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 Residential Service
Name of provider:	RehabCare
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	18 June 2019
Centre ID:	OSV-0003420
Fieldwork ID:	MON-0026433

About the designated centre

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

Nenagh residential service currently supports to residents in Co.Tipperary. This service provides supports to five adults with an intellectual disability and a diagnosis of mental health.This is full-time service. Staffing levels are dependent on the assessed needs of the residents as reflected within each individualised personal plan. All residents are supported to attend a RehabCare resource centre or individually tailored day service on a full time basis. The premises is a two storey semi-detached property which presents as warm, homely and tastefully decorated and with ample private and communal space for the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
18 June 2019	09:30hrs to 18:00hrs	Noelene Dowling	Lead
18 June 2019	09:30hrs to 18:00hrs	Laura O'Sullivan	Support

Views of people who use the service

Inspectors met with five of the residents who communicated in their preferred manner and allowed inspectors to observe some of their routines, including activities and relaxation. The residents appeared to be content in their environment, and the staff were seen to be supporting them with their schedules for activities and one-to-one supports for their activities.The residents said enjoyed their meals out and going for walks,singing in the choir and they said they felt safe living in the centre.

The residents were seen to be comfortable with the staff who understood their manner of communication and they were taking part in cooking, playing cards and drawing. They looked physically well cared for. There was a lot of recreational materials available which was being used by the residents.These included colouring books, DVDs and jigsaws, which one resident especially liked.

Inspectors also met with a parent who stated that their relative was well cared for and was happy to return to the centre from breaks at home. They said their sons individual preferences for his life, health and daily routines were well supported.They said there was good communication with the staff and that they trusted the staff to care for their son.

Capacity and capability

This inspection was carried out to monitor the provider's actions following the registration inspection undertaken in December 2018. That inspection identified a number of non-compliance in the centre. These were primarily influenced by the compatibility of the residents living together at that time which resulted in incidents of behaviour that challenged and safeguarding concerns for residents within the centre. In response to this, the provider gave a detailed and time bound response which involved reducing the numbers of residents living in the centre. In May 2019, the provider informed HIQA that the original time line for this reduction could not be met and this was extended until 31 May 2019. However, this inspection found that this plan had still not been progressed.

While this matter remains unresolved, this inspection found other failings identified not necessarily concerned with the compatibility of the residents. These were, the management of safeguarding for residents, adequate assessments and support plans for residents and risk management strategies. These are detailed in the quality and safety section of this report. There was also a failure to notify HIQA of events which are prescribed under the regulations.

Some matters had been addressed however, including the provision of adequate staffing levels and complaint management systems which were having a positive impact on the residents' lives.

The systems for oversight by management were not satisfactory at this point which did not support the safety and welfare of the residents. For example, there was no evidence of satisfactory monitoring or review of the incident reports for behaviours that challenge or safeguarding incidents and insufficient auditing systems evident. Given the known compatibility issues and lack of implementation of residents transition plans, this was of particular concern. Other quality assurance mechanisms were also not implemented effectively. For example, an unannounced inspection had been undertaken on behalf of the provider in January 2019. However, this primarily focused on documentation and not on the residents care needs and how these were being supported.

The provider had increased the staff ratio at crucial times to support the residents' routines and alleviate some of the tensions in the house. This was found to have helped to reduce the incidents occurring to some extent. There was also a commitment to ongoing staff training evident and all mandatory training was completed with schedules for 2019 available. Recruitment practices were also satisfactory on this inspection. Staff supervision systems had also been implemented. Other aspects of residents' care were found to be well supported.These included residents general healthcare, and access to interesting and meaningful social and day care services

At the end of the inspection and on the following day the inspectors provided feedback to the provider representative, service manager and person in charge. At that time, the provider was required to implement adequate and detailed safeguarding plans for the residents' specific needs by Wednesday 26 June in order to ensure that the issues were clearly understood and appropriate actions taken. These were completed satisfactorily. In addition to this, the provider gave assurances and plans for the reduction in the numbers of residents living in the centre.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced for the post.

Judgment: Compliant

Regulation 15: Staffing

The number and skill-mix of staff were satisfactory to support the residents.

Recruitment procedures were satisfactory.

Judgment: Compliant

Regulation 16: Training and staff development

There was a commitment to ongoing staff training evident and all mandatory training was completed with schedules for 2019 available.

Staff supervision systems were implemented.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which clearly defined the service to be provided.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints and concerns were seen to be recorded and managed transparently.

