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:	Nenagh Supported Accommodation
Name of provider:	RehabCare
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	17 February 2021
Centre ID:	OSV-0002653
Fieldwork ID:	MON-0031007

About the designated centre

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

Nenagh Support Accommodation is a designated centre operated by RehabCare. The designated centre provides community residential services to six adults with a disability. The designated centre is located in a town in Co. Tipperary and consists a five bed two storey house and an adjacent self-contained apartment. The two storey house accommodates five residents and consists of a living room, kitchen/dining room, utility room, staff bedroom, five individual resident bedrooms and shared bathrooms. The apartment accommodates one resident and consists of a kitchen/living room, bathroom and bedroom. The centre is staffed by the person in charge, care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 17 February 2021	10:00hrs to 16:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

From what residents communicated with the inspector and what was observed, it was evident that the residents received a good quality of care and enjoyed a good quality of life.

In line with infection prevention and control guidelines, the inspector carried out this inspection in line with public health guidance and HIQA enhanced COVID - 19 inspection methodology at all times. The inspector ensured physical distancing measures were implemented during interactions with residents, staff and management over the course of this inspection.

The inspector had the opportunity to meet with three of the residents of the designated centre during the inspection. Residents were observed to appear relaxed and comfortable in their home. Some residents told the inspector they liked living in the service. One resident showed the inspector recent art work they had completed. The residents told the inspector about their day and discussed their plans for the evening including relaxing and watching soccer. The residents highlighted the impact of COVID-19 on their lives in relation to accessing the community and visiting people important in their lives.

Three of the residents who lived in the centre chose not to meet the inspector on the day and this was respected. Two of the residents completed questionnaires, with the assistance of staff members, describing their views of the centre they lived in. Overall, these questionnaires contained positive views regarding the centre and indicated a high level of satisfaction with many aspects of life in the centre such as activities, bedrooms, meals and the staff who supported them.

Resident's rights were found to be respected. The staff team were observed treating and speaking with residents in a dignified and caring manner. The residents were supported to develop and maintain their relationships with family and friends. While there were restrictions on visiting in place, in line with Public Health guidance, video calls had been utilised to support residents to maintain contact with people important in their lives.

The inspector completed a walk through of the designated centre and found that it was decorated in a homely manner with residents possessions and photographs of people important to the residents. Overall the house was observed to be well maintained.

In summary, based on what residents communicated with the inspector and what was observed, the inspector found that, while there were some areas for improvement, residents received a good quality of care and support in their home.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how

these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs.

There was a clearly defined management structure in place. The centre was managed by a full time, suitably qualified and experienced person in charge. The person in charge demonstrated a good knowledge of the residents and their needs. The person in charge was also responsible for the management of another designated centre and were supported in their role by an experienced team leader. There was evidence of regular quality assurance audits taking place to ensure the service provide was safe, effectively monitored and appropriate to residents' needs. These audits included the annual report 2020 and the provider unannounced six monthly visits as required by the regulations. The quality assurance audits identified areas for improvement and action plans were developed in response.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of the roster which demonstrated that there was an adequate number of staff on duty each day and night to meet residents' assessed needs. At the time of the inspection, there was an established staff team in place which ensured continuity of care and support to residents. Throughout the course of the inspection, positive interactions were observed between residents and the staff team.

There were systems for the training and development of the staff team. The inspector reviewed a sample of staff training records and found that the staff team were up-to-date in mandatory training. This meant that the staff team had up-to-date skills and knowledge to meet the needs of the residents.

The provider prepared a statement of purpose for the designated centre which was up to date, accurately reflected the service delivered and contained all of the information as required by Schedule 1 of the regulations.

Regulation 14: Persons in charge

The centre was managed by a full time, suitably qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. Staffing levels at the designated centre were appropriate to meet the needs of the service users.

Judgment: Compliant

Regulation 16: Training and staff development

There were appropriate systems in place for the training and development of the staff team.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. There was evidence of regular quality assurance audits taking place which identified areas that required improvement and actions plans were developed in response.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose for the designated centre which was up to date and contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Quality and safety

Overall, the management systems in place ensured the service was effectively monitored and provided appropriate care and support to the residents. However, improvements were required in the areas of safeguarding, fire safety and the assessment of need.

