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:	Millbrook House
Name of provider:	RehabCare
Address of centre:	Offaly
Type of inspection:	Short Notice Announced
Date of inspection:	25 November 2020
Centre ID:	OSV-0002665
Fieldwork ID:	MON-0030285

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of three adults. In its stated objectives the provider strives to provide each resident with a safe home and with a service that promotes inclusion, independence and personal life satisfaction based on individual needs and requirements. All three residents have individualised day services. Transport is provided to facilitate these day service activities. Residents present with a broad range of needs in the context of their disability and the service aims to meet the requirements of residents with physical, emotional and sensory supports. The premises is a bungalow with all facilities for residents provided at ground floor level. Each resident has their own bedroom and share communal, dining and bathroom facilities. The house is located in a rural location near a village in Co Offaly. Services and amenities are accessed locally or in a nearby town. The model of care is social and the staff team is comprised of social care and care assistant staff under the guidance and direction of the person in charge. Ordinarily there is one staff to each resident with additional staff support provided if a need arises.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 25 November 2020	10:15hrs to 16:40hrs	Margaret O'Regan	Lead

What residents told us and what inspectors observed

This inspection took place in the midst of the COVID-19 pandemic. Communication between the inspector, resident, staff and management took place from at least a two metre distance and was time limited in adherence with national guidance. The inspector had the opportunity to meet and speak with one resident on the inspection day. The two other residents were engaged in activities away from their home. The resident who spoke with the inspector, used verbal and non verbal methods to communicate their thoughts and opinions.

The resident greeted the inspector and indicated they welcomed her to their home. The resident was observed to enjoy a late breakfast. This was facilitated by staff. The resident was clearly happy with having this time to enjoy their meal. They confirmed this to the inspector by nodding in agreement when the inspector spoke about how appetising the meal looked.

After breakfast the resident went out in the car with staff. Later in the day, the resident was seen to move around the house, close the open windows as it was cold outside, and generally looked comfortable in their surroundings.

The inspector had the opportunity to meet and speak with management and staff working on the day of inspection. Staff spoke in depth about their respect for the residents and the person centred support they endeavoured to provide to residents. Interactions observed between staff and resident throughout the inspection day appeared familiar and warm.

There was ongoing safeguarding risks amongst peers and numerous notifications of peer to peer challenges in the months preceding this inspection. Two residents who were experiencing these challenges were not at home on the day of inspection. Therefore it was not possible for the inspector to speak with or observe interactions with the residents involved. From reviewing documentation and from discussions with staff, the indications were that the residents were not best served by living together.

Capacity and capability

The purpose of this inspection was to monitor the centre's compliance with the regulations. In general, the inspector found that residents were well supported by staff. However, improvements were needed in the overall governance of the centre to ensure full regulatory compliance.

The provider had ensured there was a full time person in charge who had the

qualifications and experience necessary to manage the designated centre. This person in charge was in post for four months and was new to the organisation. She was also person in charge for another centre in the nearby town. The person in charge was supported by two team leaders, who had a number of years experience working with the three residents who lived in this house. In addition, the person in charge was supported by the integrated services manager. The person in charge confirmed she had regular contact with her line manager and was able to contact members of the management team when ever the need arose. The integrated services manager connected with the person in charge to complete formal supervision on a monthly basis. Other regular contact was also made between the person in charge and her manager. The project manager was the person who took on the responsibility for completing the six monthly reviews of the service.

There were aspects of the governance and management which were robust. For example, there was a clear reporting structure; the centre was well resourced in terms of staffing levels and the standard of the physical environment; there was an annual review of services and six monthly inspections organised by the provider. However, there were also aspects of the governance systems that needed improvement. For instance, there were discrepancies, gaps and delays in ensuring the documentation that informed practice was up to date and accurate. These are discussed in more detail under quality and safety below.

Apart from the person in charge and the two team leaders, the staff team also engaged support workers. Staffing was generally 1:1. At the time of inspection one resident was receiving 2:1 staffing. Most of the day was organised in such a manner that not all residents and staff were in the house at the same time. Given that there were risks of peer to peer issues, it was important that the length of time everyone spent together in the house was minimised. Consideration was being given to find ways, including alternative accommodation, in which a high level of staffing was no longer needed. The longer term aspiration was to reach a situation where residents could operate with increased independence and with less staff surveillance.

