated adequate oversight, including clinical oversight, so as to ensure the consistent safety and quality of the services and supports provided to residents, was not adequately evidenced.

Inspectors were not satisfied that the provider had adequately addressed the reliance on relief and agency staff so as to ensure the consistency that residents required. Inspectors were not satisfied that the provider had completed the committed to staff training needs analysis or, completed a programme of staff training that the provider itself had identified in February 2017, as required to ensure the quality and safety of the supports and services provided to residents.

Following professional reviews completed since the last inspection, there was clear evidence that the premises and model of shared living did not meet the individual and collective needs of the residents. Given the complex and diverse needs of the residents, the environment presented challenges to residents and staff and posed risks, on a daily basis, to resident welfare and safety. A consistent theme, as evidenced in records seen and staff spoken with, was the incompatibility of residents' needs.

A significant failing that impacted on the compliance evidenced across outcomes was the absence of a comprehensive assessment of needs for residents. While residents had received some inputs, it was not demonstrated how the assessment process was holistic and comprehensive as it did not fully reflect residents' needs, for example, in relation to communication, dietary, healthcare or psychological supports. Where allied health services had been provided, these (with the exception of psychiatry and behaviour support), based on records seen, had been provided on a one-off basis with no clear arrangement in place for follow-up, re-referral or monitoring of the success or otherwise of recommendations.

Nine regulatory Outcomes were inspected and the provider was, based on the inspection findings, found to be in major non-compliance with seven Outcomes and in moderate non-compliance with two. The evidence and the failings that informed these judgements are discussed in each respective Outcome in the body 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 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The person in charge told inspectors that staff had and were continuing to work so as to promote positive communication and relationships with families. It was clear from records seen that families did monitor the supports and services delivered and did raise concerns they had as to the quality of these supports and services. Inspectors reviewed the complaints log; six complaints were logged since the last inspection; all from family members. In the same timeframe however, five compliments from family members had also been logged by staff. In response to the matters complained of there was evidence of action taken by staff to address the complaint and prevent a reoccurrence. There was, however, one confirmed unrecorded complaint, though there was evidence of action taken (bathroom repairs) in response to the matter complained of (as reported by staff to inspectors).

There was evidence of tools to support and enhance communication with residents; for example visual schedules, a visual staff rota and a pictorial menu. There was evidence in some support plans, as discussed in Outcome 5, as to how staff facilitated residents' preferences. However, staff did still not adequately evidence how they sought, ascertained and facilitated residents' choices, preferences and decisions. Staff described this as a process of trial and error; for example staff said that "talking mats" (cards with symbols attached) had been trialled and did not work; a residents' forum was reported to have not worked. However, evidence to support inadequate consultation with, and the participation of residents in the daily routine included the findings of the two provider unannounced reviews completed in March and May 2017; findings included complaints from families to changes made to planned activities "often" without a valid

reason, irregular key worker meetings and little evidence of how residents inputted into the daily menu and schedule of activities.

Inspectors reviewed the management of residents' finances. There was evidence of each transaction, receipts including the purpose for which the monies were used and receipts for any monies received. Since the last inspection a system of oversight, as required by the provider's policy and procedures, had been implemented; there was recorded oversight on a regular basis by either the person in charge or the team leader. However, based on feedback from staff, action was required of the provider to ensure that all residents had control over their own finances.

Records seen indicated that residents had received advocacy support.

Judgment:

Non Compliant - Moderate

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors reviewed a sample of personal plans. On the day of inspection, inspectors found inconsistency between personal plans. For example, one personal plan required updating and more specific information about the resident's likes and dislikes. This had also been identified by the provider in a recent unannounced visit. Another personal plan was individualised and contained specific up-to-date information that reflected information articulated by staff to inspectors. In addition, an example of an easy-to-read folder was reviewed, which had been developed by staff to support residents' in relation to their daily routine and daily activities.

Residents either attended a day service or were provided with an individualised day service in the centre to suit their needs. Where an individualised service was provided, residents were supported to be active, to pursue interests that they enjoyed and to choose between different options.

