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:	Graifin House
Name of provider:	RehabCare
Address of centre:	Dublin 18
Type of inspection:	Short Notice Announced
Date of inspection:	11 February 2021
Centre ID:	OSV-0002636
Fieldwork ID:	MON-0031473

About the designated centre

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

This community based residential centre provides a high support residential service for adults with Prader-Willi Syndrome (PWS). Each individual has complex needs in relation to their PWS, pertaining to food, behaviour that challenges, and mental and physical difficulties. The house is a two-storey, six bed roomed building located on a main road in a suburban area in Co. Dublin. Residents can also access the building from a side entrance. A large garden area is available to the front and side of the premises. Each resident has their own single room with one located on the ground floor and four on the second floor. The house is close to a broad range of services and amenities, with a public transport system also locally available. There is capacity for five residents and they are supported over the 24 hour period by care support workers, team leaders and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 - 2015 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
Thursday 11 February 2021	10:40hrs to 17:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

From what residents told the inspector and what the inspector observed throughout this inspection, it was evident that the residents were supported to feel safe in their home and enjoy a good quality of life in which their preferred routine was respected. The residents were supported to understand their own support needs and to be active participants in their support delivery and in the running of the house. The residents were also supported to remain active in their recreational and social interests, both in the community and remotely, in light of the changes to routines caused by the ongoing health emergency. The residents were also being supported to have their voices heard in the arrangements for more suitable accommodation to meet their needs.

During the day the inspector met with all residents living in this house, with the exception of one resident who had been staying with family since the start of the COVID-19 pandemic. The residents welcomed the inspector into their home and two residents spent time chatting with the inspector about the house, the staff and their experiences living there.

The house was nicely decorated and comfortable. Bedrooms were highly personalised based on the residents' choices, and communal areas were decorated with photographs of the residents involved in activities and events, as well as certificates residents had been awarded. The residents' specific support needs required there to be limited access to the kitchen facilities, however this restriction was not excessively applied, with residents support to access to the facilities to prepare their meals and snacks when accompanied by staff members.

The residents understood the current health emergency and how it was necessary for some of the community activities to close for now. The residents were not anxious about the pandemic and felt safe, and were observed following good practice in washing their hands, observing social distancing, and wearing face coverings. The residents were also supported to adapt to the change in routine caused by the social restrictions and to ensure they respected the space and routine of their housemates.

While the residents were looking forward to some community activities recommencing, they were heavily involved in alternative recreational opportunities and services which could be continued. One resident continued to attend a day service and also went horse-riding on the day of inspection. Residents were also keeping busy in the house, with one resident enjoying typing on his personal laptop, and another resident making baked good that evening. Residents participated in remotely organised social groups and one resident was involved in a rights advocacy group. One of the residents had recently celebrated a birthday party in the house, and the inspector was shown pictures of events the residents attended at Christmas.

For the inspection, the residents filled in a questionnaire in which they told the

inspector they got along well with the staff and felt confident that they could go to staff members if they wanted to make a complaint and knew that it would be addressed. One resident told the inspector how they raised a matter over which they felt unsafe, and were happy with the action taken to manage the issue.

Two of the residents who lived upstairs in the house told the inspector both in person and through the questionnaire that they were having an increasingly difficult time climbing the stairs and that the building wasn't ideal for them to get around. They had raised this with the management of the house and the inspector found that plans were in progress to source accommodation which was more suitable for their needs and preferences, and the resident was involved in the discussions on this. The inspector also spoke with a family member who spoke positively on the support from this service but reflected their wish to find more ideal accommodation for their needs.

The next two sections of this report present the findings of this inspection in relation top the governance and management arrangements in place in the designated centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The residents were supported by a team of staff with whom the residents had a good rapport and who had a good knowledge of the residents support needs, personalities and preferences. Staff numbers shift patterns were identified and were reflected in worked rosters for recent months. These rosters also indicated that were there gaps in shifts occurred due to vacant posts, which were at interview stage, and other absences, this was filled by regular and consistent relief staff, to provide a continuity of support to the people living in the service. On the rare occasion on which agency personnel were required, this was also clearly indicated. Of a sample of personnel files reviewed, all information required under Schedule 2 of the regulations, including qualifications and Garda clearance, were present.

