

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Castleview
<b>Centre ID:</b>	OSV-0002659
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	RehabCare
<b>Provider Nominee:</b>	Rachael Thurlby
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	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 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:
03 November 2016 09:15	03 November 2016 19:00
04 November 2016 09:15	04 November 2016 15:30

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**

Background to the inspection:

This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA) and was undertaken to inform the decision to register the centre.

The first inspection was undertaken on the 1 October 2014. At that time the centre consisted of two adjacent houses that accommodated seven residents in total. The centre now (since August 2016) consists of one house that accommodates four residents. While failings were identified in the maintenance of healthcare related

records, overall those first inspection findings were satisfactory.

How we gathered our evidence:

Prior to the inspection the inspector reviewed the information submitted with the application for registration of the centre, the previous inspection findings and any other information held by HIQA such as notifications submitted on events occurring in the centre.

The inspection was facilitated by the recently appointed person in charge and one of the two team leaders (and nominated persons participating in the management of the centre). The acting regional manager was also available and present in the centre. The inspector met and spoke with frontline staff on duty, spent time with the residents and observed the interactions between staff and residents and the manner in which residents were supported. The inspector also met with one family member who was visiting the centre.

Over the course of the two days residents relaxed with the presence of the inspector in their home and the inspector's interactions were led by their needs and their cues. Residents communicated their comfort in the house and with staff through their general demeanor, gesture and facial expression or clearly verbally articulated how they were feeling and how their day went.

The inspector reviewed and discussed records including policies and procedures, fire safety and health and safety records and records as they pertained to the supports and services provided to residents.

Description of the service:

The provider is required to produce a document called the statement of purpose which describes the service and the supports provided. The inspector was satisfied that the centre was as described in this document. Residential services were provided to four residents with a diverse range of complex needs in a domestic type setting in a relatively rural location. Transport was available including daily transport to the day service.

Overall Findings:

The overall findings were good. There was evidence that the centre was effectively governed and the quality and safety of the care and supports provided to residents was monitored on a consistent basis. There was evidence of open communication and working with families so as to achieve positive outcomes with and for residents.

Staff spoken with had sound knowledge of residents, their ability, their needs and required supports. The inspector was satisfied that these supports were in place. The inspector saw that the residents had choice and flexibility and that the routines of the centre reflected the individuality of each resident.

A good level of regulatory compliance was evidenced. Of the full eighteen outcomes inspected the provider was judged to be compliant in 13 and in substantial compliance with two.

Three moderate non-compliances were identified due to failings in;

- aspects of the premises which were not suited to all residents needs
- medicines management systems
- staff records.

**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):**

No actions were required from the previous inspection.

**Findings:**

Over the course of the inspection the inspector observed that residents were given choice, and that the individuality of residents, though living together was respected.

As necessary staff used augmentative communication tools such as pictorial cues to facilitate choice and ascertain preferences, for example in planning the weekly menu. The inspector saw that there was on-going communication and negotiation with residents but formal weekly house meetings were also convened to discuss and agree the routines of the house. Staff were seen to record each resident's participation and any requests; at intervals a more substantive issue was discussed at the meeting such as fire safety and how to complain.

Staff spoke respectfully of residents and to residents and were seen to give them sufficient time to complete their daily routines.

Staff had established each residents spiritual/religious beliefs and how and if they wished to exercise these.

On speaking with staff and from records seen the inspector saw that there was a strong ethos on behalf of staff and family of advocating for residents, for example in relation to accessing services or the quality of the services delivered to them. The provider also operated an internal advocacy network. While there was no evident need for additional advocacy, it was discussed by way of recommendation with the person in charge as to how families could be formally made aware of this service.

Staff spoken with understood the implementation of the provider's complaints policy and procedures and articulated an understanding and acceptance of why people may complain or express dissatisfaction. Details of how to make a complaint were prominently displayed; the complaints policy had been made available to each family. A relative spoken with said that staff were open to receiving any concerns and responded appropriately. Staff maintained a record of any complaints received, the actions taken in response and the level of complainant satisfaction.

The inspector saw that the management of residents' finances, all of whom required family and staff support, was in line with the provider's policy and procedures. Each resident had a financial transaction record; financial transactions were recorded as was the purpose for which monies were used; supporting receipts and vouchers were in place for each transaction. There was documentary evidence of daily reconciliation and monthly oversight by the person in charge.

**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):**

No actions were required from the previous inspection.

**Findings:**

Staff spoken with were aware of each resident's communication ability and articulated an understanding of communication that was broader than simply verbal communication ability.

