Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Nenagh Supported Accommodation
Name of provider:	RehabCare
Address of centre:	Tipperary
Type of inspection:	Announced
Date of inspection:	21 January 2019
Centre ID:	OSV-0002653
Fieldwork ID:	MON-0021714

About the designated centre

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

The statement of purpose outlines that the service provides full time residential care for six adults, male and female with an intellectual disability, autism and a diagnosis of mental health. Residents are supported to live as independently as possible and where additional supports are needed, this is provided. The service currently has a dual purpose with both low and high support needs catered for in the two units. The premises is spacious, well maintained and homely with a five bed residential unit and an adjacent self-contained apartment which supports a resident with high support needs. There are a number of different day services attended by the residents with some of these managed by the provider organisation.

The following information outlines some additional data on this centre.

Current registration end date:	03/05/2019
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
21 January 2019	09:30hrs to 19:30hrs	Noelene Dowling	Lead

Views of people who use the service

The inspector met with all six residents. They showed the inspector around their home. Residents said that they had very busy lives and the staff supported them with this. They enjoyed going to their various jobs, training and their recreational activities and shopping for clothes, going to the beauticians, reading and playing their music and going to various football and rugby matches. Residents said that they made decisions together at their house meetings about their activities and meals for the week. The residents explained that the house rules highlighted that they all had to try to get on together, which they thought was fair. They said staff gave them good advice on managing this.

The residents said that they liked living together and mainly got on very well. They explained how staff supported them with their care needs, advice, managing their monies, saving and shopping. Residents had housekeeping responsibilities that they said the enjoyed doing as this was their home. They also said they hoped the staff 'passed the test for the inspection' as they were very good.

Capacity and capability

The inspector found that the service was well managed with good oversight and direction of practices to ensure the safe, effective and person-centred delivery of care to the residents. There were a number of actions required following the previous inspection and progress had been made in most areas with the exception of the medicines management systems and comprehensive reviews of residents care.

Since the last inspection in 2016 the provider had altered the use of an adjacent apartment from a transitional semi-independent unit to a self-contained single occupancy high support unit. The centre was therefore operating a dual purpose. While this arrangement was originally intended as short term it had, of necessity, been extended. A number of the actions identified in this report are influenced by this arrangement. The provider was aware of these difficulties and there was evidence of communication with the funding body in relation to it but there were no definitive plans to address it.

There was a suitable and experienced management structure in place which included the person in charge, team leader and the regional manager. All of the roles were found to be carried out effectively. It was also evident that all of the

residents were very familiar with and comfortable with the managers.

There were good reporting, communication and accountability systems evident. There was a robust system for monitoring the service with frequent effective inspections by service managers and unannounced inspections on behalf of the provider. The annual report for 2018 was in progress and the details available at the time of the inspection indicated that this was a transparent review of the service with actions identified and evidence of progress being made. The views of the residents and where appropriate their representatives were elicited and listened to. Other quality assurance systems included audits on medicines management, behaviour incidents, accidents and residents finances which helped to protect the residents.

However, these systems could be used more effectively to identify changes to practices and take actions to prevent re-occurrences or identify any specific areas for change. The inspector was also concerned at the current care arrangements in the high support unit and the lack of definitive plans to address this. These are outlined in more detail in the Quality and Safety section of this report.

Staffing arrangements for both units were entirely separate with a two-to-one ratio required in the high support and one staff in the residential unit, with additional supports to ensure residents chosen activities were supported. The numbers of staff in both units were found to be sufficient. There was evidence of a commitment to mandatory training for staff and recruitment, induction and supervision processes were found to be satisfactory.

However, based on observation, review of documents/incidents reports and information provided the inspector was not assured that the skill-mix and level of professional training of staff was suitable to meet the complexity of needs in the high support unit. Of necessity, the focus had been on ensuring the correct numbers of staff was available at all times with, in most cases, only minimal training available to the staff. This was in contrast to the main residential unit. The inspector was advised that this was a funding issue. This factor was further impacted on by a lack of clinical oversight detailed in the quality section of this report and the lack of pertinent multidisciplinary assessment for the resident and the environment.