However, a significant failing was identified in relation to the absence of a comprehensive assessment of needs for residents that informed the personal plan. While residents had received some inputs, it was not demonstrated how the assessment process was holistic and comprehensive and informed inputs, as it did not fully reflect residents' needs, for example, in relation to communication, dietary, healthcare or psychological supports.

Where allied health services had been provided, these, based on records seen had been provided on a one-off basis, with no clear arrangement in place for follow-up, re-referral or monitoring of the success or otherwise of recommendations. For example, inspectors found that recommendations made by an occupational therapist in relation to a sensory diet had not been implemented and that there was no plan to track or follow through on recommendations made by a psychologist. Overall, based on the findings above, satisfactory clinical oversight of assessments, plans and their effectiveness was not demonstrated.

Personal planning meetings were held annually and in consultation with residents or their representatives and a representative from the provider's main funder. However, the review of the personal plan was not multidisciplinary, as required by the regulations and clearly as required by residents. As a result, it was not evidenced that the review satisfactorily considered the adequacy of supports provided to residents, any required referrals or other relevant issues, such as the compatibility of residents and the appropriateness of living arrangements.

There was no identified responsible person, action plan or implementation timeframe seen for the follow-up of the reviews.

A consistent theme as evidenced in records seen and staff spoken with was the incompatibility of residents needs; for example family had raised it; the provider review of May 2017 has identified it; it was clearly articulated in occupational therapy and psychology reviews that had been completed. Again what was not clear, as discussed above, was the follow through and plan for this finding and relevant recommendations.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was clearer evidence from professional reviews completed since the last inspection that the premises and model of shared living did not meet the individual and collective needs of the residents. Given the complex and diverse needs of the residents, the premises presented daily challenges to residents and staff and posed a risk on a daily basis to resident welfare and safety.

The report of a psychology assessment completed since the last inspection clearly stated that one resident for their safety and well-being in line with their assessed clinical needs required a tailor-made, low stimulation environment where items of risk were "designed-out" at the planning stage. Given the clinical needs of the other residents this was not possible to achieve in this current environment. Where staff made modifications, this placed restrictions on other residents and led to shared areas that were bleak such as the dining room and bathrooms. It was clearly recorded that other residents were impacted by the "lack of environmental enrichment". A second clinical opinion, again sought and given since the last inspection, concurred and stated that a resident required a service where they, in line with their clinical requirements, could choose when and whether to interact with others.

As at the time of the last inspection, inspectors saw that one of the main bathrooms was not operational due to required repairs. The details of why these repairs were required again attest to the unsuitability of the premises to meeting resident's individual and collective needs and the impact of this on residents.

Inspectors noted that there was an offensive odour throughout the day from the ground floor bathroom that was available to residents. Staff confirmed that this was a regular occurrence as was the requirement for staff to unblock drains or get them commercially unblocked.

The provider representative confirmed that the provider was not in a position to provide evidence of compliance with planning requirements and that a substantial financial investment was required to secure this.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors reviewed a sample of resident-specific risks and their management. Failings were identified in control measures or the degree to which controls could be implemented and managed by staff.

For example, there was a clear identified risk of PICA (the eating or placing in the mouth of non-edible or non-food items). Staff spoken with were clear on the risk and the management protocol. However, given the diversity of residents' needs, environmental items presented challenges to the degree that the behaviour was exhibited and required intervention on a daily basis.

There was an identified risk of choking unrelated to and in addition to the risk posed by PICA; the required controls were unclear and unsupported by the appropriate speech and language review and recommendations. A required control was first-aid training for staff; however, only four staff were listed as having completed first aid training. Training was scheduled for July 2017 but inspectors were not assured as to the timeliness of this training given the risk from PICA that presented on a daily basis.

