

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002654
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Rachael Thurlby
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
09 March 2016 09:15	09 March 2016 17:00
10 March 2016 09:30	10 March 2016 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This inspection was the first inspection of the centre by the Health Information and Quality Authority (HIQA). The inspection was facilitated by the person in charge and the team leader, both of whom were recently recruited to the centre. The regional manager was also available to the inspector and attended verbal feedback at the conclusion of the inspection.

The inspector met with staff and residents and reviewed records including policies and procedures, support plans, staff files and fire and health and safety related records.

The centre offered respite supports and services to approximately 38 residents and their families on a rotational basis.

A core failing in relation to the operation of this service was the design and layout of the premises which did not meet the needs of some of these residents. The assessment and placement process had not taken due regard of this fact. Consequently residents had been assessed and accepted for respite when it was clear that the premises and the facilities that it provided, were not appropriate to their needs and did not enable staff to provide residents with contemporary, evidence based quality supports.

Given the fact that the arrangements within the centre were significantly insufficient to meet the needs of a core cohort of residents, the provider was judged to be in major non-compliance with four Outcomes. These Outcomes were, admissions, individualised assessment and support planning, safe and suitable premises and the statement of purpose and function.

The regional manager, the person in charge and the team leader all understood the failings within the service and these inspection findings. The regional manager told the inspector that the provider was currently accepting no new referrals to the centre.

While action within the centre was possible to address some of the identified failings across the full eighteen Outcomes, there was a requirement on behalf of the provider to ensure that residents were robustly and accurately assessed and based on assessment were then provided with the required and appropriate accommodation, supports and services.

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):

This was the centre's first inspection by the Authority.

Findings:

Staff said that a house meeting was convened each Friday evening with residents at the commencement of respite to plan the weekend ahead. Records seen by the inspector confirmed this with each resident's suggestions and preferences as to activities and meals recorded. Substantive issues were also discussed with residents including the fire evacuation procedure, their charter of rights and personal goals. Staff were heard to discuss upcoming local events for exploration with residents so as to ascertain from them if they would like to attend.

However, the person in charge confirmed that a house meeting was not convened with all residents and this was recently addressed with staff as to how consultation with and the participation of more dependent residents would be facilitated and evidenced. Staff were observed to interact respectfully with residents and were seen to ascertain choices and preferences through interpretation of gestures and other non-verbal responses. Residents were clearly comfortable with staff. Staff had also commenced a process of recording their consultations with more dependent residents.

The provider operated an internal advocacy network; one resident was said to be actively engaged in this structure and attended the relevant meetings. Residents ordinarily accessed the advocacy structures through their respective day service. The person in charge confirmed however that she had invited the advocate to attend the weekly house meetings so as to expand upon the accessibility of advocacy to all residents.

Staff spoken with had a good understanding of the provider's complaints policy and procedure. How to make a complaint was discussed at the resident's weekly house meetings. The person in charge and the team leader on their appointment had advised all families that their comments and concerns were at all times welcome. A log of complaints received was maintained; there was evidence of action taken by staff, whether the matter was resolved or not and a plan to revert to the complainant to ascertain satisfaction.

A number of residents required staff support to manage their finances. Financial records were maintained by staff indicating all transactions and supporting receipts indicating the purpose for which monies were used were in place for each transaction. Staff completed a record of all personal possessions brought to the centre by each resident.

Judgment:
Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Staff spoken with were clear on the communication abilities and needs of residents. Residents were seen to have explicit communication plans that detailed ability, communication methods both verbal and non verbal and the required appropriate response from staff to support effective communication with residents. Two staff had recently completed training on the use of PECS (picture exchange communication strategies) and there was evidence of the use of visual prompts by staff to ascertain resident's choices and preferences.

Residents had access to a computer; the communal area and each bedroom had a television. Residents were seen to have access to their preferred communication activities including music and interactive toys. Staff were seen to interpret, understand and respect residents' non-verbal methods of communication.

However, all relevant information was not incorporated into the communication support plan to ensure that the required supports were in place. Omitted information included sensory disabilities and known methods of communication including manual signing. There was no clear evidence that residents had been assessed to ascertain their suitability for and how they might benefit from assistive technology.