Residents told the inspector they were happy and felt safe in the designated centre. The inspector observed residents appearing comfortable in the centre and having positive interactions with staff. However, the policy and process regarding safeguarding required improvement. For example, while there was an organisational safeguarding policy in place, this was not fully implemented in practice and did not account for the safeguarding of residents who can make repeated allegations. The designated centre had developed separate local policies and procedures to manage this with input from the behavioural therapist and safeguarding officers. There was also a system for recording, monitoring and responding to all safeguarding concerns in order to ensure a comprehensive safeguarding system was in place. However, this practice was not guided by the national policy or by the organisation's policy.

The inspector completed a walk through of the premises accompanied by the person in charge and found that the centre was decorated in a homely manner. However, it was observed in the apartment that one cupboard door required replacing. This had been self-identified by the provider and repairs had been delayed due to COVID-19.

The inspector reviewed a sample of residents' personal files. The resident's needs were assessed through an annual screening form and a dependency assessment. These assessments informed the residents' personal plans which were found to be up-to-date and to guide the staff team in supporting residents with identified needs. However, the inspector found that the assessment of need process was not fully comprehensive. For example, one resident's healthcare needs were not fully and clearly identified through these assessments. While, the person in charge provided evidence of documentation and knowledge of this need, the assessment of need process required review to ensure that it is fully comprehensive.

Residents were supported to access allied health professionals as required including General Practitioners (GPs), speech and language therapists and opticians. Overall, the healthcare plans reviewed were up to date and suitably guided the staff team to support residents with identified healthcare needs.

There were support plans in place to support the residents to manage their behaviour. The inspector reviewed a sample of the behaviour support plans and found that they were up to date and guided the staff team appropriately. There were restrictive practices in use in the centre which were identified and appropriately reviewed by the provider.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting the residents to evacuate and there was evidence of regular fire evacuation drills. However, the arrangements in place for the containment of fire in

the apartment required review. For example, it was observed that self closing devices were not installed on the fire doors between the kitchen and resident's bedroom. The person in charge provided assurances on the fire safety arrangements in place in the apartment until a review could be undertaken by a person competent in fire safety. The assurances included a waking night staff, regular fire safety checks and fire safety equipment.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection. The centre had access to support from Public Health.

Regulation 17: Premises

The designated centre was found to be clean and homely.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risk.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with infection.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. However, improvements were required in the arrangements for the containment of fire as outlined in the report.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal support plans in place appropriately guided the staff team in supporting residents however, the assessment of need to identify residents' health and social care needs was not fully comprehensive, as outlined in the report.

Judgment: Substantially compliant

Regulation 6: Health care

The resident's health care needs were appropriately managed. Healthcare plans in place were up to date and suitably guided the staff team to support the resident with identified healthcare needs. Residents were supported to access allied health professionals, as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' were supported to manage their behaviours and there were positive behaviour support plans in place, as required.

Restrictive practices in use in the centre were appropriately identified and reviewed by the provider.

Judgment: Compliant

Regulation 8: Protection

Residents told the inspector that they were happy in the designated centre and appeared comfortable in their home. However, the policies and processes in place regarding safeguarding residents who can make repeated allegations

required improvement.
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 - 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	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Nenagh Supported Accommodation OSV-0002653

Inspection ID: MON-0031007

Date of inspection: 17/02/2021

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 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Assessment of fire safety arrangements required for apartment will be carried out by person qualified in fire safety, to be completed by 15.04.2021. • Self-closing device will be installed on door between resident's bedroom and kitchen to be completed by 15.04.2021.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Annual needs screening and dependency assessment processes currently in place have been reviewed. Elements of both have been combined to ensure clear and comprehensive assessment and identification of all support needs for residents. This process will be completed and implemented for all residents by 05.05.2021.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • Organisational Safeguarding Policy is currently under review. Feedback from this	

inspection report has been provided to the policy reviewer.

• Local Safeguarding Protocol has been reviewed in consultation with the Social Work Team Leader of the HSE Safeguarding and Protection Team (Vulnerable Persons) and the organisation's Designated Officer for the region. A number of the measures have been strengthened such as specific reporting requirements and regular review of protocol and preliminary screenings submitted with Safeguarding and Protection Team to ensure that the process is in compliance with National Policy and provides adequate safeguarding for the resident. Completed 26.03.2021.

• The Provider's Safeguarding Lead will review the situation and provide additional guidance to the PIC identifying any areas that require further discussion and clarification, ensuring there is a person centred approach to the provision of support and alignment with the policy. This will be completed by 02.04.2021.

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 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/04/2021
Regulation 05(1)(b)	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 subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	05/05/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	02/04/2021