



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

Name of designated centre:	Laccabeg Accommodation Service
Name of provider:	RehabCare
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	02 May 2018
Centre ID:	OSV-0005626
Fieldwork ID:	MON-0022041

About the designated centre

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

This designated centre was established in 2017 for a specific cohort of residents transitioning from a congregated setting. Full time residential services were provided; a maximum of four residents can be accommodated. A team of social care staff supported residents on a 24 hour basis. The provider aims to provide residents with the supports they require to meet their assessed and developmental needs in a safe and homely environment. The premises consists of a two storey house on its own private site in a rural but populated area. The premises had been refurbished and fitted to a high standard prior to its operation in 2017.

The following information outlines some additional data on this centre.

Current registration end date:	13/06/2020
Number of residents on the date of inspection:	4

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
02 May 2018	09:30hrs to 18:30hrs	Mary Moore	Lead

Views of people who use the service

Residents had high support needs and engaged with the inspector in a variety of ways including some verbal communication, physical gestures and their overall demeanour. Therefore residents' views of life in the centre were informed largely by the inspector's observations. The inspector saw that staff provided supports on an individualised basis. Residents presented as comfortable and at ease with staff, were happy to agree to staff requests and to receive staff assistance. Equally when a resident indicated an alternative preference staff respected the resident's choice. One resident guided the inspector by gesture to view their bedroom; another resident indicated their satisfaction with a thumbs-up gesture.

Capacity and capability

The inspector found that this was a well managed centre and the provider had arrangements in place to ensure that the quality and safety of the service was delivered to a good and consistent standard. The operation of the centre was focused on each resident and the achievement of positive outcomes with them and for them. The provider had effective systems of review and used the data and the information available to it to continuously develop and improve the service. High levels of compliance was found in the areas assessed on this inspection.

There was a clearly defined and accountable management team which comprised of the team leader, the person in charge and the regional manager. There was clarity on roles, responsibilities and reporting relationships; supportive, collaborative ways of working were evidenced. The person in charge worked full-time and was suitably qualified and experienced for the role. The person in charge demonstrated clear accountability for the care, support and services provided to the residents.

On a day to day basis the team leader supported the person in charge and again the team leader had the knowledge and experience required to participate in the management of the centre and to respond to the needs of this particular cohort of residents. The person in charge and the team leader had implemented systems that standardised the operation of the centre and supported effective governance and good quality care. This was evident in areas such as designated staff responsibilities and standardised systems for recording and reporting care and practice.

The provider had put effective systems in place to monitor the care provided to

residents. The person in charge and the team leader regularly reviewed quality and safety parameters such as the weekly formal reviews completed by the team leader of areas such as the management of residents' personal finances and medicines management. The provider was also complying with the requirement of the regulations to conduct an annual review of the quality and safety of the service and had undertaken a six monthly unannounced visit to the centre. The person in charge, who was an internal auditor of services, had completed a further comprehensive audit of the centre. The reports of these reviews from November 2017 and March 2018 were made available to the inspector who saw that residents and their representatives were invited to contribute and provide feedback as part of this process. This showed that the provider wanted to insight into how residents experienced the service. The feedback was positive. Action plans were followed through so as to effect the required improvements. The inspector noted that the failings identified were predominantly of a documentary nature such as staff not signing off on policies as opposed to actual deficits in care or support.

The provider had ensured good staffing arrangements were in place. There were Adequate numbers of staff working in the centre to support residents in line with their needs and to implement their personal plans both in the centre itself and in the community. The requirement for relief staff was managed so that residents received continuity of support and care; staff spoken with were knowledgeable about the support needs of residents. Staff confirmed their attendance at training and training records seen by the inspector indicated that staff had completed all required baseline training; refresher training was scheduled to reflect mandatory requirements. Staff were also provided with a range of training that was specific to residents needs and informed how they supported residents. For example the team leader who was appropriately qualified to do so providing training on autism; the behaviour therapist facilitated positive behaviour support training.

Staff practice and the operation of the centre were informed by regular team meetings, day to day supervision and formal supervision. For example each accident and incident was reviewed by the team leader and the person in charge and then discussed at the next team meeting. This discussion was focused on what may have gone wrong and what learning was required to improve practice and resident safety. An example was given of how an incident had resulted in more detailed planning of community activities so as to avoid particular triggers for behaviours that challenged. The inspector saw that staff completed a good record of each incident including what was happening at the time and the corrective actions taken. The information which was recorded provided for learning and improvement of the service.

