

# eDeposit Ireland

## Cairdeas, Limerick

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Cairdeas
<b>Centre ID:</b>	OSV-0002651
<b>Centre county:</b>	Limerick
<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>	Carol Maricle
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	6
<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 August 2016 09:30	03 August 2016 18:00
04 August 2016 09:15	04 August 2016 17:00

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 a registration decision.

The first inspection was undertaken on the 17 December 2014. At that time inspectors found ambiguity in relation to the stated purpose and function of the centre. This ambiguity led to a significant level of regulatory non-compliance with five outcomes; the statement of purpose, admissions and the contract for services, social care needs, healthcare needs and governance and management.

How we gathered our evidence:

Inspectors reviewed the information submitted with the application for registration of the centre.

Prior to the inspection residents and relatives were invited to complete on a voluntary basis questionnaires to ascertain their experience of the service. Sixteen completed questionnaires were received by HIQA. Overall the feedback received was positive; both groups were complimentary of staff and the quality of care and services received; respondents articulated a desire for more opportunities for respite.

The inspection was facilitated by the newly appointed person in charge, the outgoing person in charge who was to assume the role of interim area manager and frontline staff on duty both days of inspection. Inspectors reviewed records including policies and procedures, fire safety and health and safety records. Inspectors met and spoke with all of the six residents over the two days of inspection and relatives who expressed an interest in meeting with inspectors. The feedback received from both groups was positive. Residents said that they had choice and control and were supported in a dignified and respectful manner. Residents said that they looked forward to their respite stay and some described it as a home from home.

Description of the service:

The centre was purpose built. Respite care and support was provided to adult persons with a physical and/or sensory disability on a planned short-term or limited extended basis. Some day respite was also provided. Approximately 100 residents were registered to avail of the service; the maximum number of residents that could be accommodated at any one time was six. The centre was ordinarily open on a Monday to Friday basis, 222 nights per year. At the time of this inspection however, and in line with its statement of purpose it was open seven nights per week.

Overall findings:

Inspectors were satisfied based on the feedback received from both residents and relatives that this was a service that they valued and that was of benefit to them. Residents said that they looked forward to their stay; some saw this as an opportunity to relax and have some quiet time while others enjoyed the opportunity it gave them to meet with others and engage in social activities. It was evident to inspectors that these choices were respected.

The ambiguity evidenced at the time of the last inspection was addressed; the stated purpose and function of the centre was clear. Respite care and support was provided, at times this was for extended periods. There were revised policies and procedures on admission and discharge including discharge due to ill-health; these policies supported planned, safe discharge as and if necessary. There was evidence of a balanced approach to needs and supports rather than a clear demarcation between what was social and what was medical as evidenced at the time of the last inspection. Inspectors were satisfied that residents were supported in the centre in times of illness.

Consequently of the full eighteen outcomes inspected the level of regulatory

compliance had improved and the provider was judged to be compliant with nine, in substantial compliance with three and in moderate non-compliance with five outcomes; one major non-compliance was identified in Outcome 11; Healthcare needs.

There was evidence that staff had the required information, skills and multi-disciplinary supports to meet resident's holistic needs including any increasing medical/nursing/physical needs. However, while there was evidence of good healthcare related practice, deficits were identified in the arrangements in place to meet a specific healthcare need; this resulted in a major non-compliance. Two deficits were addressed with immediate effect and the person in charge and the interim area manager were requested with immediate effect to put protocols in place to prevent a reoccurrence; these failings are discussed in detail in Outcome 11: Healthcare needs.

Prior to the issuing of the draft report and based on the verbal feedback received from inspectors, the provider confirmed to HIQA that action had and was being taken to address the concerns and failings identified.

**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:**

Residents surveyed and spoken with said that they were consulted with prior to admission to ascertain their needs and also on admission to establish if they had any particular requests for their respite stay. Residents said that they had good choice and control over their routines while in the centre such as what time they retired to bed and what time they got up at. Inspectors saw that there was no established morning routine and residents got up and had breakfast on an individual basis.