Judgment:
Substantially Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Residents ordinarily continued to live at home. Staff said that the planning and provision of respite was completed in close consultation with residents and their families. Staff maintained a family communication agreement that set out the frequency and preferred method of communication; staff maintained a record of communication and records seen by the inspector confirmed a dual process of communication between staff and families. Staff were seen to make and return calls to residents and families during the course of the inspection.

Staff were heard to discuss local upcoming events that residents might like to attend. Staff described the local community and facilities as welcoming and inclusive. Staff said that some residents liked to attend for respite when friends or peers were also attending and this was facilitated whenever possible.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:

There were agreed policies and procedures for accessing respite services. This included the input of the statutory body and assessment by the provider to ensure that the supports available met assessed needs.

However, based on these inspection findings there was clear evidence that this was not a robust or effective process. Residents had been assessed and accepted for respite when it was clear that the premises and the facilities that it provided were not appropriate to their needs and did not enable staff to provide residents with contemporary, evidence based quality supports.

Residents did have a contract for the provision of supports and services generally signed by themselves or their representative and a representative of the provider. The sample of contracts seen by the inspector specified the nature of the service provided, that is a respite service, and any applicable fees or contributions.

Judgment:

Non Compliant - Major

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector reviewed a purposeful sample of support plans. The plans presented and read as functional and task orientated and this was reflected further in the daily narrative notes maintained by staff. Regular and repeated entries referred to the attendance to hygiene requirements, the consumption of meals, the administration of medication and sleeping patterns. Only two support plans were seen to include multi-disciplinary review (MDT) and it was therefore not always clear why supports were required, for example a modified diet. Where there was evidence of MDT review the findings of the MDT review was not seen to inform the support plan. Of further concern was the fact that the premises, given the deficit of accessible suitably adapted sanitary facilities, clearly did not facilitate the implementation of the required support plan, specifically in relation to promoting independence in personal hygiene and toileting.

Identified supports were vague and simply referred to "staff support" or "staff reassurance".

There was little or no social dimension to the support plans; the assessment of activity participation, peer contact and community integration was generally either not completed or ticked "no". There was no evidence in this sample of support plans of personal goals and objectives. In the absence of same, the predominance of attention to physical care and the limitations of the physical environment it was difficult to see how the support plan improved and ensured quality outcomes for residents.

Given that residents were accepted for admission into a premises that could not meet all of their needs and the deficit of information available to staff on core support areas such as behavioural supports, it was difficult to see how the support plan was supported by a comprehensive assessment of the health, personal and social care needs of each resident prior to their admission to the centre. Furthermore, if such an assessment was completed, it was difficult to see how the centre was deemed suitable for the purposes of meeting the needs of each resident.

There was evidence of transition plans when residents transitioned or progressed between services. However, the assessment and plan did not ensure that all of the required supports would be in place for each resident.

There was a fundamental deficit between resident's needs and the available supports and services with the consequent inappropriate placement of residents in premises that was not suited to their needs.

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):

This was the centre's first inspection by the Authority.

Findings:

The design and layout of the premises did not meet the needs of a cohort of residents.

The premises was located on a spacious site in a rural but well-populated area and staff reported that the local community was welcoming and inclusive; transport was provided.

The premises was a domestic style two storey building. Each resident was provided with their own bedroom; bedrooms were of a suitable size and provided ample provision for personal storage. There was one ground floor bedroom available to residents. There was one ground floor sanitary facility with toilet and wash-hand basin and at first floor level there was a main bathroom with toilet, wash-hand basin, bath and shower; a further en-suite sanitary facility was located off the staff office/sleepover room and staff said that residents had access to this.

However, there was clear evidence that more than one resident accommodated at a time required or would have benefited from a ground floor bedroom as they either could not physically use the stairs, declined to use the stairs or used the stairs with staff guidance and supervision and adaptive physical techniques.

Consequently this cohort of residents could not access the available sanitary facilities. There was clear evidence that their high personal and hygiene needs were attended to by staff in the bedrooms with the provision of "bed-baths" and "body-washes". In addition to the barrier to access, all of the available facilities (the bath and the two showers) were of a standard domestic type and did not meet any requirement for universal access. The ground floor facility was compact with a door width that was even less than standard width measuring only 59 centimetres.

The premises was not suitably equipped with supportive equipment such as handrails and grab-rails with windowsills regularly cited as used by staff to provide the required support to residents.