There was an identifiable infection control risk; some measures had been put in place to prevent the spread of infection. These included the provision of personal protective equipment (such as gloves), liquid hand gel and appropriate cleaning agents. A risk assessment was in place that related to the prevention of the spread of infection and an intimate care support plan had also been developed. However, it was not demonstrated that the control measures in place in this centre were adequate or that they were being fully implemented. For example, the importance of hand hygiene highlighted in both the risk assessment and the service's infection control policy was not supported by a staff training programme and there were no arrangements in place to ensure adequate oversight of infection control practices in place in this centre. In turn, the policy itself was not centre-specific, meaning that the arrangements required to ensure practices in place were satisfactory in this centre were not outlined in a policy or procedure.

Inspectors reviewed the fire-fact file and saw that fire safety measures, that is, the fire detection system, emergency lighting and fire fighting equipment were inspected and tested at the required intervals and most recently in March 2017. However, it was noted that an escape route through two adjoining communal rooms was not serviced by emergency lighting; this will require review and confirmation that the escape route is adequately illuminated by the existing system.

Staff undertook simulated evacuation drills with residents. However, a review of the records did not confirm the adequacy of the evacuation strategies. Inspectors noted that in August 2016, one resident had not co-operated with the drill and had not evacuated the house; staff had still recorded an evacuation time of just over one minute. As the identity of the resident was not recorded, it was not evidenced if the resident had participated and successfully engaged in a further evacuation drill. The possible failure to evacuate was not referenced in any PEEP (Personal Emergency Evacuation Plan)

seen. There was a possibility that one resident would require physical assistance from staff to evacuate successfully; no strategies were outlined as to how this could be safely achieved by staff, that is, the possible requirement of a proprietary evacuation assistive device.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Records seen and staff spoken with indicated that residents and staff received good support from the behaviour therapist in the compilation and review of behaviour management guidelines and the facilitation of workshops for staff. Staff spoken with had good knowledge of specific behaviours, risks and protocols as raised with them by inspectors. However, the fundamental issues of comprehensive assessment, appropriate referral, and the failure to follow through on all recommendations, impacted on the prevention and therapeutic management of behaviours.

Residents presented with complex and diverse needs that required different supportive interventions in terms of shared living, noise management and environmental modifications. For example, incident records seen indicated regular periods of particular behaviours that were an identified trigger for another resident's behaviours. Some assessed needs required a specifically modified low-stimulating environment while others required a stimulating environment.

Residents were seen to have regular access to psychiatric review; however, the referral system for psychology was not clear.

While intrinsic clinical needs would always impact on the level and type of behaviours exhibited, this incompatibility of needs increased the likelihood of behaviours and the risk of harm; notifications recently submitted to HIQA reflected an emerging pattern of peer to peer incidents particularly between two residents with diverse needs and

requirements. This was viewed as a protection issue for one resident by staff; referral had been made to the local safeguarding team, there was a risk assessment and there was a safeguarding plan. However, a staff spoken with did not articulate adequate knowledge of the safeguarding risk or the safeguarding plan.

It was of concern to inspectors given the findings of two provider-led investigations requested by HIQA in early 2017 that training for staff in areas including professional boundaries, client-centred values, care-provision and best practice approaches, had not been completed; training records indicated gaps in baseline and refresher training in safeguarding and the management of actual and potential aggression (MAPA).

There were detailed medicines management protocols in place for PRN medicines, (medicines only taken as the need arises), as an adjunct to the management of behaviours of concern or risk; all staff spoken with provided feedback that was consistent with the instructions of the protocol.

Based on a sample of records cross-referenced by inspectors, there was some limited inconsistency between the daily notes and daily recording sheets in the recording of behaviours that challenged.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Records seen indicated that staff did seek medical advice and review and supported residents to attend their general practitioner (GP). Residents were also seen to have regular review by the psychiatrist and the behaviour therapist.

However, in the absence of a comprehensive assessment by an appropriate healthcare professional it was unclear how residents' healthcare needs were identified, how referrals were made so that residents had access to the appropriate service, and how the implementation and effectiveness of recommendations was monitored and follow-up review was requested as needed.

For example, one resident was, based on records seen, identified as at risk of choking;

the resident had not had a speech and language assessment. Consequently, staff spoken with did not describe clear evidence based practice on the requirement for and the provision of modified diets and safe and unsafe foods.

