Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Group F - Community Residential Services Limerick
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	22 October 2018
Centre ID:	OSV-0003953
Fieldwork ID:	MON-0023754

About the designated centre

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

This designated centre consists of two domestic type houses in separate locations but both in close proximity to the provider's main campus where services such as the day service, training centre, administration and nursing services are based. Full-time residential services are provided to a maximum of nine residents. The service supports residents with higher needs in the context of their disability; the provider aims to support each resident in a person centred manner so that they enjoy a good quality of life based in their local community.

Residents attend day services Monday to Friday or enjoy a quieter pace of life as tailored to their individual needs; each house is staffed when residents are present. The staff team is comprised of care staff and social care staff managed by the social care leader; the person in charge is the manager with regulatory responsibility and is a clinical nurse manager 2 (CNM2) based on the main campus.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
22 October 2018	09:30hrs to 18:30hrs	Mary Moore	Lead

Views of people who use the service

There were five residents living in the centre; one house was vacant due to plans for the reconfiguration of the centre as advised by the provider and agreed with HIQA (Health Information and Quality Authority).

The inspector spent time in this house in the evening when the residents returned from their respective day service. Engagement with residents was led by residents, their choices and individual needs; three residents engaged with the inspector. Residents in turn greeted and welcomed the inspector into their home. Residents spoke about what was good in life such as ongoing family contact, activities that they enjoyed and their goals for 2018 including a brief summer trip away. Residents invited the inspector to view their bedrooms, spoke of how the room was personalised to their liking and how much they enjoyed this personal space.

Residents also spoke of a recent matter of concern to them and clearly expressed how they felt about this. The inspector discussed the matter raised with the provider at verbal feedback and it is discussed again below in the context of complaint management.

Capacity and capability

Overall the inspector found that the provider managed this service well. The service was managed so as to provide residents with support and services that were safe and appropriate to their needs. For example the provider had and was progressing plans submitted to HIQA in response to previous failings; these plans had included the provision of premises better suited to some residents needs (this was complete) and the completion of works to improve fire safety; some of these were complete and the remainder were in progress in accordance with planned time frames.

The governance structure was clear as were reporting relationships and individual accountability and responsibility. The management team was made up of the social care leader, the person in charge and the director of services; there were regular team meetings at each level; these ensured that relevant information was exchanged and issues were escalated to the appropriate level within the organisation. The person in charge described her systems of oversight; she visited the centre at a minimum weekly, met with residents and staff on a regular basis on the main campus and received three formal reports each week from staff on the general operation of the centre.

The provider was undertaking the internal quality and safety reviews and the annual review required by the regulations. The inspector reviewed the findings of the annual review and the most recent unannounced review completed in July 2018. The reviews sought feedback from residents, their representatives and staff on their views of the service; the feedback was positive. The objective of these reviews was to bring about improvement and each review did follow up on the progress made on the previous action plan. Overall the reviewer found satisfactory progress and substantive evidence of good practice.

In addition to these reviews the provider had additional systems for self-identifying both good practice and where improvement was required; these reviews were undertaken by designated responsible persons for areas such as health and safety or clinicians in relation to the review of medicines management. Feedback to inform improvement was seen to be given to staff, for example at team meetings.

The provider had addressed deficits in staffing previously identified by HIQA. The inspector found that staffing numbers and arrangements reflected the individual and collective needs of residents; there were three staff on duty when all five residents were in the house; there were individual staffing arrangements in response to individual needs, for example to facilitate a slower pace of life.

While the inspector did not review staff training records staff spoken with confirmed that they had completed training in safeguarding, fire safety, responding to behaviours that challenged and medicines management practice.

A deficit was identified in the provider's complaint management process. The inspector was advised that there were no open complaints and the complaints log indicated that the last complaint received was in 2016. However, in the days prior to this inspection a much anticipated social event for residents had not been facilitated; a rationale was provided for this. However, the residents' disappointment and dissatisfaction at both the cancellation and the lateness of the communication of the cancellation was clearly evident to the inspector but it had not been recognised and recorded by staff as a complaint. This failing did not provide the opportunity for review and learning for example to establish if the rationale provided was reasonable and acceptable, if alternative arrangements could have been put in place and how to address the residents disappointment and prevent a similar re-occurrence.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge was available to staff and residents on a daily basis and had sound knowledge of the residents and their needs and of the general operation and administration of the

designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs of the residents. There was an ongoing requirement for relief staff but consideration was given to familiarity and continuity when completing the staff rota. This ensured that residents received continuity of care and supports. Residents were familiar with the staff on duty some of whom were employed on a relief basis.

