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:	Nagle Adult Residential Service
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	08 February 2021
Centre ID:	OSV-0004475
Fieldwork ID:	MON-0031891

About the designated centre

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

Nagle Adult Residential Service is a designated centre operated by Brothers of Charity Services Ireland. The designated centre provides community residential services to up to 17 adults with a disability. The designated centre consists of four residential units, located close to another in the outskirts of urban areas in Co. Tipperary. Of the four units, one is a three-storey semi detached house, two are detached two-storey houses and one is a detached bungalow with an adjacent single apartment. Each resident has their own bedroom and other facilities throughout the centre include kitchens, sitting rooms, bathroom facilities and garden areas. The centre is staffed by the person in charge, social care workers, care assistants and a staff nurse.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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
Monday 8 February 2021	10:30hrs 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 the inspection mostly from an office located close to the units of the designated centre. The inspector also ensured physical distancing measures and use of personal protective equipment (PPE) was implemented during interactions with residents and staff during the course of the 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 and the staff team were observed treating and speaking with residents in a dignified and caring manner. Some residents told the inspector they liked living in the service. However, one resident spoken with highlighted that they were not happy in the service and discussed with the inspector their views on the centre.

Thirteen residents who lived in the centre also 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. However, some individual questionnaires noted areas for improvement including access to bathrooms, bedroom paint and availability of storage. In addition, the questionnaires noted the negative impact of COVID-19 for residents in relation to community outings and visiting people important in their lives. The inspector also reviewed the annual review which consulted with the residents and their families. Overall, the feedback was positive on the quality and safety of care provided by the service. However, staffing arrangements was one area identified that required further improvement.

Resident's rights were found to be respected and the inspector observed the staff team treating residents with respect and dignity. 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 visited one unit 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. However, there were areas of the unit which were in need of maintenance and upkeep.

In summary, based on what residents communicated with the inspector and what was observed, the inspector found that, while there were 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. However, improvements were required in the areas of staffing arrangements and staff training and development.

There was a clearly defined management structure in place. The centre was managed by a full-time person in charge who was responsible for the management of the four units of the designated centre. The person in charge demonstrated a good knowledge of the residents and their needs. 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 2019 and the provider unannounced six monthly visits as required by the regulations. The annual report for 2020 was in draft at the time of the inspection. 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. A review of rosters demonstrated continuity of care was maintained by covering shifts within the existing staff team and the use of regular relief staff. At the time of the inspection, the centre was operating with one whole time equivalent (WTE) vacancy and the inspector was informed that the provider was actively recruiting to fill this vacancy. As the resident's day service was closed due to COVID-19, there was evidence of additional staffing supports in place during the day. Throughout the inspection, staff were observed treating and speaking with the resident in a dignified and caring manner.

However, the inspector found that staffing levels required further review to ensure staffing levels were appropriate to the changing needs of residents. While, there was evidence that the provider had made an application to the provider's funder regarding increasing staffing levels, it was not demonstrated that the staffing arrangements in the centre were appropriate to meet residents' changing needs. For example, the centre's annual review in 2019 and six monthly audits identified concerns regarding staffing levels due to the changing needs of residents. A number of individual risk assessments reviewed identified the need for staffing support or supervision to keep residents safe and meet their assessed needs. From a review of rosters, it was not demonstrable that the provider had

appropriate staffing arrangements in place to meet the residents changing needs.

There were systems for the training and development of the staff team. The inspector reviewed a sample of staff training records and found that, for the most part, the staff team were up-to-date in mandatory training. However, of the records reviewed, two members of the staff team required refresher training in areas including de-escalation and intervention techniques and safe administration of medication. This meant that they did not have up-to-date training to meet the needs of the residents. This had been self identified by the provider and refresher training had been scheduled where necessary. The inspector was informed by the person in charge that the delays in scheduling refresher training were due to the impact of COVID-19.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced and demonstrated a good understanding of residents and their needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. The staffing arrangements at the designated centre required review to ensure they were appropriate to meet the changing needs of residents.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. However, two members of the staff team were not up-to-date in areas of training as outlined in the report.

Judgment: Substantially 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

Quality and safety

The management systems in place ensured the service was effectively monitored and provided safe, appropriate care and support to the residents. However, improvements were required in the areas of fire safety, premises, oversight of restrictive practices and positive behaviour support.

The inspector visited one unit of the centre accompanied by the person in charge and found that the centre was decorated in a homely manner. However, it was observed that the unit required some general upkeep in areas including painting and flooring. This had been self-identified by the provider and plans were in place to address this.

On the day of inspection, some improvement was required to ensure the premises meet the residents needs. For example, the provider also identified in a recent audit in November 2020 that one bathroom required works to meet the residents needs. The inspector observed that planning permission had been granted and that the provider was in the process of securing funding for same. In addition, the previous inspection found that one unit required review to ensure that it fully provided for some residents with mobility issues. While a referral was made to an allied health professional to review the premises, this remained outstanding at the time of the inspection. The person in charge noted that the delay was due to the impact of COVID-19 and interim measures were in place including handrails and lighting. The inspector was also informed of early plans to reconfigure the service in order to ensure the premises meet the residents needs.