Residents said that staff were at all times respectful of their privacy and dignity and inspectors observed that staff/resident interactions were appropriate; bedroom and bathroom doors were closed while needs were attended to. The records in relation to residents maintained by staff were seen to be respectful in content and in the tone and language used.

Residents had good access to information as to how to seek advocacy services, how to make a complaint and how to contact the confidential recipient if they had a concern or worry. Both residents and relatives said that they would speak to any staff and in particular to the team leader if they had a concern or worry.

There were policies and procedures on the receipt and management of complaints and staff maintained a record of complaints received. Inspectors reviewed this log and saw that five complaints were recorded as received in 2015 and two to date in 2016. The majority of residents and relatives surveyed said that they had never had a reason to complain.

There was evidence that complaints were investigated and brought about improvement, for example inspectors saw that access to Wi-Fi (wireless internet access) had been requested and was now available to residents.

There was a formal system for consulting with residents on a weekly basis. However, based on the records seen and staff spoken with inspectors concluded that this process did not clearly demonstrate meaningful consultation with and the participation of residents in the actual planning, organisation and running of the centre. The names of those in attendance was not recorded therefore it was difficult for inspectors to be reassured as to how representative and meaningful these meetings and their conclusions were. There was evidence that the process did not include all residents living in the centre. The primary focus of these discussions was the provision of structured activities but it was not evidenced that planned activities were directly influenced and requested by residents.

The procedures for the management of residents' finances required review. Practice was not fully reflective of the provider's policy and procedure on these matters which provided clear guidance where residents were independent and for those that required staff support. Inspectors were told that no resident accessing the service required staff support in the management of their finances, however, this did not concur with records seen. These records indicated that while residents had capacity they clearly required staff support to access monies, purchase items on their behalf and pay for items. Records to safeguard both staff and residents of these actions were not maintained by staff.

**Judgment:**

Non Compliant - Moderate

**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 reported that the majority of residents enjoyed good verbal communication ability and literacy skills and communicated effectively with staff. The majority of records seen did indicate that residents communicated effectively without the use of assistive or augmentative tools. Staff told inspectors that they had access if it was required to assistive technology but were currently not using it with any particular residents.

Based on the sample of records seen each resident had a communication support plan.

The plans seen identified each resident's communication ability and addressed both comprehension and expressive ability. Where a resident utilised other communication strategies such as gestures these were also highlighted in the support plan. Responses required of staff so as to support effective communication such as adequate time and attentive listening were also included in the support plan.

Residents were seen to have access to radio, television, wireless internet access, a computer and personal laptops.

Transport was available and residents were seen to have access to the amenities in the local community during their respite stay.

**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:**

Services were provided to adults, many of whom self-directed their respite stay and care and ordinarily lived in the community. Staff said that they communicated with families and residents directly by phone and a hard copy newsletter (seen by inspectors) was circulated on a quarterly basis.

There was evidence as appropriate to each resident's ability and choice that family members were consulted with and participated in decisions relating to the provision of care and services such as multi-disciplinary team meetings.

There were no unreasonable restrictions on visitors; residents and relatives confirmed this.

Relatives surveyed and spoken with described staff that were approachable and accessible and said that they were informed by staff as necessary of any changes or concerns. Staff maintained a log of family contact.

**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):**

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

**Findings:**

Inspectors were satisfied that the failings identified at the time of the last inspection were addressed.

Staff said that approximately 100 residents availed of the service at a frequency that was matched to their needs and requirements. While some residents and relatives surveyed and spoken with said that they would welcome enhanced access there was no evidence available to inspectors that there was inequity of access.

Each resident was provided with information on respite availability on a quarterly basis. Staff were seen to maintain a record of each residents access to the service and said that they followed up on residents who may not have availed of respite for some time.

Inspectors saw organisational and local policies and procedures for admission and discharge to and from the service. Inspectors were satisfied that these were clear and set out the required criteria to be followed.