The premises did not facilitate the implementation of the required support plan as specified in MDT minutes, specifically in relation to promoting independence in personal hygiene and toileting.

The kitchen was adequately equipped and incorporated the dining area; residents had access to a pleasant and welcoming communal area. However, based on the observations of the inspector the available space was not conducive to the needs of all of the residents and did not offer them sufficient unrestricted space that was safe and free of obstacles.

The premises did not meet the requirements for universal access. There were three entrances/exits and all required the negotiation of two steps.

There was a spacious utility with laundering facilities.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector saw both organisational and centre specific safety statements that were signed as read and understood by staff. The safety statement included the procedures for the identification and assessment of risks and the recording, reporting and investigation of accidents, incidents and adverse events.

The inspector reviewed the local risk management folder. The folder included a broad range of risk assessments, the risks as specifically required by Regulation 26 (1) (c) as well as risks specific to the centre; all were signed and dated as recently reviewed by the person in charge. However, some identified resident specific risks as seen in support plans did not have risk assessments completed, for example the risk of leaving the centre unaccompanied by staff or the risk of food and fluid aspiration. Controls were in place such as modified diet and one to one staff supports but there was no direct co-relation in the form of a risk assessment between the controls and risk. Some identified controls were not sufficient to reduce or manage risks, for example advising the resident of interventions required for their safety when it was clearly recorded that the resident did not have safety awareness.

The provider had a centre specific business continuity staff that set out for staff the actions to be taken in defined emergency situations; the plan included alternative accommodation for residents if required.

The inspector saw that emergency lighting and an automated fire detection system were in place. There was evidence of fire resistant doors (labelled accordingly) and fire alert call points. Both diagrammatic and pictorial fire action notices were displayed. Final escape routes were clearly indicated.

Fire related records were maintained in the fire fact file. The inspector saw certificates confirming that the fire detection and fire fighting equipment and the emergency lighting were inspected and tested at the prescribed intervals and most recently in February 2016, November 2015 and March 2016 respectively. Staff maintained records of the in-house inspection on a daily, weekly and monthly basis of escape routes and fire safety equipment.

Training records indicated that staff were provided with fire safety training on an annual basis. Each resident had a current personal emergency evacuation plan (PEEP) and simulated fire drills were convened on a regular basis. However, the simulated evacuations had identified that all residents did not respond to the alarm and did not leave the building when requested by staff. The person in charge confirmed that in this

regard she had sought advice from appropriate persons including advice on the use of proprietary evacuation devices. The person in charge confirmed that the PEEP would be reviewed again and in a timely manner once the equipment was in place and the evacuation plan was agreed.

Staff completed a weekly visual safety check of the available transportation. There was a central transport department that co-ordinated the maintenance and servicing of the vehicle.

Judgment:

Substantially Compliant

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons, risk assessments and staff training. Staff said that there had been no incident of alleged, suspected or reported abuse. The person in charge described staff as committed to and invested in the welfare of residents.

Staff training records indicated that staff had attended training on safeguarding vulnerable adults and responding to behaviours that had the potential to challenge or harm the resident and others.

Staff completed body maps to record any injuries of unknown origin. However, it was not clear how the completion of the body map supported safeguarding measures. The person in charge confirmed that staff had not brought recently completed maps to her attention for review and follow-up to ensure that there were no safeguarding concerns.

There were no reported restrictive practices. However, based on records seen there was reference to one monitor in use at intervals in one bedroom to alert staff to seizure activity. There was no supporting documentation for its use or its evaluation as a potential restrictive practice in that it had the potential to infringe upon the residents

right to privacy.

Staff said and records seen confirmed that residents did exhibit behaviours that required intervention both for the residents dignity and safety and the safety of others. Staff spoken with articulated respect and understanding for residents and any associated behaviours; records seen indicated that staff responded therapeutically. There were some resident specific risk assessments for behaviours that challenged for example while in the car or when out and about with staff.

However, there was scant evidence of behavioural history prior to admission, of multi-disciplinary reviews and information. Staff did not have access to detailed therapeutic behaviour support plans, informed and devised with the appropriate professional expertise.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

Records were maintained of accidents and incidents that occurred in the centre and these records were available for the purpose of inspection. The person in charge was aware of the events that required notification to the Chief Inspector and had exercised her legal responsibility to submit them as outlined in Regulation 31 (1) to (3) inclusive.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

This was the centre’s first inspection by the Authority.