The inspector was advised that no complaints had been received since the centre commenced operation. Narrative and easy-read pictorial information was available as to how to complain and who to complain to. There was a discussion as to how staff captured resident dissatisfaction given their high support needs. Staff described how residents expressed choice and dissatisfaction such as particular words or a particular behaviour that was a cue for staff to not persist with a particular request or activity. Staff also explained that while a resident may not be able to verbally express that they did not like a particular meal, they would return their plate to the

staff thereby communicating their dislike. This demonstrated that the service was actively seeking and responding to residents' feedback.

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 facilitated the inspection with ease 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. Residents received continuity of care and supports.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre including those employed on a relief basis had completed the required mandatory training within the required time-frames. Staff had also completed training that supported them to safely meet resident's needs including the administration of medicines, first-aid, hand-hygiene, autism specific training, report-writing, health and safety at work and food hygiene

Judgment: Compliant

Regulation 23: Governance and management

The centre was effectively governed and resourced so as to ensure and assure the delivery of safe, quality supports and services to residents. The provider utilized the

findings of reviews to inform and improve the quality of the service.
Judgment: Compliant
Regulation 31: Notification of incidents
There were effective arrangements for ensuring that the required notifications had been submitted to HIQA.
Judgment: Compliant
Regulation 32: Notification of periods when the person in charge is absent
The provider was aware of its requirement to notify HIQA (Health Information and Quality Authority) of absence of the person in charge and of the arrangements for the management of the centre in her absence. There had been no absence that required notification; that is greater than 28 days.
Judgment: Compliant
Regulation 34: Complaints procedure
The provider had policy and procedures on the receipt, recording, investigation, learning from and review of complaints. Staff were clear on how residents in the context of their needs expressed their dissatisfaction as necessary.
Judgment: Compliant
Quality and safety
The centre was effectively managed to ensure and assure the quality and safety of the service in the majority of areas reviewed. In general, residents' quality of life had improved since moving into the service in 2017. The inspector was satisfied that each individual resident received high quality supports based on their individual assessed needs. However, as staff came to know residents better in their new home environment, there was evidence that collectively, residents' needs were not always compatible. While the provider was aware of this matter, it had not yet

been reviewed and addressed at the time of inspection. This incompatibility issue impacted negatively on the quality life of residents in some instances.

This particular group of residents had previously lived together and had been assessed as compatible to live together as part of a transition plan from a congregated setting. The inspector saw that each resident had adapted very well to this significant life transition. However, the environment, routines and model of care were very different to that previously experienced by residents and as residents had adapted, grown and developed it was evident that they had different needs and requirements and that the service provided was not suited to all residents' needs. Staff spoken with stated that they had identified this; the inspector also saw evidence of this in inspection. For example the inspector saw that the pace of the house altered to one of constant activity dependent on what residents were present. One to one staff arrangements were disturbed as was the activity that was ongoing at the time and other residents' bedrooms were entered without permission. Staff reported that residents were regularly disturbed at night-time from their sleep and that particular residents' personal and private space was impinged upon; this would concur with notifications submitted to HIQA.

Notwithstanding the failing above staff were committed to ensuring that each resident was provided with safe, quality, evidence based supports on an individual basis. The assessment of resident needs was comprehensive and informed the plan of support. Residents presented with a diverse range of complex needs and a long history of institutionalised living. Staff spoke of the absolute requirement of adherence to and the consistent implementation of the support plan to assure the safety and quality of support and care. The inspector was satisfied that the plan of support informed and guided practice on a daily basis. This had a positive impact on the way care was provided and helped to ensure that care was informed and consistent. Staff kept each plan under review; the person in charge was in the process of arranging the annual multi-disciplinary review of the plan and the annual review of each resident's personal plan (their individual goals and objectives). Families had been invited and had confirmed their intent to attend.

The inspector saw that the support provided to residents had achieved improved quality of life outcomes for residents. Residents went to the local day service where they participated in programmes suited to their needs and at a pace that they enjoyed. These programmes included art and crafts, music therapy, cookery, swimming and participation in a local men's -shed; residents enjoyed other local recreational amenities, socialising and eating out. A range of therapeutic activities were also facilitated in the house including a room equipped with sensory and recreational equipment; an internal therapeutic swing had been fitted as had blackboards so that residents could draw as they relaxed. Residents had and were developing independence and autonomy in their environment and in their routines and to develop this further the behaviour specialist had recently facilitated "active support" training for staff; a way of supporting so as to best enable choice, control and meaningful community participation for residents. Staff described the strategies that they employed so that all residents engaged safely and successfully in their neighbourhood and in the general community.