An occupational therapist had completed a review of residents needs in 2016; it was not adequately evidenced that the recommended sensory diet was implemented (an individualised therapeutic programme designed to assist sensory regulation). Where interventions had been rejected, there was no structured system of re-referral.

The pathway for access to psychological review and follow-up was unclear.

There were outstanding issues in relation to healthy eating and weight management. Inspectors saw support plans for both; staff said that nutrition training had been facilitated; the inspector saw that staff spoken with had an understanding of healthy eating and endeavoured to provide residents with healthy, freshly prepared meal choices. The person in charge confirmed that current referrals for dietary assessments were being made through the residents' general practitioner. There was healthy eating guidance seen to have been supplied by a dietitian in 2016. However, weight loss was not evidenced and staff spoken with did not describe practice that was consistent with the support plan seen in terms of weight management.

In addition, a further particular diet was in place and it was not clear whether this had been clinically assessed and deemed appropriate.

Overall, based on the findings above, satisfactory clinical oversight of assessment, referrals, plans and the effective implementation of plans and recommendations was not demonstrated.

Judgment:

Non Compliant - Moderate

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

At the time of the last inspection inspectors were not reassured that medication management systems were conducive to safe medication management practice. One of the failings identified at that time were ten medication errors reported between 1

November 2015 and 9 February 2016. These inspection findings would indicate that the safety of medicines management practice was not adequately addressed by the provider so as to ensure the safety of medicines management practice.

A review of the service completed by the provider in early 2017 on foot of a provider-led investigation requested by HIQA, had found a further 17 errors in the management of medicines between May and July 2016. This review had also identified "vast inconsistencies" in the administration of PRN medicines and non adherence to PRN protocols.

A provider review in early March 2017 found staff without current safe administration of medicines training, staff uncertainty as to the content of PRN protocols and six further medicines errors since January 2017; the auditors concluded that improvement measures that had been put in place were not effective.

The most recent provider unannounced review of the 12 May 2017 found one staff with no safe administration of medicines training and discrepancies between the prescription and the affixed pharmacy label.

The failings identified by this current HIQA inspection included;

- a dating error by the prescriber not identified by staff
- the non administration of a prescribed medicine on the 12 May 2017 with no explanation provided
- the administration by staff to a resident of an incorrect medicine on the 7 May 2017
- medications requiring disposal within a specified timeframe were not signed and dated by staff when opened
- blank entries in the medicines administration record where a designated code identifying the reason why, should have been used but was not used
- evidence to support deficits in both baseline and refresher safe administration of medicines training
- the use of an un-validated audit tool that did not effectively review medicines management systems and their safety.

In summary inspectors concluded that there was insufficient clinical oversight of medicines management practice and any improvement measures identified and implemented were not effective.

The exception to this was in relation to the PRN medicines. Inspectors found that staff were familiar with resident's PRN protocols and, based on the records seen, did adhere to the specifics of the protocol.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Given the longstanding complexities and challenges within this service, which the provider accepts and acknowledges, governance that demonstrated adequate oversight, including clinical oversight, and support for staff so as to ensure the consistent safety and quality of the services and supports provided to residents was not adequately evidenced.

The evidence to support this statement is discussed throughout the body of this report from the absence of the comprehensive assessment of residents needs, the stand-alone nature of referrals and reviews, the absence of follow-up, the incompatibility of residents' needs, staffing and staff training, the absence of clinical oversight as evidenced by ongoing medicines management failings and the improvement needed in healthcare needs supports.

The management structure of this centre has been historically unstable and this instability continued throughout 2016; the provider recognised this. Ultimately however, it is the provider's responsibility to ensure that there is, at all times, management systems in place in the designated centre that effectively and consistently ensure the appropriateness, quality and safety of the supports and services provided.

It could be stated that there was evidence of monitoring by the provider; since the Feb 2016 HIQA inspection there had been an annual review, three unannounced provider reviews and two service reviews on foot of provider-led investigations requested by HIQA. What was not clear was how the provider, as an entity, intended to definitively and effectively address the failings identified throughout these reviews so as to assure itself and others including families and HIQA as to the quality of service provided. There was a performance improvement plan for the centre that was shared with inspectors; the recommendations were specific, but the required actions, in effect "the how" were not; it was not strongly evidenced that this was a live plan; the last recorded date was February 2017.