Each resident's communication strengths, preferred means of communication and required supports were detailed in a communication support plan. The plan made reference to receptive and expressive ability, the role of behaviours in communication and any supporting and augmentative tools that were used to support communication. The inspector saw that staff utilised tools such as social stories, communication diaries (where the significance of words and expressions used by residents was explained) visual schedules and pictorial cues. These tools were used so as to provide choice and ascertain preferences, communicate routines and schedules so as to prevent anxiety and to communicate events and information such as a medical appointment.

The inspector saw that residents also had access to common forms of media and entertainment and personal ipads.

**Judgment:**  
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):**

No actions were required from the previous inspection.

**Findings:**

There was evidence that the care and supports provided to residents were agreed and delivered in close consultation with families.

Staff maintained a family communication agreement and a log of communication; at times these were detailed narrative records on well-being, changes or any concerns. Records indicated that families participated in the annual review of the person centred plan. The inspector was satisfied that staff sought to work collaboratively with residents and their families so as to achieve the best possible outcomes for residents.

There was no evident restriction on visits and the inspector saw that staff supported residents and families to enjoy on-going home visits.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were organisational and local policies and procedures governing admission to and transfer and discharge from the designated centre. Admission practices to the centre



were set out in the centre's statement of purpose. Three of the residents had been living together in the centre for over six years.

Each resident had an agreed written contract which outlined their support, care and welfare in the centre. The contract included details of the services provided, however, the contract did not include details of any applicable fees including those for services that may be availed of but were not funded by the provider.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Each resident had a plan of support based on the current assessment of their holistic needs. The inspector saw that the plan was updated as frequently as was necessary in line with any changes in the residents needs or in their required supports. The plans were detailed, person-centred in tone and language used, reflected what staff said and what the inspector observed to be implemented in practice.

Resident consultation and participation in the plan was facilitated through the key-worker system and regular key-working meetings. Family representation on behalf of the resident was also evident.

Staff were in the process of making the support plan available to residents in an accessible and meaningful format; one was in place and staff confirmed that this initiative would be completed for all of the residents.

The support plan incorporated the process for identifying, agreeing and progressing residents personal goals and objectives. This was based on an annual person centred planning meeting that the resident, family, residential and day staff attended. There was a clear link between what was agreed at this meeting and the goals in progress such as activities or planned outings and social events; timeframes and responsible persons

were identified. The inspector was satisfied and a relative confirmed that this was a meaningful and purposeful process.

**Judgment:**

Compliant

**Outcome 06: Safe and suitable premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The premises was a spacious, two-storey, domestic type building of relatively recent construction, located on a spacious site in a rural location; transport was available.

While some areas were in need of maintenance or decorative attention, overall and on balance the premises was well maintained. The premises did meet the current needs of residents but also presented some challenges and modification of bathroom facilities was required.

The house was spacious and staff said that this aided them in providing appropriate supports as the diverse and unique needs of the residents could be accommodated. For example communal/ recreational space was available to residents on both the ground and first floors.

The kitchen was adequately equipped and incorporated a dining area; a further separate dining area was also available.

There was a spacious utility area that accommodated laundry equipment and storage.

Each resident was provided with their own bedroom; one resident could be accommodated on the ground floor, three resident's bedrooms and the staff sleepover room were located on the first floor. Resident's bedrooms were pleasantly decorated to reflect each residents taste and interests; adequate space was provided including personal storage space. The statement of purpose reflected the availability of only one ground floor bedroom and the limitations this placed on admission and placement options.

There was adequate provision for sanitary facilities; two bedrooms had en-suite

facilities, there was a ground floor bathroom and two additional ground floor toilets; there was a further two bathrooms on the first floor, one with both bath and shower and the other with a shower. However, staff said and a recent occupational therapy (OT) review indicated that all of these facilities were not suited to the needs of all residents and would have benefited from modification in line with any OT recommendations made. This pertained in particular to the main bathroom on the ground floor and the shower room on the first floor.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

The inspector saw both an organisational and a centre specific safety statement dated August 2016 that was signed as read 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 centre risk management folder. The risk management folder included a comprehensive range of centre specific and work related risk assessments and the risks as specifically required by Regulation 26 (1) (c), for example the risk of self-harm or the unexpected absence of any resident. These risks were also supported by centre specific policies and procedures. Resident specific risk assessments were incorporated into their personal support plan. Risk assessments were dated as reviewed by the person in charge in September 2016. Controls to manage and or reduce risk were clearly stated and there was an evident link between resident specific risk assessments, controls and resident's assessed needs as described by staff and in their personal plan. Risk assessments supported positive risk and resident independence and autonomy.