Staff has continued to be facilitated to attend training during the health emergency, and the inspector found that all staff were up to date in their mandatory training including fire safety and safeguarding of vulnerable adults. As part of a safeguarding plan to enhance compatibility between residents and to most effectively support their needs, the provider identified that specialised training in supporting people with Prader-Willi Syndrome was required for all staff. At the time of the inspection, only 36% of staff had received this. The person in charge was aware of this gap and committed to ensuring it would be resolved when sessions were next available.

The provider had continued to conduct regular audits of the service to ensure the quality and safety of the service. Weekly internal audits took place around aspect of the service such as medication checks, daily notes and handovers, ensuring incidents are reported where required, and that staff are observing good practice

around infection control measures. Where these audits identify areas in need of improvement or development, there was a clear and time-bound action plan with identified persons responsible for meeting the objective. Audits findings were communicated and discussed with staff in regular meetings. The provider had also completed their six-monthly unannounced inspection in January 2021 in which they reviewed the progress towards quality enhancement objectives and ensured that compatibility issues, complaints and resident feedback was being addressed in a timely fashion.

A new person in charge had commenced in the role in January 2021. They were suitably experienced and qualified for the role, and there structures in place for them to be supervised and supported in their new role. The person in charge had identified their priorities for service enhancement and at the time of inspection provided evidence of their progress towards bringing centre processes in line with provider procedures, including structured staff supervision and revision of the house risk register. The residents told the inspector they liked the new manager and had met her before in a previous setting.

The inspector found a detailed log of complaints raised by the residents and found evidence that the matters raised were addressed and the outcome discussed with the resident. At the time of inspection, the provider was discussing a residents wishes regarding a more suitable house they may wish to live in. The residents told the inspector that they would have no issues making a complaint and felt confident that it would be heard and treated seriously.

Regulation 14: Persons in charge

The person in charge worked in this role full time, and was suitably experienced and qualified for their role.

Judgment: Compliant

Regulation 15: Staffing

Resident were supported by a team of support workers with the appropriate number and shift pattern to meet their assessed needs. Continuity of support was retained in the event of staff absence, through use of regular relief personnel.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were up to date in core training such as fire safety and safeguarding of vulnerable adults, but had not all received specialised training identified as required to best support the residents' needs in this centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had systems and structures to review the ongoing quality and safety of the service. Where items had been identified as in need of improvement, they were incorporated into a time-bound action plan. The provider had plans in progress to respond to current challenges including the global health emergency, and the suitability of the houses for all its current residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had notified the chief inspector of adverse incidents in this designated centre and regularly reviewed records to ensure notifiable events were submitted in the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were confident that any complaints they made would be addressed promptly, and the inspector found a log of ongoing and completed complaints with detailed outcomes and feedback to the complainant.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre policies were under review at the time of inspection, however some were a year overdue for review, including key policies and procedure for the risks identified in this service, including nutrition support, behaviour support and visitor

arrangements.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found this to be a service which was safe and which prioritised the needs and preferences of the residents. The residents in this service all required supports related to Prader-Willi Syndrome, and the inspector found evidence that they were being well supported to manage their assessed needs, and that residents were also supported to observed and respect each others' needs and routines.

It was identified that this two-storey house was no longer an ideal living space for residents. While residents were physically able to walk up and down the stairs, they expressed that it was getting increasingly uncomfortable to do so over time and that they would prefer to live in a single-storey house. The provider was in the process of considering options for addressing this challenge going forward. The inspector was shown evidence of communication seeking more appropriate accommodation based on needs and preferences, and also options being considered regarding new premises as a long-term solution. This process was being discussed with the resident and they would play an active part in decisions made when these options are further progressed.

Aside from this challenge, the house overall was safe, clean and designed to support residents' needs. The residents has a large comfortable living space in which they could work on projects, watch television, socialise and look after two pet guinea pigs. Each resident has their own bedroom which were highly personalised in their decoration. Residents had a large closed garden as well as a small annexe house in which they could relax away from the busy main house. Overall the house was in good condition, however one of the bedrooms, which was currently vacant, required some work to address large cracks in the wall and ceiling.

In line with the residents' assessed needs, the residents had restricted access to the kitchen facilities unless accompanied by a member of staff. This area was locked when not in use. This environmental restrictive practice was kept under regular review with detailed rationale for its continued use and ongoing input from the behavioural therapist to ensure the measures taken remained the most effective means of supporting the residents and their general health and wellbeing.