The policy and procedure on discharge from the service in the event of illness had been reviewed to ensure that this was a safe and planned process and based on a multi-disciplinary decision. Records seen by inspectors supported that this policy was implemented in practice by staff and residents were supported as necessary to stay in the centre and/or receive the required medical care and attention that they required in the event of illness.

The template for the contract for the provision of services to be agreed with each resident had also been reviewed to include the policy on discharge in the event of illness as mentioned above.

Based on the sample of records seen residents had an agreed contract with the provider for the provision of services. The contract set out the supports and services provided, the fee for the services and the contract was seen to be tailored to individual requirements.

**Judgment:**

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):**

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

**Findings:**

Based on the sample of support plans seen improvement was noted in the standard of assessing, identifying and planning supports with and for each resident.

Each resident had a support plan that detailed their strengths and where support was required from staff; in general these supports were outlined in detail. The information was presented in a person-centred and respectful manner and paid due regard to individual resident choices and preferences, independence and autonomy.

There was documentary evidence confirmed by relatives spoken with that prior to each admission, there was a reassessment of needs, changes were recorded and support plans were seen to be updated where change had occurred, for example where there was a recent increased risk of falls.

As appropriate to each resident's needs there was evidence of multi-disciplinary team (MDT) input and MDT recommendations, for example eating and drinking guidance were incorporated into the support plan.

The participation of the resident in the support plan was facilitated.

Inspectors saw an explicit MDT transition plan supporting resident transition between services.

Staff had introduced a system for ascertaining with each resident on admission any particular action or objective that they wished to achieve while on respite. At times none were identified and this was signed by the resident. Other residents did make specific requests and these were signed off as achieved, when achieved and by whom.

**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 located on a campus operated by the provider; other unrelated services were also provided on the campus.

The premises was a single-storey, purpose built stand alone building. The premises was well maintained, homely and inviting in appearance. Overall inspectors were satisfied that the design and layout was suited to the stated purpose and function, however, there was insufficient space particularly for support services such as laundry.

Services and supports were provided to persons with physical and sensory disabilities. The main entrance supported universal accessibility.

The kitchen and dining area were combined. The kitchen was adequately fitted and equipped. The dining area provided sufficient space for the numbers of residents accommodated including residents dependent on equipment such as a wheelchair for mobility and independence.

Communal space while homely and comfortable was limited. Residents had access to one main communal room; some additional seating was available in the main foyer and in the dining area. Residents spoken with said that the available space was not a problem as residents had different routines and were rarely all together in the main communal area. Some residents said that they preferred to spend time in their own room and could watch television there if they wished.

Each resident was provided with their own bedroom for the duration of their stay. Bedrooms were seen to provide sufficient space to meet resident's needs. Each room was equipped with a ceiling mounted hoist for resident handling which maximised the amount of floor space available. Adequate provision was made for personal storage.

Each two bedrooms shared an en-suite accessible bathroom equipped with shower, toilet and wash-hand basin. There was an additional spacious main bathroom equipped with shower, toilet, Jacuzzi- bath and wash-hand basin.

Circulation areas were equipped with a hand rail; bathrooms were equipped with grab-

rails. Residents had access to a staff call-bell system and records seen indicated that residents were instructed and reminded by staff to use this. Other equipment such as shower-chairs and a bath-trolley were in place.

Residents had access to paved external areas and the site was pleasantly landscaped.

However, there was inadequate space for the suitable storage of cleaning equipment and general equipment. A hoist was stored on a corridor and was seen to partially obstruct access to one bedroom door.

The facilities for the laundering of linen and personal clothing were not appropriate. There was one narrow galley type room that accommodated multiple tasks and was seen to be used for;

- the storage of cleaning equipment (it was stored externally by day and brought in at night)
- the segregation and completion of laundry as it contained a tumble dryer and two washing machines
- the storage and preparation of medicines
- the storage of clinical equipment.

This was not an appropriate arrangement from an infection prevention and control perspective. Also it did not ensure that the required controls were in place for the storage and administration of medicines including ensuring the required room temperature, a clean environment and a quiet environment free of distraction for staff completing medicines management.