Findings:

Residents presented for respite with a broad range of very differing and diverse needs. Some residents lived independently in the community; some residents enjoyed gainful employment or continuing education; other residents were fully dependent on staff in all aspects of their daily living.

It was clear on speaking with staff that the majority of residents enjoyed their respite stay, meeting with their peers and enjoyed planned activities supported by staff. Staff said that they had commenced a process of consultation with residents in relation to their personal goal or objective for respite; staff also where possible attended the personal plan reviews that were largely co-ordinated by the day service. Staff reported that residents enjoyed the amenities available locally. Transport was available and activities enjoyed included the cinema, bowling, swimming, gardening and themed day trips. Recent suggestions from residents included rock-climbing and surfing.

However, where residents presented with higher needs it was not clear how staff supported these residents to enjoy new experiences and engage in activities that were meaningful and beneficial to them and their development. It was not evidenced in the records seen which were functional and task orientated with an emphasis on physical supports. Where potential and development in these areas had been identified and planned at MDT, it was difficult to see how the lack of appropriate services in the centre supported and continued the plan/goal for enhanced resident independence.

This failing and the required action is addressed under Outcome 5 Social Care Needs.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

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

This was the centre’s first inspection by the Authority.

Findings:

Because residents were not ordinarily resident in the centre staff said that residents themselves or their family took responsibility for health care related matters. This was evidenced in the records seen by the inspector. Likewise staff said that family co-

ordinated services received from other healthcare professionals such as psychiatry and neurology.

Staff did through consultation with families ascertain healthcare requirements and took action as required, for example in the event of illness.

Staff spoken with were familiar with the healthcare needs of residents and there was documentary evidence of communication and updates between families and staff; there was evidence of some healthcare related support plans. However, the inspector was not reassured that care was evidenced based or that all of the required information was available to staff to ensure the required supports were in place and that there was continuity of care for residents.

For example a record seen indicated that a resident was on a healthy eating plan and while there was some narrative reference to this there was no clear health promoting support plan based on this healthy eating programme so that it was implemented across all support settings. Staff were not aware of a documented history of choking episodes and there was no support plan for managing the risk. Residents were in receipt of modified diet but why this was required was not explicitly stated or supported by records of speech and language recommendations. It was unclear why a resident did not consume liquids while in respite or if a speech and language referral and review had taken place. Residents did not have plans including dietary intervention for supporting and monitoring bowel health other than the administration of prescribed laxatives.

Plans for the management of seizure activity were in place but they did not provide sufficient guidance to staff on recovery times or action to be taken in the event that emergency medications were ineffective. One identified control in one plan was inappropriate and not evidenced based and advised staff to contact emergency services if appropriately trained staff were not on duty. The current person in charge reassured the inspector that staff with the required training to administer the prescribed medication were on duty at all times.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector saw organisational and local policies and procedures governing the management of medication in relation to residents availing of respite. The practice observed and as described by staff was as outlined in these policies and procedures.

Each resident had a current signed and dated prescription, a corresponding administration record and a medication plan and protocol for the administration of any p.r.n medicines, (a medication only taken as the need arises). The maximum daily dosage of p.r.n medications was stated. Medications were accepted only when supplied by community pharmacies to each individual resident. Secure storage was provided.

Staff were seen on admission to check the medication supplied with the current prescription record and to question and clarify any noted difference prior to administration. Staff undertook and recorded counts of all medication supplied and returned and these counts facilitated monitoring of administration as prescribed. There was a low reported incidence of errors and staff spoken with were clear on their responsibilities, possible consequences for residents and learning from any such errors.

Staff reported that approximately 50% of the residents were in receipt of no medications and some residents independently managed their medications; a detailed assessment of willingness and capacity to support this practice was completed by staff.

Judgment:

Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

A revised statement of purpose was submitted to The Authority prior to this inspection. It contained most of the information required by Schedule 1; room sizes were not however included.

However, of primary concern was the fact that the statement of purpose was not an accurate reflection of the services and supports that could be provided in the centre. The statement of purpose stated that admission to the centre was dependent on assessment and the suitability of needs to the services provided. The statement of purpose stated that residents with "high support needs" could be accommodated. Based

on these inspection findings both of these statements were inaccurate. Admission procedures did not accurately match needs with available supports and the premises and the facilities that it provided to residents and staff were not suited to meeting high support needs.

