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:	Ballard House
Name of provider:	RehabCare
Address of centre:	Offaly
Type of inspection:	Short Notice Announced
Date of inspection:	03 June 2020
Centre ID:	OSV-0002667
Fieldwork ID:	MON-0029505

About the designated centre

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

Ballard House is a residential centre facility located in a busy town in Co.Offaly which provides a service to four adults with an intellectual disability over the age of eighteen years. The service operates on a 24 hour 7 days a week basis ensuring residents are supported by care workers at all times. The level of supports afforded to each resident is based on the assessed needs of the individual as set out within the individualised personal plan. The premises is a large two storey dwelling which is decorated internally and externally providing a homely environment to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 June 2020	11:30hrs to 16:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and speak with three residents on the inspection day. One resident decided not to meet with the inspector and this decision was respected. Residents spoken with used verbal methods to communicate their thoughts and opinions. Communication was carried out while maintaining a 2 metre distance secondary to COVID19 restrictions in place.

One resident spoke with the inspector about living in the centre and communicated that they loved living in the house and thought all the staff were great, especially their key worker. The resident spoke about various activities they had taken part in during the COVID19 lockdown. Another resident spoke about their plans for some day trips and a concert they would go to once social distancing restrictions were lifted. The resident also expressed how they normally loved swimming and to go shopping. The inspector observed staff and residents sitting together comfortably in the afternoon having a cup of tea. One resident was reading a book and spoke with the inspector about the book and the topics of interest. The centre appeared homely and welcoming and the smell of home cooking was present in the centre in the afternoon. Residents spoken with, expressed no complaints about staff or living in the centre when asked. One resident communicated they were nervous about all the new managers and didn't like the changes.

The inspector had the opportunity to meet and speak with management and two staff members 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 residents throughout the inspection day appeared familiar and warm.

Capacity and capability

The purpose of this inspection was to monitor the centres ongoing levels of compliance with the regulations. In general, the inspector found that residents did enjoy living in the designated centre and were well supported by staff. However, improvements were needed to promote higher levels of compliance. There was ongoing compatibility issues and safeguarding risks amongst peers and some issues from the centres most previous inspection had not been addressed regarding supporting residents with behavioural needs and notification of incidents.

The staff team consisted of the person in charge who was a nurse, two team leaders and support workers. The centre had a full staff team in place as per the

centres Statement of Purpose. There were appropriate staff numbers in place in the centre and a roster was appropriately maintained to reflect staff on duty on the day of inspection. Regular staff supervisions were completed with the centres team leader 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. The inspector observed a sample of staff files on the day of inspection and found that all documents specified in Schedule 2 were in place as required by Regulation 15. Arrangements were in place for access to additional staffing in the event of large numbers of staff absence's secondary to a COVID19 outbreak in the designated centre.

There was a full time person in charge in place on the day of inspection who had the skills and experience necessary to manage the designated centre. The person in charge was supported by two team leaders. Systems were in place for the regular auditing and review of the services provided by persons participating in management. The centres most recently due six monthly unannounced audits had not been completed due to restrictions in place secondary to COVID19. The person filling the role of person in charge had changed three times in recent months and another change was due to occur in the weeks following the inspection. Following a review of the service provided and speaking with staff and residents, it appeared that the recent changes had contributed to an inconsistent management structure and inconsistent service provision at times as detailed in other sections of the report. One resident communicated they were nervous about new managers and didn't like the changes. The registered provider and person in charge had not ensured that a written report was provided to the chief inspector at the end of each quarter calendar year as required. Some notifications of concern had also not been submitted to the chief inspector within three working day as required. This had been an issue highlighted during the centres previous inspection.

There was a clear complaints procedure in place and this was prominently displayed in the designated centre. Residents spoken with on the day of inspection expressed no complaints regarding the service provided and were familiar with who to raise a concern or complaint with. Any complaints appeared to be responded to in a serious and timely manner and there was a designated person in place nominated to respond to any complaints or concerns.

Regulation 15: Staffing

There were appropriate staff numbers in place and a roster was appropriately maintained to reflect staff on duty. Regular staff supervisions were completed with the centres team leader.

Judgment: Compliant

Regulation 23: Governance and management

The person in charge had changed three times in recent months and another change was due to occur post inspection. This had contributed to an inconsistent management structure and inconsistent service provision at times as detailed in other sections of the report. One resident communicated they were nervous about new managers and didn't like the changes.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that a written report was provided to the chief inspector at the end of each quarter calendar year as required. Some notifications of concern had not been submitted to the chief inspector within three working day as required.

Judgment: Not compliant

Quality and safety

The inspector found that in general, staff were striving to promote a safe service to residents. Systems were in place to identify and manage actual and potential risks and auditing systems were in place to drive improvements where needed. However, the provider had identified that the centre was not suitable to meet the needs of one resident on a long term basis. This contributed to ongoing safeguarding and compatibility issues amongst residents.

