Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Raceview Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	12 June 2023
Centre ID:	OSV-0008242
Fieldwork ID:	MON-0036749

About the designated centre

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

Raceview Services provides a supported accommodation service for four male adults with an intellectual disability who have been identified as requiring minimum to moderate support. The centre comprises of a dormer style two-storey house located in an urban residential area close to a range of amenities and public transport. Each resident has their own bedroom and there is a variety of shared living space. Residents have access to a large garden area and the centre has its own vehicle available for residents to access the community. Residents at Raceview Services are supported by a staff team which includes both social and care staff as well as sleep in staff at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as 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
Monday 12 June 2023	09:30hrs to 16:30hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to follow up on non compliance's identified during the previous inspection of this centre, to assess the provider's compliance with specific regulations and also the regulatory compliance plan submitted to the Chief Inspector of Social Services on an organisational level.

The inspector met and spoke with staff members on duty, the person in charge and the assistant director of client services. Raceview services provides four male residents with full-time residential placements, however, some residents were still in the process of transitioning and were not yet living in the centre on a full-time basis. On the day of inspection there was one resident living in the centre, another resident was attending the special Olympics in Berlin and two residents were at home with their families. The inspector did not meet with the resident living in the centre as they had already left to attend their day service earlier in the morning and had not returned to the centre by the time the inspector was leaving.

Raceview services is a dormer style two-storey house designed and laid out to meet the number and needs of residents. It had been extensively renovated in early 2022 and was finished to a high standard. It was spacious, bright, visibly clean and furnished in a homely style. There were four large bedrooms, two with en suite shower facilities for residents use. Three of the bedrooms were located on the ground floor and one bedroom was located on the first floor. Bedrooms were decorated and furnished in line with residents individual preferences. Each bedroom had a television, adequate storage space for personal belongings and were personalised with family photographs and other items of significance to each resident. There was an additional bathroom/shower room available on each floor. There were two additional bedrooms available for use by staff. There was a variety of communal day space available including a well equipped kitchen, dining room, two sitting rooms and a conservatory. There was a separate utility room, storage rooms and an external store. Residents had easy access to well maintained mature garden areas with suitable outdoor furniture provided for residents use as well as a swing and basketball hoop. There was a thread mill, pool table and ice hockey table located in the external store for resident use. The building was accessible with suitable ramps provided to the front entrance area and adequate car parking spaces provided.

Staff reported how they continued to support residents in keeping active and partaking in activities that they enjoyed both in the house and out in the community. The inspector reviewed the minutes of weekly house meetings which showed that residents decided on and planned their preferred activities on a weekly basis. A review of residents files and photographs showed that residents regularly enjoyed a variety of activities including bowling, going to the cinema, going for walks, going on day trips, eating out and getting takeaways. One of the residents enjoyed partaking in many sporting activities including basketball, swimming, football and kayaking and was attending the special Olympics at the time of

inspection. The inspector was shown photographs of a resident enjoying recent birthday celebrations and having a BBQ with family and friends at the house. Residents' independence continued to be promoted. Residents were supported to assist with shopping, cooking, cleaning and laundry.

Visiting to the centre was being facilitated in line with national guidance. Residents were supported to receive regular visits from their family members and all residents regularly visited and stayed at home with their families. Staff reported that there was regular and ongoing communication with all families, that family members were supporting one resident attend the special Olympics and another resident was due to travel to Lourdes later in the month with the support of his family.

Throughout the inspection, it was evident that staff prioritised the welfare of residents, and that they ensured residents were supported to live person-centred lives where their rights and choices were respected and promoted. Staff spoken with advised that staffing levels in the centre had improved since the last inspection and that a number of new staff had been recruited. The person in charge confirmed that there was still one vacant post and following recent reassessment of residents needs further staffing resources were identified.

While some improvements were noted to the governance and management arrangements and management of risk, further improvements were still required. Improvements were also still required in relation to assessment and personal planning and further clarity was required in relation to the management and payments of utility bills, all of which will be outlined further in the the next two sections of the report.