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):

This was the centre's first inspection by the Authority.

Findings:

There had been some instability in the governance structure of this centre with three changes to the person in charge between August 2014 and November 2015. The current person in charge was appointed to the role in November 2015 and is currently person in charge for two designated centres with a further one planned. The person in charge was suitably qualified in the provision of social care services and management and was employed full-time. The person in charge had established experience in the service, in the provision of supports to residents and in the supervision of staff having worked as a team leader. The person in charge was clear on the challenges in this service and was confident that she had the capacity and support to ensure effective governance and administration of all of the designated centres concerned.

On a day to day basis the person in charge was supported by the team leader who was also the PPIM (person participating in management). The team leader was also recently recruited to the role, was suitably qualified and had established experience in the provision of social care supports. Both the person in charge and the team leader said that they worked well together and with staff. Both though recently recruited were familiar with the residents and their needs. Both were clear on their respective roles and responsibilities and confirmed that they had ready access as required to the regional manager. Further opportunities for discussion, learning and peer support were facilitated through structured regional management meetings and team leader meetings.

Staff confirmed that there was an on call out of hour's manager available within the wider organisation and the rota was readily available to staff.

The person in charge confirmed that since her appointment she had supported staff to voice any concerns they may have had through the completion of formal supervision and team meetings. The person in charge reported that staff welcomed the new governance structure and the stability that it brought to the service.

Arrangements were in place for the completion of annual reviews and unannounced visits to the centre as required by Regulation 23 (1) and (2); reports were available for inspection. The person in charge confirmed that she had requested the most recent review completed in December 2015 and was satisfied that actions were either completed or in progress by her.

However, from the perspective of governance it was of concern to the inspector that a core cohort of residents had been admitted to the centre when it was clear that all of their needs could not be met there in a quality evidence based manner. In that context it was difficult to conclude that the overall organisational management and review systems ensured that the service provided to all residents was appropriate to their needs and effectively and consistently monitored.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

Arrangements were in place for the management of the centre in the absence of the person in charge. The team leader was recently recruited and was also the PPIM. The team leader said that she understood the role and responsibilities of the PPIM and would undertake it as required. Support was available to her as necessary from the regional manager and other local managers.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

This was the centre's first inspection by the Authority.

Findings:

The person in charge confirmed for the inspector that sufficient resources were available to the centre.

Judgment:

Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

This was the centre's first inspection by the Authority.

Findings:

Staff reported that there were no specific challenges to the maintenance of adequate staffing levels and an established team of front-line staff worked in the centre. A planned and actual staff rota was maintained. There was some dependence of relief and agency staff but staff said that this was managed with the same limited number of staff so as to minimise any lack of consistency. Staffing levels and arrangements were managed to reflect occupancy and the individual needs of residents. Night-time staffing arrangements consisted of one "waking" and one sleepover staff. For example staff said that as required night time staffing was increased to two "waking" staff; this was also reflected in the staff rotas seen by the inspector.

Staff files were made available for the purpose of inspection. The sample reviewed was well presented but two did not contain all of the information required by Schedule 2. One file did not contain evidence of the person's identity and another did not contain documentary evidence of relevant qualifications.

Based on inspection findings to date staff training records were presented in a format that allowed the inspector and any other person including the person in charge to extract information as to the status of training for each staff member. The records included all staff including those employed on a relief and agency basis. The records indicated that staff had completed the required mandatory training in fire safety, manual handling, safeguarding and responding to behaviours that challenged. Staff had also completed further relevant and required training including medication management training, first aid, basic life support, epilepsy awareness and the provision of personal supports. Staff spoken with confirmed that two staff had not completed training on the administration of specific medications required by some residents but this training was planned for May; the person in charge confirmed that staff with the training completed were always on duty. There was no evidence available to the inspector to the contrary.

Records were maintained of regularly convened staff meetings and there was a structured formal process for supporting and supervising all grades of staff.

Judgment:

Substantially Compliant

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

This was the centre's first inspection by the Authority.

Findings:

Overall the inspector was satisfied that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place and available for inspection.

There was documentary evidence that the provider had appropriate insurance in place.

The residents guide had been updated to reflect the new management structure.