The premises was of sound construction and was maintained in a suitable state of repair internally and externally. The centre was a large two story house located near a busy town in Co. Offaly and was designed and laid out to ensure that residents had space and privacy. The centre had communal spaces and a garden to the rear of the house. Residents all had their own bedrooms and the registered provider had ensured the provision of all matters set out in Schedule 6.

The inspector did not observe all aspects of the designated centre secondary to social distancing guidelines in place and residents preferences. However, following a review of aspects of the premises it was observed that appropriate systems were

not in place for the containment of fire in the designated centre. Areas of high risk were not protected by a containment system. Residents had individualised personal emergency evacuation plans (PEEP's) in place. Fire detection systems and firefighting equipment were noted around the designated centre. Residents spoken with were familiar with the fire drill process and the assembly point to go to in the event of a fire. All staff had received up-to-date training in fire safety.

Appropriate systems were in place for protection against infection and the management of the COVID19 crisis in the designated centre. Staff had completed additional training in donning and doffing personal protective equipment (PPE) and the inspector observed appropriate supplies of alcohol hand gels and PPE in the centre. Staff were wearing PPE in line with national guidance on the day of inspection and regular temperature checks were being completed with staff and residents. Staff teams had been divided to reduce contacts in the designated centre. Guidance was available on the management of COVID19, and clear protocols were in place for in the event that a member of staff or resident should present as symptomatic for COVID19. Management were aware of the requirement to notify public health and the chief inspector in the event of an outbreak. Visitation to the designated centre had been limited, in line with national guidance during the lockdown period.

Residents had comprehensive assessments of need and personal plans in place which considered all areas of need. These were subject to regular review with the resident's key workers. Key workers spoke with residents about their goals and aspirations and devised steps to support the residents to achieve their goals. Resident had annual scheduled person centred planning meetings and these were used as an opportunity to plan the year ahead and discuss their goals including any holidays they had planned. Personal plans comprehensively guided the provision of care and support in areas including health, mobility, environment, nutrition, personal care, communication, sleep, sensory needs, and medication. In general, the designated centre was not suitable for the purposes of meeting the needs of one resident long term. The resident was assessed as needing a high level of support with mental health needs. This had been identified by the provider and plans were in place for an alternative placement for this resident.

Residents with mental health needs had access to some mental health support services including psychology and psychiatry. This continued through the COVID19 lockdown with one resident continuing their appointments through video calls. Residents with behavioural support needs had behavioural support plans in place, however, these had not been reviewed in over two years and staff were not referring to positive behavioural support plans when providing support to residents with behavioural needs. Clear guidance was not available for staff to best support all identified behaviours of concern for each resident. This had been an area of concern highlighted during the centres most previous inspection.

Some restrictive practices were in place in the centre and the majority of these were implemented in line with the service policy and reviewed and approved by a committee of multi disciplinary supports. However, resident's finances were stored in a locked press in the staff office. Residents did not have free access to keys for this

press and staff and management communicated with the inspector that one resident was given a set amount of money per day and was not allowed to spend more than this. This had not been considered as a restrictive practice by staff or management and had not been notified on a quarterly report to the office of the chief inspector as required by regulation 31.

All staff had received up to date training in the safeguarding and protection of vulnerable adults. Individualised plans were in place to guide staff on the provision of personal care. There was a designated safeguarding officer in place to initiate an investigation into any allegation of suspected or confirmed abuse. Residents spoken with were satisfied that they felt safe in the centre and communicated they were happy with how management responded to any safeguarding concerns they may have. However, there was an ongoing safeguarding risk present secondary to some residents living together in the designated centre. Staff and management spoken with acknowledged that residents were not compatible at times and one resident posed an ongoing safeguarding risk to their peers. Residents had witnessed incidents of concern involving their peer and found these distressing.

There was a centre specific risk register in place that identified any potential or actual risks in the designated centre. Identified risks were mitigated where possible and control measures were communicated with staff. Individualised resident risk assessments were also in place that were subject to regular review. A resident at risk of absconsion had a comprehensive risk assessment in place and steps in place to mitigate risk in the event of absconsion. Records of any accidents and incidents were appropriately maintained and risk assessed when appropriate. Individualised risk assessments included a review of the hazard, the person that may be affected, controls in place, the person/people responsible and a risk level evaluation.

Regulation 17: Premises

The premises was maintained in a suitable state of repair internally and externally and was designed and laid out to ensure that residents had space and privacy.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a centre specific risk register in place that identified an potential or actual risks in place. Identified risks were mitigated where possible. Individualised resident risk assessments were also in place.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate systems were in place for protection against infection and the management of COVID19 in the designated centre. Staff had completed additional training in donning and offing personal protective equipment (PPE) and the inspector observed ample supplies alcohol hand gels and PPE in the centre. Staff were wearing PPE in line with national guidance on the day of inspection.