Capacity and capability

This designated centre is run by Ability West. Due to concerns in relation to Regulation 23 Governance and management, Regulation 15 Staffing, Regulation 14 Person in Charge, Regulation 5 Individualised assessment and personal plan, and Regulation 26 Risk management procedures, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider’s registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in April 2023 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has outlined an action plan to the Chief Inspector highlighting the steps they will take to improve compliance in the registered centres. These regulations were reviewed in this inspection and this report will outline the findings found on inspection.

The findings from this inspection showed that the provider had not fully implemented its own compliance plan which was submitted to the Chief Inspector following the last inspection, however, some deficits in governance and management identified during the last inspection had been addressed. These

included a review of restrictive practices to ensure compliance with the national standards, notification of incidents as required by the regulations, complaints procedure was updated, individual risk assessments had been reviewed and updated. A formal management on-call system had been put in place for out of hours and the person in charge had been facilitated with 12 hours per week protected time to their management and operational role. However, staffing resources were still not in line with the statement of purpose and the assessed needs of residents. While a social care worker and care assistant had been recruited since the last inspection and an internal staff transfer of a care assistant was almost finalised, there was still one vacancy for a social care worker. The person in charge advised that a recent reassessment of residents needs had identified that additional staff resources were required to meet the needs of one resident who required one to one support. Non compliance's identified at the last inspection in relation to individual assessment and personal planning had not been addressed.

There were now formal on-call arrangements in place for out of hours seven days a week. The details of the on-call arrangements were notified to staff on a weekly basis and clearly displayed in the centre. Staff spoken with were familiar with the arrangements in place.

Training was provided to staff on an on-going basis and records reviewed indicated that all staff had completed mandatory training. Additional training in various aspects of infection prevention and control, feeding, eating, drinking and swallowing, medication and epilepsy management had also been provided to staff. Records of induction training provided to recently recruited staff was also available. Further training was planned in risk management and 'Talking Mats' a picture based communication tool. Regular team meetings were taking place at which identified areas for improvement and staff training updates were discussed and learning shared.

In line with the regulatory plan submitted by the provider, the person in charge confirmed attendance at a number of recent training workshops which had been arranged by the provider to support and enable persons in charge in their role. Training included roles and responsibilities, risk management, Flex maintenance system, quality enhancement plans and discussion on new templates, filing systems and assessments being implemented by the provider across all services.

While the provider had systems in place to monitor and review the quality and safety of care in the centre including an annual review and six monthly unannounced audits, some key areas for improvement had not been mentioned in these reviews and some required improvements identified had not been completed. The annual review for April to December 2022 and a recent provider led audit April 2023 had been completed. Consultation with residents and their families as well as an overview of key areas of regulation had been used to inform these reviews. Priorities and planned improvements identified for 2023 were set out in a quality improvement plan, however, issues relating to lack of staffing resources had not been mentioned or included in the improvement plan and improvements required to residents records by 19 May 2023 had not yet been addressed. The person in charge continued to regularly review identified risks, health and safety, accidents

and incidents, complaints, restrictive practices, medicines management, fire safety and residents finances. The person in charge showed the inspector the standardised quality enhancement plan which had been recently introduced by the provider and which was being developed for the centre at the time of inspection. They advised that the quality enhancement plan will provide improved oversight of actions that are required to be addressed. It will include actions from provider led audits, HIQA compliance plans, control measures to mitigate identified risks, learning from incident reports and will be reviewed and monitored by the local management team on a quarterly basis and discussed at monthly team meetings.

Further clarity was required to ensure transparency and accuracy in relation to fees and daily contributions charged to residents in accordance with their contracts of care. The inspector reviewed a contract which set out the standard daily contribution for the resident and stated that it would be used to fund shared communal costs such as food, electricity, heating and water. However, the person in charge was unclear as to how utility bills were being managed and charged. They advised that they had recently sought clarity from the finance department regarding these issues and a meeting had been scheduled to discuss same in the coming week.