The actions from the previous inspection in regard to the management of complaints was satisfactorily resolved and the inspector found that there was a prompt and fair response to any concerns raised and residents confirmed this. From a review of the incident reports, it was evident that the person in charge was forwarding the required notifications to HIQA (Health Information and Quality Authority) and that actions taken in relation to these were appropriate, proportionate and responsive.

The statement of purpose and all of the required documentation for the renewal of the registration had been forwarded in a timely manner. Some alterations were required to the statement to accurately reflect the current function of the service. These changes did not affect the numbers of residents however.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration was forwarded correctly and within the required time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced and carried out the role effectively.

Judgment: Compliant

Regulation 15: Staffing

While the numbers of staff were satisfactory the skill mix was not suitable to meet the complexity of needs in the high support unit.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had the required mandatory training and recruitment, induction and supervision processes were found to be satisfactory.

Judgment: Compliant

Regulation 22: Insurance

Evidence of current insurance was forwarded as part of the application for renewal of registration.

Judgment: Compliant

Regulation 23: Governance and management

While there were good management systems in place and all persons were aware of their legal responsibilities, the provider did not take timely actions to provide suitable and sufficient care to residents in the high support unit.

Systems for monitoring the service such as audits did not consistently result in changes to practices where these were identified as necessary.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents had suitable signed agreements for their accommodation, care and support.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was revised during the inspection to reflect the service being provided.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had complied with the requirement to forward the required notifications to the Chief Inspector.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The Chief Inspector has been advised of the procedures in the event of the absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints process was effective and implemented according to the regulations.

Judgment: Compliant

Quality and safety

The inspector found that residents' quality of life and safety of care was prioritised and their wishes and preferences were supported. There was a commitment evident to promoting residents' rights to make choices and live their lives as independently as they wished with the supports they needed. They were fully involved in all decisions including their health care, medicines, finances, day-to-day living in their home at a level pertinent to their needs. They were kept informed by staff of fire safety plans, how to make complaints and legal changes which affected them as citizens.

Residents' social care needs and preferences were encouraged and actively promoted. They all did interesting, meaningful and varied activities of their own choosing with frequent access to all local amenities. A number of residents had part-time work experience and told the inspector of the training they had been doing to change roles or gain more independence and life-skills.

The residents had personal plans which were very clearly informed by their own choices and with their participation. These were detailed and covered all aspects of the residents lives and well-being.

However, in some instances this process was not entirely satisfactory.There was a lack of evidence of multidisciplinary assessment including psychiatry, psychology and adequate care review for a resident with complex and high support needs. Specialist referrals had been made at the time of the inspection. However, the resident had been living in the centre for a number of years. Significant environmental and staffing strategies had been implemented but the lack of pertinent multidisciplinary guidance for staff impacted on their ability to provide suitable and sufficient care and to do so in the current physical environment.

Overall the inspector was satisfied that residents' healthcare needs were being

supported and promoted with evidence of regular healthcare reviews and referrals. However, the inspector found that there was a lack of cohesive planning and clarity of information in regard to emerging and and significant underlying healthcare symptoms for a resident. This impacted on the ability of staff to provide adequate support plans for the resident on a day-to-day basis.

There were effective systems in place to protect residents from harm and residents were supported by key workers in learning how to keep themselves safe and in managing relationships. Peer-to-peer incidents within the unit were not a significant feature of the service. From a review of safeguarding reports, records and conversations during the inspection it was apparent that the person in charge took a considered and balanced response to any such issues which arose. Residents' own wishes, understanding and the level of support needed were taken into account. The reporting structures and systems were in accordance with national guidelines.

Nonetheless in some instances, the inspector found that the decision making process in relation to what may constitute risk of abuse required further advice and collaboration from external agencies including the regional safeguarding office. This would ensure that the resident's level of vulnerability was fully considered and provide better assurances and supports for the person in charge as to the decisions being made with residents. These matters were discussed with the person in charge and service manager at the feedback meeting who agreed to review the process. Taking the overall safeguarding procedures into account however, the inspector was satisfied that residents' safety and well-being was prioritised.