**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:**

There were measures in place to promote the health and safety of residents, staff and others. 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; this 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 and as they applied to individual residents. The risk assessments seen were detailed, reflected residents assessed needs and outlined meaningful controls for managing and/or reducing the risk. Each risk assessment was seen to be signed as read and understood by staff.

However, there were risks that had not been identified. Inspectors saw that access to high risk areas such as the sluice room which contained clinical risk waste was not restricted. There was unrestricted access to cleaning chemicals which were seen to be stored in at least three locations.

Privacy was secured in shared bathrooms by means of two sliding bolts; however, the nature of these bolts meant that staff may not have been able to access the room and the occupant if necessary. Based on the verbal feedback received, the provider confirmed that the bolts had been removed after the inspection and were replaced with more suitable and safer fastenings.

The centre was visibly clean. Staff had access to personal protective equipment and were seen to use it. Clinical risk waste was segregated from general waste and there was evidence of its removal on a frequent basis. However, staff were unclear as to whether clinical risk waste was stored externally or not. There was an external clinical risk waste bin; it was not stored in a secure area and it was not locked; it was empty on the day of inspection. There was a sluice room but it was compact; it did not incorporate a wash-hand basin and did not have adequate shelving for the drying and storage of equipment.

Infection prevention and control risk assessments had been completed. However, inspectors were not satisfied that the current arrangements for the management of bathrooms shared by two residents were conducive to infection prevention and control. There was evidence in these rooms of the use of cloth handtowels and face-cloths and personal toiletries the ownership of which was not identified or segregated. This was of concern to inspectors in particular where a resident had been identified as at risk due to compromised immunity. Based on the verbal feedback received, the provider confirmed that action including the provision of paper handtowels and risk based access to the shared bathrooms was being implemented.

Inspectors saw that residents had detailed risk assessments and plans for safe resident handling. These outlined the number of staff and the required equipment. Staff had access to a floor based hoist and ceiling mounted hoists; there was evidence that hoists were serviced in line with legislative requirements.

The inspector saw that emergency lighting and an automated fire detection system were in place. Both diagrammatic evacuation and pictorial fire action notices were displayed. Escape routes were indicated and final exits were fitted with easily released thumb-turn devices. There was an exit that facilitated bed-evacuation from each bedroom.

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. Staff maintained records

of the in-house inspection on a daily, weekly and monthly basis of escape routes and fire safety equipment; however gaps were noted in these records.

Training records indicated that staff were provided with fire safety training on an annual basis. Each resident had a current personal emergency evacuation plan that outlined the assistance required from staff and the means of evacuation by day and by night. Simulated fire drills were convened on a regular basis. The records seen indicated that adequate evacuation times were achieved. However, the drill records did not identify which residents participated in the drill and given the number of residents who availed of the service, it was possible that some residents had not participated in an evacuation drill. Furthermore the drill record did not state what action was taken in response to any issues that did arise, for example where a resident had refused or was slow to co-operate.

Inspectors noted the use of door wedges to hold open fire doors. This was brought to the attention of the person in charge on the first day of inspection but they were again noted in use on the second day of inspection. In consultation with the appropriate persons this practice requires review to ensure that a reasonable balance is achieved between accessibility for residents and fire safety requirements.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

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 completed body maps and those seen also included a rationale for any injuries noted. Residents spoken with and surveyed said that they felt safe in the centre, that they were treated with respect and had confidence and trust in staff.

However, training records seen did not provide reassurance that all staff, including staff employed on a relief basis had completed adult safeguarding training.

Feedback seen from the provider's annual customer satisfaction survey in 2015 stated that "a number" of respondents had raised concerns as to the arrangements in place for meeting personal/intimate care needs. There was evidence of action taken in response to promote good practice. Staff spoken with were aware of residents who did have specific preferences. Inspectors saw risk assessments and support plans detailing individual choices and preferences and how these were to be facilitated by staff in so far as was reasonably practicable. Staff said that choice and preference was facilitated.