Regulation 14: Persons in charge

There was a person in charge who had responsibility for the day to day management of the centre. The person in charge worked full-time and had the required qualifications and experience to manage the centre as required by the regulations. They were knowledgeable regarding the regulations and their statutory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that number, qualifications and skill mix of staff was appropriate to the number and assessed needs of residents and the statement of purpose. Staffing levels were still not in line with those set out in the statement of purpose and the assessed needs of residents. There was still one vacant social care worker post and following recent reassessment of residents needs further staffing needs had been identified. There was no negative impact on residents at the time of inspection as there were only two residents living full-time in the centre, one resident usually stayed four nights a week and one resident was currently using the service on four afternoons per week.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not fully implemented its own compliance plan which was submitted to the Chief Inspector following the last inspection. Staffing resources were still not in line with the statement of purpose and the assessed needs of residents. There was still one vacant social care worker post and a recent assessment of residents needs had identified that additional staff resources were required to meet the needs of one resident who required one to one support.

Systems in place to monitor and review the quality and safety of care in the centre including an annual review and six monthly unannounced audits require review to ensure that all areas for improvement were identified and addressed.

Non compliance's identified at the last inspection in relation to individual assessment and personal planning had not been addressed. While residents needs had been recently assessed using a new standardised needs assessment template, some sections were left uncompleted and staff were unable to interpret the score results. There were no formal review meetings held to discuss progress or effectiveness of personal plans, the names of those responsible for pursuing objectives in the plan within agreed timescales were not identified or recorded.

Further clarity was required to ensure transparency and accuracy in relation to fees and daily contributions charged to residents in accordance with their contracts of care. The person in charge was unclear how utility bills were being managed and charged.

Judgment: Not compliant

Quality and safety

The local management team and staff strived to ensure that residents received an individualised, safe and good quality service. Improvements were noted to the management of restrictive practices, however, as discussed under the capacity and capability section of this report. The inspector reviewed a sample of residents' files and noted that improvements were still required to personal plans and individual assessments of the health, personal and social care needs of residents.

Personal plans had been developed in consultation with residents, family members and staff. Review meetings took place annually, at which residents' personal goals and support needs for the coming year were discussed and documented. However, the inspector noted that some goals listed were not meaningful, the names of those

responsible for pursuing objectives in the plan within agreed timescales were not identified or recorded. There were no evidence of formal review meetings held to discuss progress or effectiveness of the plans, therefore, the inspector was unable to assess if personal goals had been achieved or were in progress. The person in charge advised that staff had not received training in personal planning but that the provider had committed to appointing a project lead to review and provide training for staff on person centered personal planning processes in line with the regulatory compliance plan submitted.

Residents needs had been recently assessed using a new standardised needs assessment template 'My support needs assessment'. The assessments had been carried out by the person in charge and an assigned member of the multi-disciplinary team. However, the assessments had not been fully completed. For example, the type of supports required, action required due to risk identified, staff skill set, staff training needs to support the needs of residents had not been completed. A total numerical score had been calculated for each resident but staff and the person in charge were unable to interpret the score result. The person in charge outlined that two residents had been identified with complex needs and that additional staffing resources had been identified for one resident who required one to one support but this information was not evident from these assessments.

The inspector reviewed the risk register which had been updated on 9 June 2023. The person in charge was in the process of updating risk assessments on the new standardised risk register template. The person in charge had recently completed a training workshop on risk management and training was planned for all staff in the coming months. The person in charge outlined the risk escalation pathways and confirmed that the top five centre risks will be discussed at the monthly team meetings. Minutes of recent staff meetings reviewed showed that these risks had been discussed.

Regulation 26: Risk management procedures

The risk register which had been updated on 9 June 2023. The person in charge was in the process of updating risk assessments on the new standardised risk register template and was scheduled to discuss identified risk and risk ratings with the assistant director of client services at a service review meeting scheduled on the day of inspection. The person in charge had recently completed a training workshop on risk management and training was planned for all staff in the coming months.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had not implemented its own compliance plan which was submitted to the Chief Inspector following the last inspection, improvements were still required to personal planning and individual assessments. Residents needs had been assessed using a new standardised needs assessment template, however, the assessments were not informative, some sections were left uncompleted and staff were unable to interpret the numerical score results.