However, all risks had not been identified and assessed specifically in relation to the physical environment. The inspector saw that first floor window openings had not been risk assessed, the front entrance to the house was inadequately lighted and the surface of the two approaching/exiting driveways were in poor condition and very uneven.

There was a centre specific business continuity plan 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 an automated fire detection system was in place as was emergency lighting and fire fighting equipment. Fire related records were kept in a well maintained fire fact file. The inspector saw a certificate confirming that the fire detection system was inspected and tested on a quarterly basis and most recently in September 2016 as was the emergency lighting; fire fighting equipment was serviced in August 2016. The action that emanated from the last inspection was addressed; automatic door closures were installed in October 2016 and the inspector saw that final exits were on easily released thumb-turn devices.

There were procedures in place for the monitoring of fire safety measures by staff on a daily and weekly basis. Records of these checks were complete and their completeness was signed as overseen by the regional manager.

Staff spoken with confirmed their attendance at fire safety training. Staff undertook simulated fire evacuation drills with residents; the drills included a recent exercise that simulated the night-time scenario. Recommended evacuation times were seen to be achieved and each resident had a personal emergency evacuation plan (PEEP). The PEEPS reflected any challenges to safe evacuation and the interventions to be used by staff to ensure safe and effective evacuation; staff spoken with described these interventions.

Residents support plans included resident handling risk assessments and plans.

Staff said that there were no specific infection prevention and control risks but staff described and the inspector saw infection prevention and control measures in practice such as a colour coded cleaning system, disposable hand-towels, access to personal protective equipment and the risk based segregation of linen.

**Judgment:**

Substantially Compliant

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

There were measures in place to protect residents from harm and abuse. These included organisational and national policies and procedures, designated persons, risk assessments, staff training and regular and consistent communication with families. Staff spoken with confirmed their attendance at safeguarding training which had been updated to reflect nationally agreed safeguarding policy. Staff articulated a good understanding of what constituted abuse and their personal responsibility to safeguard residents by reporting any concerns. Staff told the inspector that they had no knowledge of any incident of alleged, suspected or reported abuse in the centre. A relative spoken with said that they had no safeguarding concerns in relation to the centre. The inspector noted that residents did not demonstrate any discomfort or hesitancy in approaching staff or being with staff.

The name and contact number of the designated safeguarding person and the national confidential recipient were clearly displayed for staff, residents and families.

The inspector saw that there were risk assessments and plans for the delivery of personal and intimate care.

Residents did present at times with behaviours of concern or risk to themselves and others. The inspector saw that behaviour management support plans/ guidelines were in place; these had been reviewed in conjunction with the behaviour therapist and were informed by the functional analysis of behaviours. Staff described therapeutic support for residents and their behaviours and this was also reflected on the low dependence and usage of medicines as an adjunct to the management of behaviours.

There were practices that were deemed restrictive and used only as a last resort. There were clear processes and procedures in place for the identification, sanction and review of the justification and ongoing requirement of restrictive practices. The inspector having spoken with staff and reviewed restrictive practice documentation was satisfied that these were robust and meaningful processes that were evidence based. Staff maintained records of the use and notification of planned and unplanned restrictive practices, that is, MAPA (management and prevention of actual and potential aggression) interventions. There was a clear rationale for their requirement (resident safety and the safety of others) and staff confirmed that they had completed MAPA training.

**Judgment:**  
Compliant

### **Outcome 09: Notification of Incidents**

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

**Theme:**  
Safe Services

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

No actions were required from the previous inspection.

**Findings:**

The person in charge was clear that it was her responsibility to ensure that notification of incidents and events were submitted to HIQA as required by Regulation 31, for example any serious injury to a resident.

There were policies and procedures for the identification, recording, reporting and investigation of accidents and incidents that occurred in the centre; electronic and hard copies were maintained. Based on the records seen by the inspector, the inspector was satisfied that any required notifications had been submitted to HIQA.

**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):**

No actions were required from the previous inspection.

**Findings:**

There was consistent evidence confirmed by a relative spoken with that staff supported and facilitated residents to live full lives. Supported by planning and an ethos of positive risk staff supported residents to pursue their interests and hobbies and enjoy new experiences and opportunities.

Each resident attended the day service Monday to Friday and had a weekly planner of scheduled activities. These activities included swimming, horse-riding, computer classes, table top activities, computer skills, social training and independent living skills. In the house staff supported residents to socialise in their local community such as trips to the cinema, the library, walks in local parks, dining out and attending musical events and concerts.

There was a clear link between each residents person centred plan, their agreed goals and objectives and the activities that they engaged in.