Judgment: Compliant

Regulation 28: Fire precautions

Following a review of aspects of the premises it was observed that appropriate systems were not in place for the containment of fire in the designated centre. Areas of high risk were not protected by a containment system

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had comprehensive assessments of need and personal plans in place which considered all areas of need.

However, the designated centre was not suitable for the purposes of meeting the needs of one resident longterm. This had been identified by the provider and plans were in place for an alternative placement for this resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents positive behavioural support plans had not been reviewed in over two years. Staff were not referring to positive behavioural support plans when providing support to residents with behavioural needs.

Residents finances were stored in a locked press in the staff office. Residents did not

have free access to keys for this press and staff communicated that one resident was given a set amount of money per day and could not spend more than this. This had not been considered as a restrictive practice by staff or management and had not been notified on a quarterly report to the office of the chief inspector as required by regulation 31.

Judgment: Not compliant

Regulation 8: Protection

There was an ongoing safeguarding risk present secondary to some residents living together in the designated centre. Staff spoken with acknowledged that resident were not compatible at times. All staff had received up to date training in the safeguarding and protection of vulnerable adults.

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 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Ballard House OSV-0002667

Inspection ID: MON-0029505

Date of inspection: 03/06/2020

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 permanent Residential Services Manager has commenced on 15th June and will take on the position of PIC from 1st July 2020. The PIC will be supported by the Integrated Services Manager (ISM) and the Team Leader who has a full time position within the house. • All residents have been informed of the commencement of the new PIC in preparation for the adjustment of having a new manager in the house and have been afforded the opportunity to familiarize with the new PIC during the two-week handover period. • The new PIC has now had an opportunity to meet with each of the residents.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The permanent PIC will be in place on the 1st July 2020 which ensure all notifications will be submitted within the correct timeframe. A diary alert has been set up by the PIC to ensure quarterly notifications are submitted in line with requirements. • Staff teams were reminded at meetings on the 14th and 18th May by the PIC that each staff member has a responsibility to immediately notify the manager or manager on call of any notifiable incident.	

PIC will ensure that all notifications are processed within the three working day requirements.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Newgrove housing association (landlords) will replace fire doors that were identified as being not fire complaint.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• In August 2019 the Provider submitted costings to the HSE to provide an alternative residential service for one resident.

• A revised Business Case will now be submitted to the HSE, this will be completed by July 15th.

• The PIC and PPIM have both had discussions with the HSE Disability Manager in late May and early June 2020 to request an MDT review for the resident. The outcome of these conversations was that HSE requested the Business Case to outline the support required.

• The resident is registered on the local authority housing list. Local Authority has been approached re CAS scheme funding for a property for the SU.

• On June 8th a meeting was held with the Resident, Keyworker and the PIC to discuss their preferences for moving to an alternative location. The resident has indicated that they wish for the move to occur.

• A comprehensive transition plan will be developed with the resident and agreement achieved with HSE (funder).

Regulation 7: Positive behavioural support	Not Compliant

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

• One of the residents' Behaviour Support Plan will be reviewed by 17/7/20

• Two of the residents are currently assessed as not requiring behaviour support.

• The fourth resident was re-referred on 16th April 2020 for Behaviour Therapy Input in order to review previous Behaviour Support Plan. Once review, which is planned for 24th July 2020, is completed staff will be provided with guidance to support day to day practice. (24/7/20).

• A meeting will be scheduled for the staff team to discuss the implementation of the revised Behaviour Support Plans with the Behaviour Analyst for both residents.

• A review of the financial processes for the residents who require some support with managing their finances was completed on 16th June 2020. One of the residents is fully independent in managing her finances. Two other residents require some support with managing their finances and have been given keys to enable them to have access to their own money, this is reflected in their risk assessments.

• A Restrictive Practice was authorised for one of the residents on 18th June in consultation with the PIC, Clinical Psychologist and Behaviour Analyst to support the person to manage their finances on a daily basis. This additional Restrictive Practice will be notified on the quarterly returns.

Regulation 8: Protection	Substantially Compliant

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

• A revised Business Case will now be submitted to the HSE; this will be completed by July 15th.

• In the interim, the PIC will facilitate a Safeguarding Programme developed for the residents.

• Safeguarding Plans are in place and will continue to be implemented.

• Additional staff already in place will continue to be deployed to support all residents to minimise safeguarding incidents.

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	01/07/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/08/2020
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation,	Not Compliant	Orange	24/06/2020

	suspected or confirmed, of abuse of any resident.			
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Not Compliant	Orange	24/06/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	24/06/2020
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	Substantially Compliant	Yellow	30/08/2020

	paragraph (1).			
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.	Substantially Compliant	Yellow	07/08/2020
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 practice.	Not Compliant	Orange	07/08/2020
Regulation 7(5)(a)	The person in 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.	Substantially Compliant	Yellow	07/08/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2020