Improvements were required to personal planning to ensure residents were supported to achieve meaningful goals, to include the names of those responsible for pursuing objectives in the plans within agreed timescales and to formally review progress and effectiveness of personal plans.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Raceview Services OSV-0008242

Inspection ID: MON-0036749

Date of inspection: 12/06/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment efforts are ongoing to recruit a vacant post of a Social Care Worker within the Service. The Person in Charge ensures that there is adequate staffing in place with effective skill mix daily to support the Residents within the Service to include one Resident that requires 1:1 support. A relief Social Care Worker is available to work in the Centre when required.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Recruitment efforts are ongoing to recruit a vacant post of a Social Care Worker within the Service. The Person in Charge ensures that there is adequate staffing in place with effective skill mix daily to support the Residents within the Service to include one Resident that requires 1:1 support. A relief Social Care Worker is available to work in the Centre when required. A Quality Enhancement plan which captures the actions identified in recent HIQA inspections and Provider led Audit inspections will be completed monthly by the Person in Charge and detail all actions and measures taken to address non compliances and outstanding actions. The Quality Enhancement plan will be reviewed monthly by the quality and compliance department and the Person Participating in Management and any outstanding actions or concerns will be addressed immediately. In addition, the quality enhancement plan will be reviewed at quarterly service review meetings between the Person in charge and the Person Participating in Management and actions identified as required. The Annual Review now highlights concerns in relation to staffing within the Centre for 2022. Systems for monitoring and review of quality and safety is also being reviewed organizationally currently.	

A Provider Needs Assessments for Residents has recently been completed by the person in charge and verified by the multi-disciplinary team. This document is stage one of a Provider needs assessment to inform current and future needs each resident in Ability West. All sections relevant to stage one of this process are now complete for each Resident within the Centre. This process was discussed at a workshop with all Managers on 26th June 2023.

PCP reviews are currently taking place within the Centre to ensure that the progress and effectiveness of personal plans for each Resident within the Centre are recorded with identified keyworkers supporting the Residents with their identified objectives. Formal meetings to review the effectiveness of personal goals have been scheduled to include all members of the Residents circle of support. PCP training will take place commencing in September 2023 for all staff whereby an external agency will lead out on the delivery of this training within Ability West and guide best practice.

A meeting has taken place between the Person in Charge and the Finance Dept. to clarify how utility bills are paid and the contracts of care are under review for each Resident by the Person in Charge and the Person Participating in Management to ensure they accurately reflect what Residents daily contributions fund and what is funded by Ability West.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The staff team will complete risk management training by the end of August 2023 to further support them in their roles within the Centre. The Centre risk assessments are currently under review within the Centre and the risk register will be updated to reflect the top 5 risks within the Centre. The Person in Charge will review the risk register monthly and forward the top 5 risks to the quality and compliance department and the Person Participating in Management who will then review at a monthly meeting to determine trends within the Centre. Any concerns noted will be escalated to the relevant department for further review and support.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The All About Me Assessment document is an existing Ability West document which reflects the current assessed needs of a resident. It is completed and maintained by the Person in Charge and the Keyworker. This document is filed in a Resident's personal plan for the purpose of review.
The Person in Charge will ensure that this document is regularly reviewed when an emerging/ changing need is identified.

Separate to the local needs assessment, the Provider is undertaking an additional robust review of needs assessments across Ability West services to inform planning at a strategic level. It is completed by the PIC and a member of the Multi-Disciplinary Team, and recorded in the 'My Support Needs Assessment'. This is also filed in the Resident's

personal plan. This process was discussed at a workshop with all Managers (PICs) on 26th June 2023.

Person Centre Plan (PCP) reviews are currently taking place within the Centre to ensure that the progress and effectiveness of personal plans for each Resident within the Centre are recorded with identified keyworkers supporting the Residents with their identified objectives. Formal meetings to review the effectiveness of personal goals have been scheduled to include all members of the Residents circle of support. PCP training for staff will take place commencing in the latter months of 2023.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/09/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/09/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	30/09/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/08/2023
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the	Not Compliant	Orange	30/09/2023

	designated centre.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	31/12/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/12/2023
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	31/12/2023