The residents were supported as necessary with their financial management following assessment of this and the oversight systems had been improved satisfactorily since the previous inspection. The requirements of a legal arrangement, however, was not fully adhered to as staff had misunderstood the details. This was also discussed and addressed during the inspection.

There was access to guidance for the support of behaviours that challenge and frequent review in relation to these. Residents were supported to understand and manage their own behaviours where this was feasible. However, there was evidence of challenging behaviours, which necessitated the use of a significant number of environmental restrictions including single separation. On occasion, staff withdrew from the environment in the high support secure section of the centre (in order to allow incidents de-escalate) with minimal risk of harm.

The assessment of need and review of the restrictive practice of single separation and staff withdrawal was thorough and its use was monitored. However, it was apparent that while the incidents were reviewed and audited, there was no robust examination of whether the support plans were in fact followed prior to the incident escalating to require this withdrawal. In addition, taking the residents' presenting behaviours, support guidelines and the numbers of staff into account the living environment was observed as not allowing sufficient space to de-escalate situations.These factors may contribute to the restrictions being implemented. It is acknowledged that despite these factors the provider had ensured that the resident’s quality of life in terms of access to primary care, communication strategies

and access to chosen activities had been well supported.

This high support arrangement however is currently not supported by crucial elements including:

- adequate clinical assessment of need
- clinical guidance for staff
- adequate skill-mix of staff
- a suitable long-term living environment.

The inspector saw that some of these matters had been raised at review meetings but no decisions had been made. This lack of adequate assessment impacted on the decision making process for the resident.

Risk management systems were effective and proportionate with clinical and environmental risks identified and individual risk management plans implemented to keep residents safe while also supporting them to take risks and manage these. Good fire safety management systems were in place and fire drills took place regularly which residents were very familiar with. All residents had personal evacuation plans and staff had alarms to raise additional support promptly should this be necessary in any situation. A current Health and Safety Statement and emergency plan was also in place and satisfactory. Vehicles and equipment used were maintained as necessary.

The systems for the management of medicines required some review to ensure they were the most effective for the non nursing staff. A number of actions required from the previous inspection had been addressed. However, errors were occurring and from a review of these the dispensing system may have been a contributing factor. There was also a medicine being administered regularly by an external clinician and this was not on the administration card or the prescription. This was a risk should another prescriber not aware of this medicine make changes to the medicine protocol for the residents, for example in acute care. At the time of the inspection there had been no ill effects to the residents and the errors were responded to promptly. There were suitable systems in place to support residents to manage their own medicines when on holiday or at home with family.

Regulation 10: Communication

Residents were supported with various mediums to ensure they can communicate effectively and staff can communicate with them as their needs required this.

Judgment: Compliant

Regulation 12: Personal possessions

All residents were encouraged and supported to purchase and enjoy their personal possessions and there were suitable arrangements made to keep them safe in consultation with the residents.

Judgment: Compliant

Regulation 13: General welfare and development

The provider had made suitable arrangements for residents to participate in training, education and recreation of their choice.

Judgment: Compliant

Regulation 17: Premises

The high support unit is not of a suitable size to accommodate the resident's presenting needs and the staffing levels required.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Systems for the management of risk were satisfactory to promote the residents' safety.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety prevention and management systems were satisfactory.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Current systems for the administration of medicines did not consistently support safe practices or adherence to practice requirements for the recording of all medicines administered.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a commitment evident to providing safe and supportive care to all the residents; however, this was impacted on by the following findings:

· pertinent assessments of needs were not undertaken for all residents who required this

· annual reviews were not undertaken in some instances or informed by assessments undertaken

· arrangements were not in place meet the needs of all residents.

Judgment: Not compliant

Regulation 6: Health care

Appropriate access to healthcare was facilitated and supported.