There were no reported behaviours that challenged or that posed a risk to others; this would concur with the records seen by inspectors. There was a recently implemented (February 2016) organisational policy on the use of restrictive practices. The use of bed-rails and lap-belts had been identified as potential restrictive practices.

Based on the records seen by inspectors, inspectors were satisfied that where bed-rails, lap-belts or other devices were used there was a clear rationale for their use; they were either requested by residents or clinically indicated for safety and positioning purposes.

However, the authorisation form for the use of lap-belts and bedrails in the centre was generic in nature and not reflective of the individual approach seen in practice. This was discussed and review of the form was recommended with management of the centre.

**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):**

No actions were required from the previous inspection.

**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 her legal responsibility to submit them as outlined in Regulation 31 (1) to (3) inclusive.

Based on the records seen inspectors were satisfied that the required notifications had been submitted.

**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:**

Respite supports were provided in the centre and ordinarily residents were in the centre for short periods of time only. Inspector's saw and residents spoken with confirmed that staff supported residents to avail of social activities and experiences in the local community; transport was available. Other residents said that it was their choice to stay in the centre and relax by watching television and chatting with staff.

On each admission residents were asked by staff if there was something in particular they wished to do and required support with while on respite. Based on records seen some residents identified something in particular while others did not. Where a resident regularly attended a day service ongoing access was facilitated during the period of respite.

In the newsletter circulated to residents on a quarterly basis the centre outlined the plans for proposed activities such as day trips and access to services provided by external agencies such as counselling and music.

There was a weekly planner of planned activities displayed in each bedroom. There was further documentary evidence that residents worked with other stakeholders in accordance with their own wishes and established routines, to progress personal interests and goals including academic studies.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

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

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

**Findings:**

The provider provided supports to a large cohort of residents with physical and/or sensory disabilities. Resident's needs and the level of support that they required from staff were varied and individualised and this was reflected in the records seen by inspectors.

As residents ordinarily lived in the community they themselves and/or in conjunction with their family managed their own healthcare requirements.

Staff said that residents retained the service of their own General Practitioner (GP) while on respite but if necessary, a local GP practice provided support to residents and staff, for example if the residents own GP was not geographically convenient.

Likewise residents co-ordinated their own multi-disciplinary supports but were supported while in the centre to attend any scheduled appointments. Inspectors saw that records of referrals, reviews and recommendations were on file in the centre and residents' support plans were updated with these recommendations.

On each admission there was explicit evidence that healthcare needs were reassessed, relatives spoken with confirmed this and any changes were seen to be noted and recorded. For example inspectors noted that a recent increase in falls and deterioration in swallow reflex were clearly recorded as were the supports required for resident safety.

Staff spoken with confirmed that they also accessed the local community intervention team, the out-of-hours medical cover or the local acute hospital as necessary. Staff described specific scenarios to inspectors where medical advice, review and treatment were sought by staff in response to unexpected illness of a resident while on respite.

There was documentary evidence that staff monitored and recorded body weight, supported residents in making healthy lifestyle choices, monitored blood glucose levels, completed urinalysis and monitored vital signs (temperature, pulse, blood pressure) in response to illness so as to support residents in maintaining well-being. There was documentary evidence that residents were facilitated to have ongoing access to their multi-disciplinary team and any other external agent from whom they contracted services.

Specific healthcare problems and the required supportive interventions were included in residents' support plans, for example the management of epilepsy, diabetes, eating and drinking difficulties and wound prevention and management.

There was documentary evidence that as necessary staff had access to the required expertise to assist them in supporting residents in an evidence based manner.

Inspectors reviewed practice in relation to the prevention and management of pressure wounds; there was evidence of good practice but failings were also identified.

There was documentary evidence and staff spoken with confirmed that wound management practice was supported by vascular referral and review, tissue viability and public health nursing advice in addition to the nursing input available in the centre. There was an evidence based wound care management plan in place and staff spoken with accurately described the plan including the current recommended dressing regime.