The provider had reviewed and updated many of its policies and procedures and the

most recent version of policies was the version in use and available for inspection.

Training records were maintained for staff; the records based on inspection findings to date had been amended and were presented in a manner that facilitated the retrieval of the required information for all staff working in the centre in a timely or accurate manner.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002654
Date of Inspection:	09 March 2016
Date of response:	12 April 2016

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 02: Communication

Theme: Individualised Supports and Care

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

All relevant information was not incorporated into the communication support plan to ensure that the required supports were in place; this included sensory disabilities and known methods of communication including manual signing.

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

1. Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

All support plans will be updated with the relevant information regarding communication needs.

Two staff have attended PECS training and are scheduled to present learning to the staff team.

An ipad/tablet has been ordered for the service.

Proposed Timescale: 31/05/2016

Theme: Individualised Supports and Care

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

There was no clear evidence that residents had been assessed to ascertain their suitability for and how they might benefit from assistive technology.

2. Action Required:

Under Regulation 10 (3) (c) you are required to: Ensure that where required residents are supported to use assistive technology and aids and appliances.

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

Preferred choice of communication strategies will be discussed with all relevant service user/users, support plans will be updated to reflect any changes. Any communication aids and appliances will be sourced and use of same will be implemented as required. This will be discussed with staff through team meetings.

Proposed Timescale: 17/06/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Residents had been assessed and accepted for respite when it was clear that the premises and the facilities that it provided were not appropriate to their needs and did not enable staff to provide residents with contemporary, evidence based quality supports.

3. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

A robust admissions procedure will be implemented. The PIC/PPIM will meet with each new referral and using the RehabCare Assessment of Need will ascertain the supports required.

All existing residents will have their assessment reviewed in line with the review of the support plan.

Those individuals who are unsuitable for admission will not be accepted into the service

Proposed Timescale: 01/04/2016

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:

Given that residents were accepted for admission into a premises that could not meet all of their needs and the deficit of information available to staff on core support areas such as behavioural supports, it was difficult to see how the support plan was supported by a comprehensive assessment of the health, personal and social care needs of each resident prior to their admission to the centre.

4. Action Required:

Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

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

Each resident will have a comprehensive assessment of their health, personal and social care needs prior to admission. This will be completed by the PIC/PPIM. The information obtained will inform whether or not the resident is accepted into respite.

Proposed Timescale: 01/04/2016

Theme: Effective Services

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

There was a fundamental deficit between resident's needs and the available supports and services with the consequent inappropriate placement of residents in premises that was not suited to their needs.

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:

Each resident will have a comprehensive assessment of their health, personal and social care needs prior to admission. This will be completed by the PIC/PPIM. The information obtained will inform whether or not the resident is accepted into respite.

All current residents will have will have their assessment reviewed; information gathered will inform the support plan.

Proposed Timescale: 01/04/2016

Theme: Effective Services

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

Only two support plans were seen to include multi-disciplinary review (MDT) and it was therefore not always clear why supports were required, for example a modified diet. Where there was evidence of MDT review the findings of the MDT review were not seen to inform the support plan

6. 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:

Ensure all residents attending the service who have Multidisciplinary supports will have an MDT which is attended by staff from the respite service. The information shared at these will inform the support plan.

Proposed Timescale: 29/07/2016

Theme: Effective Services

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

Where residents presented with higher needs it was not clear how staff supported these residents to enjoy new experiences, achieve goals and engage in activities that were meaningful and beneficial to them and their development. It was not evidenced in the

records seen which were functional and task orientated with an emphasis on physical supports.

7. 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:

All residents will have a support plan which will include goals and activities which are meaningful. All goals will have an action plan with agreed timescales. Each resident will have an annual review of the plan.

Proposed Timescale: 17/06/2016

Theme: Effective Services

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

The plans presented and read as functional and task orientated and this was reflected further in the daily narrative notes maintained by staff. There was little or no social dimension to the support plans; there was no evidence of personal goals and objectives.

In the absence of same, the predominance of attention to physical care and the limitations of the physical environment it was difficult to see how the support plan improved and ensured quality outcomes for residents.

8. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

A support plan will be developed within 28 days of the service user commencing respite. This will include personal goals and objectives to maximise personal development. This will be reviewed each time the resident attends the service.

All existing service users will have an annual review.