**Judgment:**

Compliant

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### **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):**

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

**Findings:**

The inspector saw that the deficits identified at the time of the last inspection were addressed. The inspector was satisfied that arrangements were in place to meet the healthcare requirements of residents; some of these needs were complex.

Staff spoken with described and records seen supported that staff worked collaboratively with families and other relevant stakeholders to ensure the best possible outcome for residents.

On a day to day basis and as they arose residents healthcare needs were identified by staff who then sought medical advice and review from a General Practitioner (GP). In line with their assessed and evolving needs residents were referred and had access to other healthcare services including occupational therapy, physiotherapy, psychiatry, neurology, behaviour support, dental review, ophthalmology, clinical nurse specialist, public health nursing and chiropody. Records of all referrals and reviews were in place. Healthcare specific support plans were in place, were up-to-date and implemented in practice. This was a social model of care but staff spoken with had sound knowledge and understanding of resident's healthcare needs and the interventions required to maintain their health and well-being. Staff sought the appropriate advice and direction and maintained detailed healthcare records.

Where a resident refused medical interventions this was respected but staff also had a therapeutic action plan in place to support residents in overcoming their fears and anxieties.

**Judgment:**

Compliant

### **Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

While there was evidence of good medicines management practice, deficits were identified in medicines management systems that increased the risk of a medicines error; this was evidenced on inspection.

There were policies and procedures in place governing medicines management practice.

Staff had completed medicines management training including the administration of emergency/rescue medicines which were prescribed.

Medicines were supplied by community based pharmacies in either the original container or in a medicines compliance aid. The inspector saw that medicines were labelled for individual resident use and were securely stored.

No resident was managing their own medicines; this decision was seen by the inspector to be informed by a current formal assessment.

Staff implemented systems that promoted the safety of medicines management. These included the reconciliation of the medicines supplied with the prescription; stock balance checks and the return to the pharmacy of any unused or unwanted medicines. Records were maintained of all medicines management activities.

Each resident had a medicines management folder that included a current medicines prescription, a corresponding administration record, guidelines on the administration of p.r.n (as required) medicines and protocols for the administration of emergency medicines. No anomalies were noted between any of these records and staff spoken with had sound knowledge of resident's medicines regimes some of which were complex.

However, deficits were identified in the systems for medicines management that increased the risk of and had resulted in medicines administration errors. The inspector saw that;

- duplicate compliance aids were stored together and created a risk for double dosage
- medicines not administered, perhaps due to home leave were not discarded contemporaneously and were left in the compliance aid.

**Judgment:**

Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the*



*manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

A revised statement of purpose and function was submitted to HIQA prior to the conclusion of the inspection. The statement contained all of the required information and the inspector was satisfied that it was an accurate reflection of the centre and the service and support provided to residents.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

There was a clear management structure consisting of two team leaders, the person in charge and the regional manager. Staff were clear on their respective roles, responsibilities and reporting relationships. Based on these inspection findings the inspector was satisfied that the management structure ensured the effective governance of the centre and effectively monitored the quality and safety of the services and supports provided to residents.

The person in charge while recently appointed to this centre had established management experience with the provider, in the supervision of staff and in the provision and monitoring of supports provided to residents. The person in charge held relevant qualifications including supervisory management and worked full-time. The person in charge was responsible for two designated centres and was confident that she had the capacity and the supports to effectively manage both of the services within her

remit. The person in charge said that she based herself in either house depending on need and priority. Staff confirmed the availability and accessibility of the person in charge.

On a day to day basis the person in charge was supported by two team leaders one of whom was on duty for this inspection. The team leader told the inspector that they both (the team leaders) worked closely together in the operational management of the centre and this was evident from the records seen. The team leader was clear on her role and duties, readily answered queries and retrieved any requested information. The team leaders worked shifts including weekends; this ensured they were present in the house when staff and residents were there. The team leaders met formally with the person in charge on a weekly basis; a formal action plan for the centre emanated from these meetings. Both the person in charge and the team leader had a sound knowledge of each resident and their required supports and articulated a positive attitude to regulation and the process of inspection.

The person in charge told the inspector that she had ready access to the regional manager, (her line manager) as required and they also met formally once a month.

There was an agreed out-of-hours manager on call rota that was available to all staff.

The provider operated a formal system of supervision for all grades of staff and regular staff meetings where staff had opportunity to raise any concerns of issues they may have had as to the quality and safety of the services that they delivered.