However, deficits were identified as follows;

- staff told inspectors that they may not always have the sterile equipment necessary
- staff were not aware of and there was no evidence of the progress of a recommendation made in July 2016 for a specific nutritional intervention to be considered for addition to the care plan
- based on their own observations inspectors were not satisfied that there were adequate controls in place for the consistent monitoring of the effectiveness of equipment necessary for patient comfort and well-being.

Inspectors requested with immediate effect evidence that staff had the required sterile equipment and that equipment necessary for patient comfort and well-being sufficiently met residents needs; these matters were immediately addressed.

The person in charge and the interim area manager were requested to put clear protocols in place to ensure that all staff had knowledge of the operation of equipment and that it's functionality was formally monitored and recorded at a minimum daily. They were also requested to follow-up on any recommendations made for additions to the care plan including the use of nutritional supplements.

The provider confirmed on the 12 August 2016 that all staff were to receive training by the 19 August 2016 on the operation of the equipment and a daily checklist for the equipment would be implemented once training was complete. The provider also confirmed that the recommendation for the nutritional supplement was being followed up with the dietician.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

Overall inspectors were satisfied that the arrangements for medicines management supported safe practice.

The inspector saw organisational and local policies and procedures governing the management of medicines. The practice described by staff and evidenced in practice was as outlined in these policies and procedures.

Staff reported that the majority of residents brought with them on admission the supply of medicines they required for the duration of their respite stay. Staff said that medicines were accepted only in the original container or in a compliance aid dispensed and labelled by the resident's pharmacist. This concurred with what inspectors saw.

Staff said that the centre was also supported by a local community based pharmacist as needed.

Residents who managed their medicines independently while at home were facilitated to continue to do so while in the centre. This practice was underpinned by an individualised risk assessment and secure storage was provided in each bedroom. Unused medicines were returned and signed out on discharge to the resident.

Each resident had a current signed and dated prescription, a corresponding administration record and a medicines management plan.

Staff employed procedures that supported safe medicines management. These included staff checks of medicines supplied against the prescription kardex on admission and twice daily stock balance checks. Medicines were reviewed prior to and on admission so as to ascertain any changes since the last admission. Access to medicines was managed so that two staff were required.

Staff were described as diligent in the management of medicines and there was a low reported and recorded incidence of medicines management errors. Inspectors saw that incidents were followed-up on with staff through the formal staff supervision process.

There were no medicines requiring stricter management controls in stock.

While there was significant evidence of good practice, inspectors however noted that the maximum daily dosage of medicines prescribed on a p.r.n. (as required) basis was not always stated.

Where medicines were prescribed with a variable dosage, that is for example, one or two may be administered; staff did not record what they had administered. This was rectified during the inspection.

While medicines were securely stored, inspectors were not satisfied that adequate controls were in place for the storage of medicines given the multi-task nature of the room. This was discussed as a failing in Outcome 6 and the required action was also

issued under this outcome.

**Judgment:**

Substantially 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):**

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

**Findings:**

The Statement of Purpose submitted to HIQA did comply with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Given the changes in management that were taking place at the time of this inspection however, a revised and amended statement was required.

The statement of purpose also stated that day respite was provided. Given the limited communal space available the facilities for accommodating day respite were discussed with the interim area manager. The interim area manager confirmed that day respite was limited to a maximum of two persons at any one time and this would be included in the revised statement of purpose.

**Judgment:**

Substantially 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):**

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

**Findings:**

There was a clear management structure and governance systems in place but change was in process at the time of this inspection. A new person in charge had been selected and commenced in post on 2 August 2016. The exiting person in charge had assumed the role of interim area manager. All staff spoken with were clear on the changes, their respective roles, responsibilities and reporting relationships.

The management structure consisted of the team leader, (the person participating in the management of the centre (PPIM)), the person in charge and the area manager.

The team leader was not on duty due to an unplanned absence but was clearly known to residents and relatives surveyed and spoken with. The team leader had established experience in the centre and worked fulltime. The interim area manager said that a decision had been taken recently to strengthen the management structure by the appointment of a second PPIM as the centre was busy and currently open on a full-time basis.