Residents were supported to establish, re-establish and maintain personal and family relationships. There was no restriction on visits; visits were reported to often be unannounced. A schedule of regular visits to family supported by staff as necessary had been established. Feedback seen that had been received from family indicated that while the initial transition from the congregated setting had caused some anxiety, the success and benefit of it to residents had gone well beyond what was expected.

Resident health and well-being was monitored by staff and timely access to the general practitioner (GP) was facilitated. Staff reported that the GP worked with residents and staff to ensure that each required medical review was successful. Staff maintained good healthcare related records and the inspector was assured that staff were alert and attuned to any changes in resident presentation. General and mental health nursing advice was facilitated by the local community resources. Residents continued to attend reviews with the psychiatrist. Where healthcare specific supports were required these were detailed in the support plan and seen to be implemented in practice; for example the provision of a modified diet and staff supervision at mealtimes.

To maintain their health and well-being residents had prescribed medications. Overall the inspector found that there were appropriate medicines management practices. Medicines were supplied by a local community based pharmacist, medicines were seen to be stored securely. Staff had completed medicines management training. To reduce risk and promote safe, accountable practice there was an assigned staff responsible for the administration of medicines on each shift. Staff were seen to check the prescription prior to administration and maintain a record of each medicine administered. However, the inspector did note that the label of one medicine container was illegible while another was only partly legible and this was an area which required review by the provider to ensure continued safe practice.

The provider had systems to protect residents from harm and abuse such as policies and procedures, a designated person and training for staff; residents also had access to the advocate so as to promote their rights and best interests. Staff spoken with had a sound understanding of their individual responsibility to safeguard residents and their reporting responsibilities.

Residents did present with behaviours of concern and associated personal risk. There was consistent evidence of therapeutic responses informed by the comprehensive assessment of residents' need, staff knowledge and active practical input from the behaviour therapist. Strategies to prevent and respond to behaviours was clearly outlined in the support plan or in specific behaviour management guidelines. Staff had completed training in de-escalation and intervention techniques and confirmed that there had been only one occasion where such an intervention was required to ensure resident safety. Medicines were used on a PRN basis (as required) as a behaviour management strategy; there were protocols for their use linked to the behaviour management guidelines and their use was monitored.

However as residents needs were not collectively compatible and as some residents

did not have the skills required to protect themselves, behaviours did result in peer on peer incidents that were managed in the centre as safeguarding incidents. The incidents resulted in breaches to residents' private space, personal space and personal boundaries. Staff stated that these incidents were directly co-related to the incompatibility of residents needs and they are therefore addressed in this report in that context.

Environmental restrictive practices to manage risk to residents were required; these were managed in a way that did not impact on the homely presentation of the house. For example while some external doors were restricted residents had ready access to a spacious, pleasant and secure outdoor area to the rear of the house. The inspector saw innovative but simple approaches to reduce the requirement for the restrictive practices; for example viewing panels that allowed residents see what was in cupboards and pictorial cues that communicated to residents whether they were allowed access to a particular item or not. Staff reported that these interventions did work; restrictive practices were the subject of regular review and a 25% reduction in their use had been achieved since opening the centre.

Risk to residents was also managed by good risk management practice. The inspector saw that the person in charge maintained a register of centre specific, work related and resident specific risks; detailed measures to control the risk were specified; again these were centre and resident specific and reduced the level of assessed risk.

There was evidence of good fire safety management systems. The fire detection system, fire fighting equipment and the emergency lighting were inspected at the required intervals and most recently in April 2018. Staff had attended recent fire safety training. Staff convened regular simulated evacuation drills with residents; staff said that there were no obstacles to the effective evacuation of residents and this was reflected in the records seen. All residents were seen to participate in the evacuation exercises and adequate evacuation times were achieved. Additional devices to alert residents with a sensory impairment were supplied, inspected and maintained.

Regulation 11: Visits

Residents were supported to develop and maintain friendships and relationships. Residents received visitors in line with their choices and preferences.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to safely exercise independence, choice and control. Residents were supported to access a range of meaningful activities and programmes in the house, in the day service and in the community. As residents developed independence and autonomy in their environment and in their routines, to develop this further the behaviour specialist had recently facilitated "active support" training for staff; a way of supporting so as to best enable choice, control and meaningful community participation for residents.