The provider had arrangements for the annual review and the unannounced visits to the centre as required by Regulation 23 (1) (d) and (2). The inspector reviewed the reports from the two most recent visits, March and June 2016. These reports indicated that a satisfactory level of compliance was evidenced, where action was required, there was documentary and physical evidence that these were progressed to completion, for example the recording of the progression of resident's personal goals and objectives.

There were formal systems for consulting with and eliciting feedback from residents and their families; overall the feedback was positive.

**Judgment:**

Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

There were suitable arrangements for the management of the centre in the absence of the person in charge. The person in charge said that in such instances the centre was managed by the team leaders supported as necessary by the area manager or another person in charge. There had been no absence of the person in charge for a period (greater than 28 days) that required notification to the HIQA.

**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):**

No actions were required from the previous inspection.

**Findings:**

These inspection findings would support that the centre was adequately resourced to ensure the effective delivery of the required care and supports to residents. The person in charge confirmed that there were no resource related issues.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that staffing numbers and arrangements were based on the assessed needs of the residents. Night-time staffing arrangements consisted of one staff on sleepover and one waking staff member. There was a minimum of three staff on duty in the morning prior to residents leaving for the day service and four staff came on duty in the afternoon. Risk assessments set out the required level of staff supports and staff confirmed that sufficient staffing resources were available, for example if 2:1 staff support was required for social or community based activities.

There was currently some reliance of relief and agency staff to maintain staffing numbers but staff understood and said that this was managed so as to minimise change and ensure continuity of supports for residents. The inspector saw from the staff rota that a small cohort of the same relief and agency staff was utilised. The person in charge confirmed that a successful recruitment initiative had recently been undertaken.

There was a planned and actual staff rota maintained; this reflected the described and observed staffing levels.

Staff files were available for the purpose of inspection. Based on the sample reviewed, one staff file did not contain the information required to ascertain that regulatory requirements had been met.

Records were maintained of training completed by staff including staff working on a relief basis. Staff attendance at training was monitored and any required refresher training was scheduled. For example while core training had been completed refresher training for people handling, fire safety and MAPA was scheduled. There was on gap in safeguarding but it was confirmed at the conclusion of the inspection that this training was scheduled and would be completed the first week of December 2016.

Further training completed by staff reflected the needs of the residents and the services provided and included medication management, occupational first aid and the administration of rescue/emergency medicines. In addition the staff files seen contained documentary evidence of relevant core qualifications including social care and disability studies.

**Judgment:**

Non Compliant - Moderate

**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)*

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that the records listed in part 6 of the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. All records seen were well maintained and required information was retrieved with ease by and for the inspector.

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

The directory of residents contained all of the required information.

The residents guide was presented in a user friendly format (Plain English and graphic support) and contained all of the required information.

The inspector reviewed the suite of policies 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. All of the required policies were in place and their review date indicated that the majority had been reviewed within the past three years as required by Regulation 4 (3). The regional manager confirmed that the policy on providing personal and intimate care support dated 2012 had been reviewed and was currently in draft for consultation and feedback.

**Judgment:**

Compliant

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by RehabCare
<b>Centre ID:</b>	OSV-0002659
<b>Date of Inspection:</b>	03 and 04 November 2016
<b>Date of response:</b>	14 December 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 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:**

The contract did not include details of any applicable fees including those for services that may be availed of but were not funded by the provider.

#### 1. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the

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

provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Contract of Care will be updated to include details of any applicable fees for services availed of by residents that are not currently funded by RehabCare.

**Proposed Timescale:** 31/12/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Some sanitary facilities were not suited to the needs of all of the residents.

**2. 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:**

Further Occupational Therapy assessment of and guidance on adaptations to bathrooms is required.

Refurbishment of bathrooms to be completed in line with OT recommendations.

**Proposed Timescale:** 30/05/2017

**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:**

All risks, specifically in relation to the physical environment had not been identified.

**3. Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

Risk Assessment for first floor windows has been put in place on 11/11/2016. Sensor light to the front of the building to be installed by 31/12/16. Refurbishment of the front driveway to be completed.



**Proposed Timescale:** 30/06/2017

## **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:**

Deficits were identified in the systems for medicines management that increased the risk of and had resulted in medicines administration errors

### **4. Action Required:**

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

Separate locked box was put in place on 05/11/2016

Blister packs are now signed in and stored in separate storage box from daily medication until required for use.

Medicines not administered are stored in a separate box within the main storage box until their return to pharmacy.

**Proposed Timescale:** 05/11/2016

## **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

One staff file did not contain the information required to ascertain that regulatory requirements had been met.

### **5. 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:**

Information and documents specified in Schedule 2 are correctly placed in each file.

**Proposed Timescale:** 05/11/2016