The newly appointed person in charge confirmed that she worked fulltime and would have responsibility for this centre and another independent living service. The newly appointed person in charge had established service with the provider and had experience relevant to the role having worked both in administration and with staff and service users in the assessment and provision of supports. She had worked as the team leader in the independent living service since December 2013. The person in charge had knowledge of residents from a previous role in the provision of home supports. Her knowledge of regulatory requirements was gained from preparation for regulation and from decisionmaking as to what constituted a designated centre.

The person in charge had recently completed a diploma in health services management, had previously completed education on care skills and participated on an ongoing basis in the providers own education and training programme.

The newly appointed person in charge and the interim area manager had an established working relationship. Structured regional management meetings and team leader meetings were convened.

There was an on call out of hour's manager available within the wider organisation and an explicit rota was available to staff.

Staff were supported to raise any issues or concerns through monthly staff meetings and a formal system of staff supervision.

Arrangements were in place for the completion of annual reviews and unannounced visits to the centre as required by Regulation 23 (1) and (2). This process involved consultation with residents and representatives. Reports were available for inspection and overall indicated a high level of compliance with the requirements of the audit. However, where action was required following internal audit there was insufficient

evidence of the progression by staff of actions to satisfactory completion. For example in relation to records pertaining to resident's finances, the storage of medicines, the integrity of fire doors and activity planners.

**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):**

No actions were required from the previous inspection.

**Findings:**

Arrangements were in place for the management of the centre in the absence of the person in charge. The team leader who was also the PPIM managed the service in the absence of the person in charge and a recent decision had been taken to appoint a second PPIM. The newly appointed person in charge said that she intended to work in conjunction and in collaboration with both PPIM in relation to planning leave and absences.

**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:**

The interim area manager told inspectors that the centre was adequately resourced in line with residents' individual required supports.

**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):**

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

**Findings:**

A planned and actual staff rota was maintained. The rota identified all persons working in the centre, the shift and the hours that they worked. There was some use 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; this was reflected in the rota. Three staff were in the process of converting onto the core staff team following a recruitment process. Residents spoken with confirmed that staff were familiar to them and with their needs.

Staffing levels and arrangements were managed to reflect the number and needs of the residents accommodated. For example the staffing numbers incorporated skill-mix and staff spoken with said that skill-mix was planned to match residents needs, that is, where nursing input was required a nurse was available and on duty .

Staff files were made available for the purpose of inspection. The sample reviewed was well presented and contained all of the information required by Schedule 2.

Staff training records were available for inspection. Based on the information extrapolated from the training records staff had completed mandatory training in safeguarding, fire safety, manual/resident handling and responding to behaviours that challenged. Staff had also completed further relevant and required training including medication management training, first aid, epilepsy awareness, the management of diabetes, wheelchair clamping and supporting persons with physical and sensory disabilities.

However, no training records were available for staff working on a relief or agency basis of whom there was at least five indicated on the staff rota. Training records did not provide adequate evidence that training had been provided. Gaps were identified in staff attendance at safeguarding and medicines management training.

<b>Judgment:</b> 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):**  
No actions were required from the previous inspection.

**Findings:**  
Overall inspectors 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, the statement of purpose and the procedure for making a complaint were prominently displayed and available to residents.

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 to staff and for inspection.

The directory of residents included the information specified in Schedule 3.

**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-0002651
<b>Date of Inspection:</b>	03 and 04 August 2016
<b>Date of response:</b>	18 October 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 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

While there were arrangements for consultation with residents, these were not effective and were not used to inform the organising of the centre.

**1. Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

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

The centre will continue to consult with individuals on a quarterly basis. The house meeting template has been revised to ensure it records evidence of meaningful consultation with individuals on a weekly basis.

**Proposed Timescale:** 05/08/2016

**Theme:** Individualised Supports and Care

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

Practice was not reflective of the provider's policy and procedure on residents personal assets.

**2. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

The admission template has been amended to identify if the individual wishes to avail of any support around caring for personal belongings or financial affairs on admission. Any supports identified through this process will be provided in line with company policy.