Judgment: Compliant

Regulation 26: Risk management procedures

There were measures in place to protect and promote the health and safety of residents, staff and others. These measures included the identification, assessment, management and review of risk. Risk assessments were seen to be kept under review; the controls in place reduced the level of assessed risk.

Judgment: Compliant

Regulation 28: Fire precautions

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

Overall there was evidence of systems that supported good medicines management. However, two medicines were noted to have illegible or partly legible labels.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Resident's needs were comprehensively assessed and a plan of support was devised based on the findings of the assessment. Resident's needs and plans were seen to be kept under review by staff. The accessibility of the plan was enhanced through the use of pictorial and photographic supports; the language used was person centred and respectful. The support plan was integral to the day to day provision of services. The inspector was satisfied that each individual resident received high quality supports based on their individual assessed needs.

However there was evidence that collectively, residents' needs were not always compatible and the service provided required review to ensure it was suited to all residents' needs. This incompatibility impacted on quality of life for residents.

Judgment: Not compliant

Regulation 6: Health care

The provider had adequate arrangements in place to ensure that each resident was provided with the appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

Practice observed in the centre reflected an individualised, positive, therapeutic approach to understanding and managing behaviours that challenged. The evidence base of this approach was informed by existing staff knowledge and active input from the behaviour therapist. Restrictive practices were the subject of regular review; review achieved reduction in their use.

Judgment: Compliant

Regulation 8: Protection

The provider had systems to protect residents from harm and abuse such as policies and procedures, a designated person and training for staff; residents also had access to the advocate so as to promote their rights and best interests. Staff spoken with had a sound understanding of their individual responsibility to safeguard residents and their reporting responsibilities.

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 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Laccabeg Accommodation Service OSV-0005626

Inspection ID: MON-0022041

Date of inspection: 02/05/2018

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 29: Medicines and pharmaceutical services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <p>Background</p> <ul style="list-style-type: none">• The organisation's Medication Management Policy governs the management and administration of medication within services. The policy has been developed and is regularly reviewed to ensure it is in line with international best practice. Within the policy there is guidance on the labelling of medication and on the completion of medication audit.• Service user medication counts are completed on daily basis, as a mechanism to monitor for errors in administration (weekly for 1 service user who self-administers in line with risk assessment). All incidents and near misses are reported and monitored on the organisation's incident management system. <p>Action</p> <ul style="list-style-type: none">• Monthly audits will be completed on all medication files including all relevant documentation, and medication packaging.• All PRN medication is now being blister packed by the pharmacy. This was completed by June 20th 2018.• New template has been put in place to for ordering and picking up medication monthly. This was completed by June 20th 2018.• Clear washable film is now being placed over all medication labels. This was completed by June 20th 2018.	

Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>Background</p> <ul style="list-style-type: none"> • All Residents have an annual screening of needs and a support plan which identifies their support needs and guides staff practice. Residents are also supported to have Person Centred Plans with ongoing action plans which enable them to pursue their goals. Plans are developed in consultation with the resident. Plans are reviewed on an ongoing basis to review their effectiveness and there is formal review at minimum on an annual basis. The review looks at the effectiveness of the plan over the previous 12 months and encourages the resident to identify goals for the coming year. • The organization is currently in the process of developing a Compatibility Assessment Tool for use in services where issues in relation to compatibility arise, the purpose of the tool is to identify areas of concern and develop a plan. The purpose of process is to identify measures to address the areas of concern this will include, skills building for service users, environmental changes etc. In the meantime compatibility issues are being managed through the risk management process through the use of a positive behavior support approach. <p>Action</p> <ul style="list-style-type: none"> • Meeting to be held with the HSE to raise concerns and consider any options available. To be completed by 01/09/2018. • Action plan to be agreed. • Multi-disciplinary team case review to be held. • ASD Training to be provided for all staff, scheduled for 29/06/2018. • Long term safe guarding plans to be reviewed scheduled for 27/06/2018. • Psychologist to be engaged to work with client scheduled for 27/06/2018. • Team to participate in refresher course on active support skills. 	

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 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	June 20 th 2018.
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as	Not Compliant	Orange	September 1 st 2018

	assessed in accordance with paragraph (1).			
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