The house was suitably equipped to contain, detect and extinguish fire. Rooms were equipped with fire doors with automatic closing mechanisms. The inspector found evidence of service and maintenance of fire safety equipment, the alarm system and emergency lighting. The provider had conducted regular fire drills in the house, including bed-time scenarios, and had identified that all residents and staff could egress in less than 90 seconds. All residents had personal emergency exit plans

which identified the supports required to most effectively get to a safe place. It was identified through drills that one resident may refuse to leave, and while this potential was communicated to the resident support plan, some additional information was required to instruct staff on what to do in response to this refusal.

The house was also equipped with personal protective equipment (PPE) and sanitizing supplies. Staff were diligently self-monitoring and recording symptoms and temperatures to ensure that potential risk was identified and responded to promptly. The provider had contingency plans in place to provide centre-specific guidance on how to respond to risk such as staff depletion, interruption of supplies and the absence of the centre leadership. The COVID-19 response plan also provided guidance on how to most effectively support residents in the event they test positive for the illness.

The inspector reviewed evidence which indicated that the provider had taken appropriate action to respond to incidents, trends and resident feedback which indicated a safeguarding concern. Through actions taken in response to these incidents, there had been a measurable benefit for the residents, with a downward frequency in negative peer-on-peer interactions, and residents telling the inspector they felt less anxious after certain actions had been taken. The inspector reviewed a detailed incident log which indicated the outcome and learning from the event, and where required, reports submitted to the safeguarding team.

Regulation 17: Premises

It was identified that the two-storey premises was no longer ideal for all of the current residents to navigate. The inspector reviewed multiple ongoing solutions currently being explored to address this concern for the residents and for the service overall.

Some maintenance work was required in a bedroom before it would be suitable to be used by a fifth resident.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The risk register was detailed and contained the risk controls for hazards related to this service and its residents. However it had not been updated to reflect some identified risks including residents having difficulty climbing the stairs, and residents who may refuse to leave during a fire evacuation.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had measures in place to control , identify and respond to risks related to COVID-19. Staff and residents had been educated on the best practices to follow to keep themselves and others safe, and were observed doing so throughout the day.

Judgment: Compliant

Regulation 28: Fire precautions

The building was suitably equipped to detect, contain and extinguish flame and smoke in the event of fire. Regular services of equipment, staff checks of mechanisms and practice evacuation drills took place to provide assurance that people could evacuate to a place of safety.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was suitable guidance for staff to support residents with their assessed needs. Where restrictive practices were utilised in response to identified risks, these were kept under regular review to ensure they were the least restrictive option to combat the relevant risk.

Judgment: Compliant

Regulation 8: Protection

Residents had appropriate supports in place to feel safe in their home. Where safeguarding risk had been identified, they had been reported through the safeguarding process, with actions taken to reduce the risks involved.

Judgment: 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 - 2015 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Graifin House OSV-0002636

Inspection ID: MON-0031473

Date of inspection: 11/02/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Prader Willi Syndrome Association of Ireland will deliver PWS specific training remotely for all staff on 22/3/21 and 26/3/21.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Policies in need of review have been updated and are currently in the final stages of the Provider's approval process. This will be completed by 27/04/2021.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The Provider will continue to liaise with Newgrove Housing Association and the HSE with regards to sourcing a single storey premises suitable to meet the changing need of our residents. A commissioning form was sent to Newgrove Housing Association on the	

week of 1/3/21. Once this process is completed, further contact with the HSE will be established by 30/06/21.
The PIC has been in touch with a contractor who has visited Graifin House and is currently preparing the attic (removing electrics, insulation) for inspection by structural engineer. Pending the structural engineer's appraisal of the work needed to be completed an estimation of completion of the work needed to address the cracks is 31/12/21.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Following a review with the staff team the PEEP of the resident who refused to evacuate during last drill has been updated to incorporate the steps for staff to follow in the event of refusal to evacuate by this resident.

• This was completed on 12/2/21. A reminder of the steps to be followed has been issued during the last 2 weekly staff meetings regarding the change and staff have been reminded to sign the updated document.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	26/03/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/06/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	31/12/2021

	state of repair externally and internally.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	12/02/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	27/04/2021