The organisation's policy in respect of supporting service users with their financial affairs is currently under review. Review is due to be complete by 31.12.2016.

**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:**

There was inadequate space for support services such as laundry and for the provision of safe and suitable storage.

**3. 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:**

The laundry room is now used for the purposes of laundry only and all of the onsite storage has been reviewed to ensure safe and suitable storage throughout the centre.

**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:**

The risk management processes used by the provider had not identified and put controls in place for a number of serious risk issues such as access to risk areas, cleaning chemicals and safety of residents using shared bathrooms.

#### **4. 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:**

On admission any risks identified in relation to the service users and risks associated with shared bathrooms will determine allocation of rooms. Where required bathrooms will be single use. All chemicals are now stored safely in clearly identified chemical storage areas.

**Proposed Timescale:** 05/08/2016

**Theme:** Effective Services

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

The provider did not have adequate infection prevention and control arrangements in relation to the sluice and laundry areas, use of shared bathrooms and storage of clinical waste.

#### **5. Action Required:**

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

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

- On admission all service users will be assessed to ensure that they will not be at risk by shared bathrooms, if any risk is identified then bathrooms will be single use only.
- All of the bathrooms now have paper towel dispensers in place of hand towels.
- The storage of clinical waste has been reviewed and any clinical waste is now stored in line with best practice.

**Proposed Timescale:** 05/08/2016

**Theme:** Effective Services

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

The provider's arrangements for reviewing fire precautions were not adequate, and risks such as the use of door wedges and recording of fire drills to inform learning had not been identified or rectified by the provider. There were gaps in records maintained by staff.

**6. Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

- All records have been reviewed to ensure that they are completed in full and no gaps in required information exist.
- All wedges have been removed from the service.
- Learning from evacuations have now been recorded on individual PEEPs and the details of the individuals who participate in fire drills are recorded.

**Proposed Timescale:** 26/08/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Training records indicated that all staff employed on a relief basis had not completed adult safeguarding training.

**7. 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 of the core staff have received the appropriate training in relation to safeguarding and the newly appointed relief staff have been scheduled to attend the safeguarding training to be completed by the end of October.

**Proposed Timescale:** 28/10/2016

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

Adequate arrangements were not in place for the consistent monitoring of all healthcare related interventions.

### **8. 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:**

Full training was provided to all staff on the management and prevention of wounds and any additional training required will be provided on an ongoing basis. Skills gained through the training has been used to inform practice in the service.

**Proposed Timescale:** 19/08/2016

## Outcome 12. Medication Management

**Theme:** Health and Development

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

The maximum daily dosage of medicines prescribed on a p.r.n. basis was not always stated.

### **9. Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

As part of the admission process all kardexs will be reviewed to ensure that all maximum dosages for any PRN are included.

**Proposed Timescale:** 05/08/2016

## 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:**

Given the changes in management that were taking place at the time of this inspection a revised and amended statement was required.

The statement of purpose also stated that day respite was provided. Given the limited communal space available explicit detail of the facilities for accommodating day respite was required.

**10. 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:**

A revised statement of purpose and function has been completed, the revised statement of purpose and function addresses the issues identified around the provision of day care and the changes to the management structure.

**Proposed Timescale:** 05/08/2016

**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:**

There was insufficient evidence of the progression of actions to ensure that the action plan was effectively implemented.

**11. Action Required:**

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

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

The most recent internal audit report has been reviewed, any remaining outstanding actions identified have been addressed. Following the next internal audit the actions will be reviewed by the PIC and addressed accordingly a record of same will be maintained in the service.

**Proposed Timescale:** 31/08/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

No training records were available for staff working on a relief or agency basis of whom there was at least five indicated on the staff rota. Training records did not provide adequate evidence that training had been provided. Gaps were identified in staff attendance at safeguarding and medicines management training

**12. Action Required:**

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

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

- Training records for relief and agency staff are now maintained in the service.
- All gaps identified in staff training records have been addressed with training scheduled to the end of October to ensure all staff have received all training required

**Proposed Timescale:** 28/10/2016