Regular staff supervisions were completed with the centre's team leaders and these were reviewed by the person in charge. This process was used as an opportunity to discuss any training needs, outstanding tasks or staffing matters. The inspector had the opportunity to meet with staff on duty on the day of inspection. Staff spoken with demonstrated knowledge and understanding of the residents' needs and preferences. A key working system was in place to ensure continuity of care and support for the residents. Arrangements were in place for access to additional staffing in the event of large numbers of staff being absence, secondary to a COVID-19 outbreak.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge. This person was new to

the role and new to the organisation. The person in charge had the required qualifications for the post.

Judgment: Compliant

Regulation 15: Staffing

The registered provider has ensured adequate staffing levels to meet the assessed needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

There were a number of aspects of the management systems which did not adequately ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. These included discrepancies in the documentation, the absence of a comprehensive annual review of the behaviour support plans, and the ongoing risk to residents of experiencing psychological distress.

The arrangements in place to support all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering was compromised by new staff not always adhering to the system of signing that they had read and understood plans of care and in other instances new staff reading and signing plans that were not appropriately updated.

Judgment: Not compliant

Quality and safety

The inspector found that staff were striving to promote the goal of an individualised and safe service to residents. There was good awareness and respect amongst staff of the challenges that residents experienced by living with each other. Incidents of unpleasant verbal interactions between residents had escalated in the four months prior to this inspection. While most incidents were minor in nature, the frequency of them was psychologically upsetting for the residents involved and staff were aware of this. With this in mind, much of the activities were organised in such a way that residents spent minimal time in each others company. Staff recorded incidents that occurred. Documentation viewed by the inspector indicated staff regularly sought

advise from specialists around managing the behavioural challenges. However, the request and receipt of advice was on emails and generally difficult to piece together. Documentation showed that requests for behaviour support plans to be updated had been made. Such updates were awaited.

Most aspects of residents' health, personal and social care needs were reviewed annually; however, the documentation did not show that the written behaviour support plans were a meaningful part of this annual review. This was an issue, given that understanding and managing residents' behaviours in the best way possible, was a key component in the care of each of the three residents. Extra staff were deployed to manage the challenging situation created by this cohort of residents living together. In some regards this worked. However, it also had the impact of curtailing a resident's capacity for independence. For afternoon and evening hours, one to one staff was deployed for two residents and two to one for another resident. Indications were, that given the right environment, residents could increase their levels of independence. Again staff were aware of these possibilities. Some discussions had begun about alternative living arrangements. However, the matter was ongoing for many months and while it was managed day to day, there was limited progress with the provider effecting the changes required to deliver the outcomes needed.

Residents' goals were set and many of them had been achieved such as the goal to visit a pet farm and the goal to purchase new clothes. In some instances progress with achieving the goals was not clear. For example a goal set in August 2020 to go to the driving range had no update. This was primarily an issue with maintaining meaningful and up to date documentation, more than residents not being afforded opportunities to engage in their interests. Some goals had to be postponed; for example, a resident's goal to take a bus journey to a nearby town.

A system was in place for new staff to read and sign that they understood the documents they were reading. These documents included procedures, policies and in particular resident care plans. This was a good practice. However, there was inconsistency it its implementation and this inconsistency weakened the effectiveness of the system. A new staff member was guided to reading and signing for what was in effect, an out of date plan. In a separate instance, a team member, who joined a few months earlier, had not signed that they had read and understood key documents, in particular a May 2019 guidance summary for managing behaviours that challenge. These variances in practice undermined the strength of an otherwise good exercise.

There was much documentation available around the management of behaviours that challenge. However, the documentation was difficult to navigate and it was unclear what the most up to date practices were. For example, there were behaviour support plans dated 2018 and 2017. In addition,there was a guidance summary document dated 20th May 2019 and there were emails throughout 2020 indicating that support was needed around behavioural issues. The emails and documentation indicated aspects of the behavioural support plans weren't working. This included an email from February 2020 about a resident declining the use of a diary to schedule their activities, yet this was a key component of the behaviour

support plan that was on file up to the date of this November 2020 inspection. In so far as the inspector could establish, one plan gave the guidance for staff to "not redirect" a resident if they were displaying specific behaviours, and for staff to "focus on the other resident" . However, notes from an incident that occurred on 17th November 2020 indicated this was not the guidance that was followed. A request had been made for behaviour support plans to be updated but updating the written plans was likely to take up to four months. This raised a question around the meaningfulness of multidisciplinary input and how it was incorporated into the annual review. The inspector was informed personal plans were to be updated in December 2020 and would include families. However, as of 25 November 2020, no date was set for any of the three reviews. Further documentation indicated the annual reviews had taken place earlier in the year, leaving it unclear to the inspector what review was actually taking place in December. The inspector concluded that staff were doing what they thought best, that there was a lack of clear direction and that therapeutic interventions that were part of the personal planning process, were not appropriately reviewed or implemented.