Inspectors would also clearly differentiate between monitoring and support and improvement. The team leader, the person in charge, the integrated services manager and the provider representative all articulated commitment and willingness; definitive action such as protective measures have been taken as and when necessary. What was not sufficiently evidenced was the "continued and improved support and oversight from

central support functions and senior operational management” identified by the provider itself as required to address the identified failings in this centre.

On a day-to-day basis, in the context of established findings and failings in this centre, inspectors were not assured that there were arrangements to support sufficient and meaningful supervision of staff and the supports and services provided to residents. Management presence was consolidated between Monday and Friday and between the hours of 08:30 and 16:30 when there was generally only one resident in the house. In early 2017 the provider itself had identified the need to provide supervision in the evenings and at weekends; in May 2017 the unannounced provider review had again expressed concerns in relation to the support and supervision of staff outside of office hours.

Judgment:

Non Compliant - Major

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:

Inspectors were not satisfied that the provider had adequately addressed the reliance on relief and agency staff so as to ensure the consistency that residents required.

Inspectors were not satisfied that the provider had completed the committed to staff training needs analysis or a programme of staff training that the provider itself had identified in February 2017 as required to ensure the quality and safety of the supports and services provided to residents.

It was reported to inspectors that reliance on both relief and agency staff was reduced and consistency had improved. However, while there may have been some improvement on the previous inspection findings, a review of six weeks of staff rotas between 3 April 2017 and 15 May 2017 demonstrated that, on a weekly basis, an average of seven relief staff and three agency staff were still required to maintain the staffing supports required by residents. It was noted that, as late as three weeks prior to this inspection, family members were still raising concerns as to the turnover of staff in the centre. The high number of staff on the weekly rota was of concern to inspectors, not only in the context

of the provider's own findings on the impact of this on the consistency of service provision and that this should be the "exception" rather than the norm; but also in the context of these inspection findings and the absence of any meaningful structure that provided for the direct supervision of the supports and services provided to residents.

There was no evidence of the completion of a training needs analysis of all staff, feeding into staff improvement plans as recommended by a review of the service in early 2017 or the completion of training recommended (again following review); the recommended training included professional boundaries, interpersonal relationships in the workplace, client centred values, dignity in the workplace and care provision and best practice approaches.

There was no one complete and accurate record of staff training available to inspectors. Two records were provided, one local and one central: there were inconsistencies between both. There were gaps in baseline and refresher training in; medicines management, the management of potential and actual aggression, manual handling and safeguarding persons at risk of abuse and harm. There was at least one post-graduate programme that was recorded as completed but was confirmed to inspectors as not completed.

Inspectors were told that training workshops had been held and facilitated by the behaviour analyst, for example in relation to supporting persons with autism and other specific conditions. Training was also reported to have been provided on the management of PICA (the eating or placing in the mouth of non-food items that can pose significant risk to the person). In addition, a recent workshop had been held in relation to supporting individual resident's behaviour support needs. However, changes in staffing meant that many staff currently working in the centre had not attended; training records listed only five of 21 staff as having attended autism and positive behaviour support training.

A random sample of staff files were made available for inspection. Only one of the four files reviewed contained all of the information required by Schedule 2. The missing information consisted of employment histories including a satisfactory explanation of all and any gaps in employment history and a missing reference.

Judgment:

Non Compliant - Major

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 report¹

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002648
Date of Inspection:	30 May 2017
Date of response:	3 July 2017

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staff did still not adequately evidence how they sought, ascertained and facilitated residents' choices, preferences and decisions. This was also a finding of the provider's own internal reviews.

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 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:

Weekly service user house meetings to be recommenced as of 17.6.17. These are to be conducted weekly with the service users and can be as part of the group or on an individual basis. These meetings will discuss the choice of activities and meals each week and will also give staff an opportunity to discuss relevant topics in accessible formats with the service users. The progress of these meetings and improvements needed to be highlighted in monthly key working reports.