Proposed Timescale: 29/07/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

More than one resident accommodated at a time required or would have benefited from a ground floor bedroom as they either could not physically use the stairs, declined to use the stairs or used the stairs with staff guidance and supervision and adaptive physical techniques.

A cohort of residents could not access the available sanitary facilities. In addition to the barrier to access, all of the available facilities (the bath and the two showers) were of a standard domestic type and did not meet any requirement for universal access.

The premises was not suitably equipped with supportive equipment such as handrails and grab-rails.

The premises did not facilitate the implementation of the required support plan

Available space was not conducive to the needs of all of the residents and did not offer them sufficient unrestricted space that was safe and free of obstacles.

The premises did not meet the requirements for universal access. There were three entrances/exits and all required the negotiation of two steps.

9. 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:

All residents that are unable to access all areas of the service in a safe and unrestricted manner will be discharged from the service. Each of the identified service user's will have an appropriate transition/discharge plan developed with all relevant agencies. An action plan has been sent to the HSE to indicate actions required and timelines.

Hand and grab rails will be installed.

Portable ramps have been ordered for the exits to provide universal access.

Proposed Timescale: 28/10/2016

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:

Some identified resident specific risks as seen in support plans did not have risk assessments completed, for example the risk of leaving the centre unaccompanied by staff or the risk of food and fluid aspiration. Controls were in place such as modified diet and one to one staff supports but there was no direct co-relation in the form of a risk assessment between the controls and risk assessment.

10. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

Risk assessments will be completed for all identified risks including a system for responding to emergencies; these will be reviewed by the PIC on an ongoing basis.

Proposed Timescale: 29/04/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Based on records seen there was reference to one monitor in use at intervals in one bedroom to alert staff to seizure activity. There was no supporting documentation for its use or its evaluation as a potential restrictive practice in that it had the potential to infringe upon the residents right to privacy.

11. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

All relevant paperwork and systems will be implemented for the use of any restrictive practices that are in use.

Proposed Timescale: 27/05/2016

Theme: Safe Services

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

There was scant evidence of behavioural history prior to admission, of multi-disciplinary reviews and information. Staff did not have access to detailed therapeutic behaviour support plans, informed and devised with the appropriate professional expertise.

12. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

All residents requiring behavioural supports will have behaviour management guidelines completed in conjunction with internal and external clinical supports.

Proposed Timescale: 29/07/2016

Theme: Safe Services

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

It was not clear how the completion of a body map supported safeguarding measures. The person in charge confirmed that staff had not brought recently completed maps to her attention for review and follow-up to ensure that there were no safeguarding concerns.

13. 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 staff have attended Adult Safeguarding training.

Safeguarding policy and the use of body maps/follow up procedure to be reviewed at staff meeting.

Proposed Timescale: 04/04/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The inspector was not reassured that care was evidenced based or that all of the required information was available to staff to ensure the required supports were in place and continuity of care for residents. This included healthy eating programmes, the management of aspiration and choking risk, bowel management plans and plans for the management of epilepsy.

14. 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:

All residents will have up to date support plans and risk assessments as required in respect of all identified healthcare needs.

Proposed Timescale: 17/06/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose was not an accurate reflection of the services and supports that could be provided in the centre. The statement of purpose stated that admission to the centre was dependent on assessment and the suitability of needs to the services provided. The statement of purpose stated that residents with "high support needs" could be accommodated. Based on these inspection findings both of these statements were inaccurate

15. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The statement of purpose and function will be updated to reflect the capacity of the service in terms of the level of need that can be supported within the service.

Those being referred to the service will have a robust assessment prior to admission.

Proposed Timescale: 15/04/2016

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:

From the perspective of governance it was of concern to the inspector that a core cohort of residents had been admitted to the centre when it was clear that all of their needs could not be met there in a quality evidence based manner. In that context it was difficult to conclude that the overall organisational management systems ensured that the service provided to all residents was appropriate to their needs and effectively and consistently monitored.

16. 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:

The PIC will ensure that the service provided is safe, appropriate and effectively monitored. A robust assessment prior to admission will promote this. All current residents will have a yearly assessment completed.

Proposed Timescale: 01/04/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Two staff files reviewed did not contain all of the information required by Schedule 2 of the Regulations.

17. 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:

The two staff files have been update to include missing documentation.

Proposed Timescale: 01/04/2016