During the early months of the pandemic, the house environment was generally calm and less anxiety displayed by a resident. At this time there were only two residents living in the house. Other factors may have also contributed to the resident experiencing low anxiety levels but the impact of a third resident in the house again, from August 2020 onwards, increased the likelihood of behaviours that challenge. On 04 June 2020 a risk assessment carried out indicated the likelihood of behaviours that challenge occurring as being low to medium. This risk was reassessed on 11 September 2020 and the likelihood was assessed as being the same. However, between June and September, a change in the cohort of residents living in the house increased the likelihood of challenges. This was well documented in notes seen. Plans were made to try and minimise the impact of a third person moving back into the house. There were many good aspects as to how the move into the house by a third person was managed but there was no doubting the likelihood of behaviours that challenge would increase. Notifications received by HIQA confirmed this. Again, this raised the validity, accuracy and meaningfulness of the documentation in place.

Staff were trained in understanding the signs of abuse and staff reported incidents when they occurred. Some of the behavioural challenges that occurred in the centre manifested as psychological trauma for residents and these were documented and reported. Incidents, including occurrences which compromised safeguarding, were recorded on the organisations data base system. Reports of incidents were accessible to personnel involved in the care of residents including the integrated services manager.

The person in charge had safeguarding measures in place to ensure that staff provided care in a respectful manner. However, the frequency in which unpleasant verbal exchanges took place between residents, resulted in psychological distress for residents. While these occurrences had escalated in recent months, they had been ongoing from at least May 2019. Given that residents were living in a fraught environment over a long period of time, the provider was failing in their

responsibility to ensure residents were protected from all forms of abuse, including psychological abuse.

The premises was comfortable, homely and kept in a good state of repair. Each resident had their own bedroom and three separate seating areas were available in the house. A spacious garden was also available to residents.

The person in charge submitted to the inspector detailed information in relation to the COVID-19 contingency plans for the centre. The inspector noted on the day of inspection, the good practices in place around infection control and prevention, which included, temperature checks, good hand hygiene facilities and practices, maintenance of a two meter distance where at all possible and the wearing of face coverings.

Regulation 17: Premises

The centre presented as a warm clean environment which was tastefully decorated in line with the assessed needs and interests of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

On 04 June 2020 a risk assessment carried out indicated the likelihood of behaviours that challenge as low to medium. This risk was reassessed on 11 September 2020 and the likelihood was assessed as being the same. However, between June and September, a change in the cohort of residents living in the house increased the likelihood of behaviours that challenge, as evidenced by the number of notifications submitted to HIQA. The systems in place for the review of risk did not adequately reflect this increased likelihood.

Judgment: Substantially compliant

Regulation 27: Protection against infection

COVID-19 contingency plans were in place. Facilities at the house were conducive to promoting infection prevention. Systems were in place to identify staff who may be unwell due to COVID-19.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment, by an appropriate health care professional, had not been carried out on an annual basis.

The effectiveness of personal plans had not been adequately reviewed. Some plans were updated, others were not.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured that residents were supported to achieve the best possible physical health.

Judgment: Compliant

Regulation 7: Positive behavioural support

The behaviour supports required for residents were addressed in a number of different documents and the documentation did not give consistent guidance to staff. This practice did not ensure staff had up to date knowledge, appropriate to their role to respond to behaviour that were challenging and to support residents to manage their behaviours.

The therapeutic interventions that were part of the personal planning process, were not appropriately reviewed or implemented.