Judgment: Compliant

Regulation 7: Positive behavioural support

While staff had access to behaviour support plans and appropriate training, the implementation of these plans and the use of the restrictive practices were not supported by adequate assessment which would help to identify and alleviate the causes of the resident's challenging behaviours.

Reviews of significant incidents were not sufficiently robust to determine the effectiveness or implementation of the support plans.

Judgment: Not compliant

Regulation 8: Protection

Systems for the protection of residents were satisfactory.

Judgment: Compliant

Regulation 9: Residents' rights

The centre is operated in a manner which respects and promotes the rights of residents and their known will and preferences.

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
Views of people who use the service	
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially 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	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Nenagh Supported Accommodation OSV-0002653

Inspection ID: MON-0021714

Date of inspection: 21/01/2019

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: • Subject matter experts including a Fragile X Ireland representative, Diabetes Nurse and Psychiatric Nurse have been invited to come to the service to provide information to the staff team. • Opportunities for further training will be identified and offered to existing staff to continue the process of up-skilling. This process has commenced as of February 2019 and will continue on an ongoing basis. • Going forward staff recruited to work in the high support element of the service will have previous experience of supporting people with intellectual disability or autism.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • An alternative accommodation has been identified as suitable and a transition plan has been commenced. Funding has been agreed (22nd February 2019). Currently awaiting to confirm date when the new service will be vacant and available, this is contingent on a number of factors. Target date for completion 30/04/2019. • Going forward actions identified in internal audits will be monitored and reviewed with updates on progress available in the service.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• An alternative accommodation has been identified as suitable and a transition plan has been commenced. Funding has been agreed (22nd February 2019). Currently awaiting to confirm date when the new service will be vacant and available, this is contingent on a number of factors. Target date for completion 30/04/2019.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The medication previously omitted, is now included on the DAR.

• PRN DAR will be changed to using labels to be consistent with the regular prescribed medications. This will be completed by 1st April 2019.

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:
• Existing reports from members of the Multi-Disciplinary Team will be collated to provide an overview of the existing identified needs and recommendations for practice. This will be complete by 1st April 2019.

• Psychological assessment has been completed, report has been received. Recommendations will be implemented into practice and follow-up reviews completed. The report is expected by 1st April 2019.

• Referral to specialist Psychiatrist has been made. Preliminary tests have been complete, initial appointment to take place on 19th March 2019.

• Referral to the public health nurse in respect of one resident in the low support element of the house will be made with a view to providing a greater degree of oversight over the persons varied healthcare needs. This will be completed by 1st April 2019.

• In-service staff training for diabetes care will be sourced for staff. This will be completed before 30th April 2019.

• Information on the resident's needs in relation to each discipline (e.g. Endocrinology, Psychiatry, Diabetes care, Vascular specialist) will be supplied at each medical appointment, to ensure all medical professionals involved in the resident's support are aware of the resident's conditions. This is will be ongoing.

Regulation 7: Positive behavioural support	Not Compliant

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

• Recording of incidents on RIVO to be discussed at staff meeting to highlight the need for staff to record adequate detail in terms of the circumstances of the incident and potential contributing factors that may be pertinent that will help identify potential triggers and trends. This will be complete by 26/03/2019.

• Behaviour Therapist is currently working with the staff team to review the current behavior support plan with a view to updating the current plan and provide more detailed guidance for staff this will include guidance for the daily recording and monitoring of behaviours. This work has commenced and will be completed by 30/04/2019.

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	01/04/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of	Not Compliant	Orange	30/04/2019

	purpose.			
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	11/03/2019
Regulation 29(2)	The person in charge shall facilitate a pharmacist made available under paragraph (1) in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland. The person in charge shall provide appropriate support for the resident if required, in his/her dealings with the pharmacist.	Substantially Compliant	Yellow	01/04/2019
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	Not Compliant	Orange	30/04/2019

	out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/04/2019
Regulation 05(6)(a)	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 be multidisciplinary.	Not Compliant	Orange	01/03/2019
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	30/04/2019
Regulation 7(5)(a)	The person in	Not Compliant	Orange	30/04/2019

	charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			