On a daily basis the service users' choice to be promoted by the use of reviewed and improved visual tools and picture sequencing.

Support and guidance on the use of communication and visual aids to be sought from Speech and Language Therapist. Initial request for support of Speech and Language Therapist sent 31.5.17 to the HSE and further communication sent on the request for support on 21.6.17. If the HSE are unable to meet this request we will attempt to source this privately.

Proposed Timescale: Immediate commencement

Proposed Timescale: 03/07/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was one confirmed unrecorded complaint.

2. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:

The outstanding complaint had been dealt with prior to the inspection on 30.5.17 but had not been recorded on the complaints and compliments system. It has now been logged adequately and all issues connected with it resolved as of 21.6.17.

Proposed Timescale: 21.6.17 - Complete

Proposed Timescale: 21/06/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A significant failing was identified in relation to a comprehensive assessment of needs for residents. While residents had received some inputs, it was not demonstrated that the assessment process was comprehensive as it did not fully reflect individual resident's needs.

3. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:

Dietician assessment scheduled for 2 service users on 6th & 7th of July.

Speech and Language therapist assessment and support sought from the HSE for all service users on 31.5.17 and contact made again on 21.6.17. If the HSE are unable to provide this service we will attempt to source this privately.

Sensory, Motor, Emotional Assessment scheduled for mid-September for all service users.

Following the assessments, resident's support plans will be updated with recommendations to inform staff practice and staff training will be provided as required.

Proposed Timescale: 31/10/2017 for completion of all actions

Proposed Timescale: 31/10/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The review of the personal plan was not multidisciplinary, as required by the regulations and clearly as required by residents. Where allied health services had been provided, these, based on records seen had been provided on a one-off basis with no clear arrangement in place for follow-up, re-referral or monitoring of the success or otherwise of recommendations.

4. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

In future, all of the professionals involved in supporting residents will be consulted as

part of the support plan review process and their contributions requested. All contributions and recommendation will be documented and used to inform updates of the support plan. Contributions from HSE personnel are dependent on the availability of these services in a timely fashion.

Proposed Timescale: 01/10/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A consistent theme as evidenced in records seen and staff spoken with was the incompatibility of residents needs. What was not clear was the follow through and plan for this finding and relevant recommendations.

5. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:

RehabCare senior management team have drafted proposals for the reorganisation of services in Limerick in an Improvement Plan. Part of this Improvement Plan sets out actions required to address the compatibility issues in this service. This plan was presented to the HSE in a meeting on 22nd June 2017. It is anticipated this plan will be fully implemented by 30th June 2018 subject to the HSE providing the funding required to reconfigure services.

Proposed Timescale: 30/06/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was no identified responsible person, action plan or implementation timeframe seen for the follow-up of the reviews; satisfactory clinical oversight of assessments, plans and their effectiveness was not demonstrated.

6. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:

Responsibility for implementation of actions arising from clinical input will, in future, be held by the PIC. The PIC will ensure that reviews of the effectiveness of interventions take place with the relevant clinician in a timely manner.

Proposed Timescale: 08/07/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was clear evidence from professional reviews completed since the last inspection that the premises and model of shared living did not meet the individual and collective needs of the residents. Given the complex and diverse needs of the residents, the premises presented daily challenges to residents and staff and posed a risk on a daily basis to resident welfare and safety.

7. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:

The Implementation Plan clearly addresses the challenges presented by the premises.

A key element of the proposed Improvement Plan for the service would see a significant reduction in number of residents and capital investment to ensure the premises is adequate to support the needs of the remaining resident

A major service reconfiguration plan including revenue requirement has been submitted to the HSE for approval. The Provider will provide capital funding to advance this proposal pending statutory allocation

Proposed Timescale: 30/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

One of the main bathrooms was not operational due to required repairs. There was an offensive odour throughout the day from the ground floor bathroom that was available to residents. Staff confirmed that this was a regular occurrence as was the requirement for staff to unblock drains or get them commercially unblocked.

8. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:

All repairs were completed in the upstairs bathroom by 20.6.17.

This issue will be addressed in the Improvement Plan and discussed with the landlord

Proposed Timescale: 20/06/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Failings were identified in control measures or the degree to which controls could be implemented and managed by staff.

9. Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:

A comprehensive review of all risk assessments and control measures will be completed with the support of organisation's Health and Safety Manager. This will ensure that adequate risk assessments and controls are introduced where deficits are identified.

All staff training needs/requirements identified in this review, in relation to the management of these controls measures, will be provided.

Proposed Timescale: 31/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

It was not demonstrated that infection prevention and control measures in place in this centre were adequate or that they were being fully implemented.

10. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:

HSE Hand Hygiene online module will be completed by all staff in the service by 31st of July 2017.

Local Infection Control Procedure to be introduced to ensure that in the case of an

outbreak or increased risk relevant control measures are in place that are tailored for the centre itself.

Further Infection Control training/advice to be provided through the Health and Safety Department.

Proposed Timescale: 30/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

An escape route through two adjoining communal rooms was not serviced by emergency lighting; this will require review and confirmation that the escape route is adequately illuminated by the existing system.

11. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:

An external contractor has been engaged to install an additional smoke detector and to review and update emergency lighting on all exits to ensure they meet regulatory standards. All required works to be completed by July 14th.

Proposed Timescale: 14/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staff undertook simulated evacuation drills with residents. However, as detailed in the body of this report a review of the records of these drills did not confirm the adequacy of the evacuation strategies.

12. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:

The frequency of fire drills will be increased to 6 weekly in order to continually monitor and review the adequacy of evacuation strategies.

Fire drill report will record the evacuation and any learning identified will be used to update individual PEEPs and this will be discussed at team meetings to inform future evacuations.

Proposed Timescale: 05/07/2017

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:

Training records indicated gaps in baseline and refresher training in the management of actual and potential aggression (MAPA).

13. 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:

Three staff attended Refresher MAPA training on 23/06/2017.

Two staff are scheduled to attend MAPA training on July 4th.

Proposed Timescale: 04/07/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Training records indicated gaps in baseline and refresher training in safeguarding; a staff spoken with did not articulate adequate knowledge of a safeguarding risk or the safeguarding plan.

It was of concern to inspectors given the findings of two provider led investigations requested by HIQA in early 2017 that training for staff in areas including professional boundaries, client centred values, care-provision and best practice approaches, had not been completed.

14. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:

All new and existing staff will receive comprehensive training in Safeguarding and Protection delivered by our in-house training team during July and August.

Proposed Timescale: 30/08/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The incompatibility of residents needs increased the likelihood of behaviours and the risk of harm; notifications recently submitted to HIQA reflected an emerging pattern of peer to peer incidents particularly between two residents with diverse needs and requirements.

15. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

This situation is being managed through a safeguarding plan, which is reviewed regularly to assess its effectiveness, control measures introduced have reduced incidents significantly.

RehabCare senior management team have drafted proposals for the reorganisation of services in Limerick, this Improvement Plan sets out actions required to address the compatibility issues in this service. This plan was presented to the HSE in a meeting on 22nd June 2017. It is anticipated this plan will be fully implemented by 30th June 2018 subject to the HSE providing the requisite revenue funding to support service reconfiguration. The Provider will provide capital funding to support this reconfiguration.

Proposed Timescale: 30/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

In the absence of a comprehensive assessment by an appropriate healthcare professional it was unclear how residents healthcare needs were identified, how referrals were made so that residents had access to the appropriate service, and how the implementation and effectiveness of recommendations was monitored and follow-up review was requested as needed. For example, in relation to any speech and language requirements, dietary and psychological supports.

16. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

A health needs screening tool will be completed for each resident by 31/08/2017 and will be completed on at least an annual basis thereafter.

The PIC will be responsible for ensuring referrals are made and facilitated as required. The PIC will also be responsible for ensuring monitoring and follow up of all recommendations takes place as required. If the HSE are unable to provide the required health care professional interventions as is their responsibility, then the Provider will seek to obtain these services privately.