Judgment: Not compliant

Regulation 8: Protection

The person in charge had safeguarding measures in place to ensure that staff provided care in a respectful manner. Staff were trained in understanding the signs of abuse and staff reported incidents when they occurred. However, the frequency in which unpleasant verbal exchanges took place between residents resulted in

psychological distress for residents and amounted to a failure to protect residents from psychological abuse.
Judgment: Substantially 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 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Millbrook House OSV-0002665

Inspection ID: MON-0030285

Date of inspection: 25/11/2020

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

· A 'Signage' box for all new and updated documents is in place to ensure all staff have read and signed all documentation. As part of their weekly audit the Team Leaders will review this box to ensure that all sign documents as required to indicate that they have read and understood the contents. This will be completed by 27/12/2020.

· One residents Behaviour Support plan has been reviewed and disseminated to inform staff practice on 18/12/20, the reviewed plan is fully updated and replaces all previous version of the plan and guidance issued in emails.

· Behaviour Supports for other two residents will be reviewed by the 28/02/2021. A summary of priority recommendations will be provided to inform staff practice.

· On a monthly basis the PIC will review incidents to ensure the practice deployed by staff is in line with the more recent guidance. Evidence of this review will recorded on the Monthly Service Audit. This will be commence in January and every month thereafter.

· The provider has secured additional specific funding from the HSE to enable it to increase the Behavioural Supports to the Midlands region. This additional support will be recruited in February and will be effective as soon as possible thereafter.

· The Quality & Governance Directorate will provide a report to the organisation's Senior Management Team and Board on a monthly basis, commencing at the end of December in respect of actions linked to non-compliances in this action plan until all actions are closed off.

· All actions arising from this compliance plan will be uploaded to the organizational action tracking system. This system is updated by the Team Leader/PIC and validated by the Integrated Services Manager once the actions have been completed (January

2021).

· A copy of this Inspection Report has been provided to the organisation's Board of Management (December 2020).

· The situation in the service will be reviewed and monitored by ISM (PPIM) on a monthly basis to ensure appropriate timely action is taken to address issues as they arrive though the Monthly status report completed by PIC and reviewed by the PPIMs (31/1/21).

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
· Risk assessment has been reviewed and updated to reflect the increase in behaviours that challenge. This was completed on 26/11/2021.

· Risk assessments will be reviewed and updated at minimum quarterly or more frequently as required to ensure that changes in risk ratings and control measures are informed by changing circumstances in the service (end of Q1 2021).

· A diary alert has been set up to ensure quarterly reviews of risk assessments are completed (05/1/21).

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:
· Team Leaders and Keyworkers supported by the PIC will review all action plans by the 31/01/2021, the aim of this review is to ensure all action plans have been reviewed and provide an accurate update of the practice and supports deployed in the service.

· Actions plans will be checked on a monthly basis as part of the monthly service audit to ensure updates are documented as required (31/01/21).

· Each of the Resident's support plans will be reviewed by 31/01/2021, the purpose of this review is to ensure each of the plans have been updated with all relevant

information this will include input from MDT meetings that will take place before 31/01/2021

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

· One residents Behaviour Support plan has been reviewed and disseminated to inform staff practice on 18/12/20, the reviewed plan is fully updated and replaces all previous version of the plan and guidance issued in emails.

· Behaviour Supports for other two residents will be reviewed by the 28/02/2021. A summary of priority recommendations will be provided to inform staff practice.

· Once the Behaviour Support plan is circulated an implementation review will take place six monthly, this will support the ongoing monitoring of the efficacy of the plan. A formal review will take place at least annually or more frequently as required (28/2/21).

· A Shared Drive will be established for all Behaviour Support Plans. The Behaviour Support Plans will be live documents and any changes will be updated immediately through the Shared Drive (28/02/21).

· All older information will be removed from the Resident's file in order to avoid confusion amongst staff (31/1/21).

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

· One resident has had a full medical and psychiatric review with a view to determining the cause of the increased expression of behaviours that challenge that are causing the safeguarding concerns. Medical review on 21/12/2020 has identified a potential underlying cause. A Psychiatric review on 22/12/2020 supports that the potential underlying cause may have been identified by at the medical review.

· The situation in the service will be reviewed and monitored by ISM (PPIM) on a monthly basis to ensure appropriate timely action is taken to address issues as they arrive though the Monthly status report completed by PIC and reviewed by the PPIMs (31/1/21).

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they	Substantially Compliant	Yellow	31/01/2021

	are delivering.			
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	31/01/2021
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.	Not Compliant	Orange	31/01/2021
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.	Substantially Compliant	Yellow	31/01/2021

Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	28/02/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	28/02/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/01/2021