The resident's needs were assessed through personal outcome measures, personal planning and an annual health care assessment. The inspector reviewed a sample of resident's plans and found that they were up-to-date, identified resident's health and social care needs and informed the resident's personal support plans.
The personal plans were up-to-date and guided the staff team in supporting the resident with their assessed needs.

There was evidence that the resident's health care needs were appropriately identified through an annual health care review and that residents were given appropriate support to enjoy their best possible health. Residents were supported to access a range allied health professionals as appropriate including General Practitioners (GP) and opticians.

There were positive behaviour supports in place to support the residents. The

inspector reviewed a sample of positive behaviour support plans and found that it was up to date and guided the staff team in supporting the residents to manage their behaviour. This plan guided staff on the potential reasons for the challenging behaviours and how to respond in order to provide consistent care to the residents. However, one positive behaviour support plan reviewed required additional detail to appropriately guide the staff team on the use of a PRN (as required) medication.

There were a number of restrictive practices in use in the centre which were appropriately identified by the person in charge. The restrictive practices in use in the centre were reviewed by the provider in 2019. However, due to the impact of COVID-19 reviews of restrictive practices had been delayed and extended. The timeliness of reviewing restrictive practices required improvement.

There were systems in place to safeguard residents and there were safeguarding plans in place for identified safeguarding concerns. The inspector reviewed a sample of incidents and found that they were appropriately managed and responded to. Residents were observed to appear comfortable in their home and in the presence of staff. In addition, the residents questionnaires noted that residents felt safe in their home.

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, improvements were required in the arrangements for the containment of fire. For example, fire containment measures were not evident throughout two of the units.

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 was supported by the provider's management team and had access to support from Public Health.

The inspector followed up on findings of the last inspection in relation to medication management. The previous inspection identified that an assessment of the residents capacity to take responsibility for their own medication was not in place for each resident. This had been addressed by the provider and assessments were in place for each resident.

Regulation 17: Premises

The designated centre was homely. However, there were areas for some improvement including general upkeep and ensuring the premises met the identified needs of the residents as outlined in the report.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were systems 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, improvement was required in the arrangements for the containment of fire as outlined in the report.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to assess residents capacity to take responsibility for their own medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The resident had an up-to-date assessment of need which identified residents' health and social care needs, informed the resident's personal support plans and appropriately guided the staff team in supporting residents.

Judgment: Compliant

Regulation 6: Health care

The residents' healthcare needs were appropriately identified and the residents were given appropriate support to enjoy best possible health.

Judgment: Compliant

Regulation 7: Positive behavioural support

The resident was supported to manage their behaviours and there were positive behaviour support plans in place, as required. However, one positive behaviour support plan reviewed required additional detail to appropriately guide the staff team on the use of a PRN (as required) medication.

Restrictive practices in use in the centre were appropriately identified. However, improvement was required in the review of the restrictive practices in the report.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Nagle Adult Residential Service OSV-0004475

Inspection ID: MON-0031891

Date of inspection: 08/02/2021

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of the staffing arrangements in the designated centre will be undertaken by the Person in Charge in consultation with the Management and staff team, taking into account the varied support needs of those using the services, the resources required to meet those needs and the distribution of those resources across the day in each house. In the interim arrangements have been put in place to address the specific risks identified, these arrangements include temporary additional staffing until the relocation of the residences as outlined in the compliance action under regulation 17 and the revision of specific care plans. Regular Team Meetings are also utilised as a forum to address emerging concerns	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff with outstanding training were booked for same at time of inspection and this was completed 22.2.2021. The Person in Charge henceforth shall ensure that staff receive refresher training within the specified timeframe.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
At the time of inspection one of the houses had been identified as no longer meeting the aging needs of the current residents. Arrangements are in place for the relocation of this group to a more suitable single-storey residence (in a different designated centre) from the 1st April 2021. This premises will then undergo works to complete fire containment measures and updating of décor to facilitate the move of another group into the premises by 9th April 2021. As a result of these changes an application to vary the registration of the centre has been submitted to reduce the footprint of the centre from four houses to three and thus negating the need to fit fire containment measures or to update décor in the fourth premises.

Works to the bathroom in one of the premises are expected to be completed by July 2021.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Arrangements are in place for the installation of fire containment measures in one of the identified premises by 9th April 2021. The provider has sought an application to vary the registration of the centre to remove the fourth premises from its registration and thus removing the need to fit fire containment equipment. This premises will be vacated by 9th April 2021.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge, in consultation with the Multi-Disciplinary Team, shall review Behaviour Support Plans and PRN protocols to ensure inclusion of additional detail to appropriately guide the staff team on the use of a PRN medication.

Restrictive practices will be reviewed by 26th April 2021 and arrangements will be put in place to ensure their timely review going forward.

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.	Not Compliant	Orange	30/06/2021
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	22/02/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	09/04/2021

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/07/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	09/04/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based	Substantially Compliant	Yellow	26/04/2021

	practice.			