Proposed Timescale: 31/08/2017

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:

The safety of medicines management practice was not adequately addressed by the provider so as to ensure the safety of medicines management practice. There was insufficient clinical oversight of medicines management practice and any improvement measures identified and implemented were not effective.

17. 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:

The organisations revised Administration of medication policy has been issued. This will be circulated to the staff team week beginning July 3rd.

The revised policy is accompanied with an audit tool that will implemented by the PIC at local level during week starting July 3rd.

A Team Meeting will held week beginning July 19th to discuss and confirm actions required for implementation.

An expert in the field of medication management from the Quality & Governance Directorate will be on site during the month of July to support the management and practice regarding all aspects of medication management.

Proposed Timescale: 25/07/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The provider representative confirmed that the provider was not in a position to provide evidence of compliance with planning requirements and that a substantial financial investment was required to secure this.

18. Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

The requirement for Building compliance is a central component in the Improvement Plan for this service and will be discussed with the landlord. As stated earlier the plans for this service will result in a significant decrease in the risks associated with the number of service users and the environment.

Proposed Timescale: 30/06/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was a performance improvement plan for the centre; the recommendations were specific, but the required actions, in effect "the how" were not; it was not strongly evidenced that this was a live plan; the last recorded date was February 2017.

19. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:

Unannounced visits will continue to be completed every six months as they have been, with clear actions identified.

The PIC has devised an action plan to address all issues identified. This action plan will also monitor progress and timelines to achieving completion. Provider senior management will maintain close oversight of the delivery of all actions.

Proposed Timescale: 30/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Management presence was consolidated between Monday and Friday and between the hours of 08:30 and 16:30 when there was generally only one resident in the house. In early 2017 the provider itself had identified the need to provide supervision in the evenings and at weekends; in May 2017 the unannounced provider review had again expressed concerns in relation to the support and supervision of staff outside of office hours.

20. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

PPIM to be rostered to work weekends and evenings from the 3.7.17.

Proposed Timescale: 03/07/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

It was not clear how the provider as an entity intended to definitively and effectively address the failings identified throughout these reviews so as to assure itself and others including families and HIQA as to the quality of service provided

21. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:

Clear management structure is in place.

PIC and PPIM have responsibility for the completion of actions arising out of any internal review.

Long term Improvement Plan is in place.

The provider nominee will take lead responsibility for the Improvement Plan.

Provider Board receiving monthly reports on implementation of Improvement Plan

Proposed Timescale: 22/06/2017

Outcome 17: Workforce**Theme:** Responsive Workforce**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A review of six weeks of staff rotas between 3 April 2017 and 15 May 2017 demonstrated that on a weekly basis an average of seven relief staff and three agency staff were still required to maintain the staffing supports required by residents.

22. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:

No agency staff have been employed in the service since 31.5.17

Full staff team has been recruited since 9.6.17, Garda Vetting is currently awaited for new staff members.

Once new staff commence the service will operate with 12 care workers, 1 team leader and 1 RSM. Relief support will be provided by 4 regular Rehab Care employed relief staff; who will play an active role within the team to ensure that they are fully aware of all supports our service users will require.

Proposed Timescale: 01/08/2017**Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Only one of four files reviewed contained all of the information required by Schedule 2. The missing information consisted of employment histories including a satisfactory explanation of all and any gaps in employment history and a missing reference.

23. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:

Further review of staff files to be undertaken, in line with schedule 2. This is to be carried out with support of HR department and to be completed by 7.7.17 and all deficits will be addressed with required documentation in place in the files.

Proposed Timescale: 07/07/2017**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was no evidence of the completion of a training needs analysis of all staff, feeding into staff improvement plans as recommended by a review of the service in early 2017 or the completion of training recommended (again following review).

There was no one complete and accurate record of staff training available to inspectors. Two records were provided, one local and one central: there were inconsistencies between both.

24. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

Local and organisation training records to be reconciled and a training needs assessment to be completed for all staff. All deficits in training to be identified.

Proposed Timescale: 01/08/2017