Judgment: Compliant

Regulation 16: Training and staff development

Staff spoken with confirmed their attendance at required and mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

The centre was consistently governed and resourced so as to ensure the delivery of individualised safe, quality supports and services to residents. The provider had and was implementing the improvement plans submitted to HIQA. The provider had systems of review and utilized the findings of reviews to inform and improve the safety and quality of the service.

Judgment: Compliant

Regulation 34: Complaints procedure

A clear expression of dissatisfaction voiced by a resident was not recognised and

recorded as a complaint.

Judgment: Substantially compliant

Quality and safety

The management of this service was focused on the provision of appropriate safe, quality supports and services to residents; overall that objective was met. Improvement was required however in how residents were supported to manage behaviour that challenged or posed risk to others including staff and other residents.

The provision of care, support and services was informed by an assessment of each residents needs and the establishment of their preferences; this information formed the basis of the personal plan of support. The plan was seen to be detailed and personalised, kept under review and updated as change occurred. The plan included the residents' personal goals, how and who identified these and how they were progressed. It was evident that residents and their representatives participated in this process; residents spoken with had access to their personal plan and were satisfied with their personal objectives.

Residents were supported to maintain and enjoy good health. The assessment of resident needs included the identification of any healthcare related needs; there were detailed plans to guide staff on how to meet these needs. Residents had access to the healthcare services that they required many of which were available from within the providers own resources, for example there was daily access to nursing advice and support; some clinical reviews were facilitated on the readily accessed main campus.

The provider had systems that ensured that residents were protected by safe medicines management. Staff had attended training; prescriptions were current and legible; staff maintained a record of each medicine administered and completed weekly stock balances; these stock checks monitored the administration of medicines as required. Medicines management was the subject of regular audit as was the administration of any PRN (as required) medicines. Several actions had issued from the audit completed in August 2018; the inspector reviewed a sample of actions that had issued and found improved practice. For example there were no gaps noted by the inspector on the medicines administration record as staff were utilising the appropriate code.

Staff spoken with understood their role and responsibilities in protecting residents from harm and abuse; staff were familiar with the providers reporting procedure and told the inspector that there were no obstacles to reporting any safeguarding concerns.

There were times when behaviours presented that posed challenges to residents themselves, to their peers and to staff. Records seen indicated that these occurrences were infrequent. However, regardless of the frequency improvement was required to ensure that the response provided was empathetic, supportive and therapeutic, based on a sound understanding of needs and the clinical basis of behaviour, proportionate and the least restrictive response possible.

The plan in place to guide practice in this area did not support such as response; the language used was problematic in the context of a clear clinical diagnosis and for example included reference to "appropriate" or "inappropriate" without adequate defining of these terms. This transferred into the language used in practice," unacceptable and elated". There was a requirement for clarification on and clear recording of what supportive strategies were implemented to deescalate and why these did not work prior to redirection or chemical intervention. There was an evident need to consider the residents overall needs including established sensory needs and review possible triggers and escalatory factors including the general noise levels in the house and staff responses. While the overall usage of PRN medicines was low (based on records seen), a protocol was required for their administration to ensure that all possible alternatives were considered first. The provider was requested at verbal feedback to prioritise the review of the support provided to residents based on the verbal feedback provided.

The provider had implemented its plan to provide each resident with an environment that was safe and suited to their needs; this had addressed previous failings and four residents had relocated to a house better suited to their needs. All facilities in this house were provided at ground floor level. A resident demonstrated to the inspector how they had sufficient space for the mobility equipment that they required.

The inspector saw that the provider had completed the works required to improve on fire safety. The house was fitted with a fire detection system and emergency lighting; escape routes were protected with fire-resistant door-sets. Certificates of the inspection and testing of these systems at the required intervals were available for inspection. Staff also undertook and recorded regular visual inspections and tested the fire detection system on a weekly basis. Staff and residents undertook regular evacuation exercises including a simulated night-time evacuation. There were no reported or recorded obstacles to evacuation and good evacuation times were achieved.

Regulation 17: Premises

The provider had addressed previous failings to ensure that the design and layout of the premises was suited to residents' individual and collective needs.

Residents were seen to be provided with the equipment that they needed for their

safety and well-being.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had completed the fire safety works committed to. The provider ensured that there were effective fire safety management systems in place including arrangements for the safe evacuation of residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had medication management policies and procedures that supported safe medicines practice. Staff adhered to the procedures for the safe administration of medication; records seen indicated that medicines were administered as prescribed. Records were kept to account for the management of medicines including their administration.

The inspector did recommend a review of the current storage system as while secure both medicines and residents personal finances were accessed simultaneously.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which detailed their needs and outlined the supports required to maximise their well-being, personal development and quality of life. The plan was developed and reviewed in consultation with the resident and their representative as appropriate. The plan was seen to be the subject of review and update.

Judgment: Compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Each resident has access to the range of healthcare services that they required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Improvement was required to ensure that the response to behaviours that challenged or posed risk was empathetic, supportive and therapeutic, based on a sound understanding of needs and the clinical basis of behaviour, proportionate and the least restrictive response possible. The plan in place to guide practice did not adequately support such as response.

Judgment: Not compliant

Regulation 8: Protection

There are policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Staff had attending training and had a good understanding of the providers reporting procedures. Staff said that there were no obstacles to reporting safeguarding concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Group F - Community Residential Services Limerick OSV-0003953

Inspection ID: MON-0023754

Date of inspection: 22 /10/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: All staff and the PIC were met by the Provider on 24.10.2018 and discussed the importance of recognizing, managing and documenting resident's complaints. The Provider also met with residents to reiterate the importance of making complaints with them if they are unhappy with any aspect of the service delivered. The Provider reassured the residents that they should continue to make complaints to the staff, the PIC, CNM or to the Provider if they so wished. The residents were reassured that this was important for the service to enhance its quality delivery. Since this meeting, complaints have been managed and complainants were satisfied with the outcome form their complaints. The PIC will ensure that at all residents meeting residents are encouraged to make complaints if they so wished Date of Completion:30.1.2018 and Ongoing	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A look back review on supporting and Managing a person who presents with behaviours that challenge by the Provider, CNM2 ehe PIC of Group F and all staff working in Group F. From this the following actions arose for completion:	

• Observations to occur of Staff / Service User actions by Studio 3 Trainer Completion Date: 09.11.2018
• PIC to meet with all staff through supervision to discuss their individual responses and approaches in supporting residents that may present with behaviours that challenge. Completion Date: Ongoing.
• Review of distraction techniques and intervention support plan adjusted to match relevant distractions for a resident. Completion Date: 14.11.2018.
• Behaviour Support Plan –PIC/CNM2/CNM3 Managing Challenging Behaviour trainer have reviewed Plan and updated it to reflect changes in low arousal approaches to be used buy all staff. Completion Date:14.11.2018.
• Training and recommendations from this review to be completed with all staff. Completion Date: 15.12.18
• PIC and staff to review noise levels in house particularly at mealtimes and 4.00 – 6.00pm Training and recommendations from this review to be completed with all staff. Completion Date: 14.11.18 and Ongoing.
• Review supports for Group F house where in times of crises – CRS Service Manager / CNM3 / CNM2 to support Staff and Residents' needs at these times. Training and recommendations from this review to be completed with all staff. Completion Date: 14.11.18

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Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to.	Substantially Compliant	Yellow	30/11/2018
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: the person nominated under paragraph (2)(a) maintains the records specified under paragraph (2)(f).	Substantially Compliant	Yellow	30/11/2018
Regulation 07(1)	The person in charge shall ensure that staff	Not Compliant	Orange	15/12/2018

	have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	14/11/2018
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	14/11/2018