Judgment: Compliant

Regulation 23: Governance and management

The systems for management oversight were not satisfactory at this point which did not support the safety and welfare of the residents. For example, there was no evidence of satisfactory monitoring or review of the incident reports for behaviours that challenge or safeguarding incidents and insufficient auditing systems evident.This was despite the defined management structures.

Judgment: Not compliant

Quality and safety

The increase in staffing and person-centred planning had ensured that the residents social care needs and integration were very well supported. This also ensured that residents were facilitated to have different day time activities and recreation.

Residents had busy lives with access to a range of social outings, training and activities of their own choosing. They went to music events, took part in local choirs, in cooking classes, and went horse riding and swimming. They had holidays and breaks away. There was good access to allied health assessments including, physiotherapy, speech and language, dietitians, neurology and gender specific screening, where appropriate. There were suitable support plans implemented and staff were found to monitor their health and primary care needs very well.

However, there were failings evident in a number of areas which could ultimately place residents of risk and diminish their quality of life, if inadvertently.

The changes to the staffing structures included more effective day-to-day planning for the residents individual activities and this was intended to reduce opportunities for friction and incidents to occur. Safeguarding systems, however, remained unsatisfactory in a number of areas. From a review of the incidents records maintained in the centre there was insufficient evidence that these had reduced.

It was apparent that these incidents continued to have a significant impact on residents both directly and indirectly. For example, either by direct assault, verbal threats, or witnessing aggressive behaviours which in some instances were prolonged. The safeguarding plans devised did not provide sufficient guidance to address these.

There were also potential safeguarding risks or concerns from external sources noted in records which staff appeared not to be aware of and therefore were not adhering to the guidelines for managing them.There was evidence of a lack of adherence to national protocols when dealing with allegations made by residents, lack of adequate screening and in some cases lack of reporting to the Health Service Executive (HSE) as the statutory body with responsibility.

There were other significant behaviours identified during the inspection which were indicative of significant risk of self-harm and required sensitive guidance to manage. These was not supported by such guidance. These matters posed potential risks to the residents overall wellbeing. Individual residents intimate care plans, which indicated that a high level of support was necessary, did not take account of the vulnerabilities and in some instances personal histories of the residents in relation to this and the potential risks to both residents and staff in this instance. For example a residents was assessed as needing to have a female staff on duty and this was not adhered to.

The assessed needs of the residents differed significantly and there was a lack of clarity as to these needs, particularly in terms of supporting residents with a mental health diagnoses. This impacted on the provider's ability to implement adequate care,support plans and to adequately review the care provided for the residents long term benefit. Given these needs, the numbers of residents living together still required to be reduced. There was also a lack of sufficient access to mental health supports on regular basis. Inspectors acknowledged that this latter finding is impacted on by access to such services in the community. None the less, the lack of awareness within the staff team of the mental health status of the residents is of concern. The risk management framework, risk register and individual residents risk management plans were not detailed sufficiently to protect the residents at this time.

Good practice was however observed in other areas. Inspectors found that there were no restrictive practices used in the centre. All medicines were reviewed and systems for the management of medicines were safe. Additionally,there had been a significant reduction in medicines errors since the previous inspection.

Fire safety management systems remained satisfactory with suitable equipment and containment systems and evidence of regular servicing evident. Fire drills took place regularly at various times and with various numbers of staff to ensure they could evacuate the residents.

Regulation 28: Fire precautions

Fire safety management systems were satisfactory with suitable equipment, containment systems and evidence of regular servicing of equipment evident. Fire drills took place regularly at various times to ensure staff and residents were familiar with the proces.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

All medicines were reviewed and systems for the management of medicines were safe. Additionally,there had been a significant reduction in medicines errors since

the previous inspection.

Judgment: Compliant

Regulation 6: Health care

There was suitable access to allied services for the residents health care needs with pertinent support plans implemented .Staff were found to monitor their health and primary care needs very well.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was guidance and support available for the management of behaviours that challenged. However, these interventions were not adequately reviewed following incidents to ensure they had been implemented correctly and were supportive of the residents.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Systems for the identification of risks, learning from and review of incidents were not satisfactory to sufficiently support the residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The residents had varied and meaningful social activities and recreation. Regular reviews of the residents care were held. However, the effectiveness of these reviews was not evident in that they did not adequately address the residents overall needs and support necessary.There were no adequate care plans implemented for fundamental needs including safety and mental health.

The compatibility of the residents living in the environment had not been addressed

in a timely manner to ensure that each residents needs could be met in the centre.

Judgment: Not compliant

Regulation 8: Protection

There was evidence of a lack of adherence to national protocols when dealing with allegations made by residents, lack of adequate screening and in some cases lack of reporting to the Health Service Executive (HSE) as the statutory body with responsibility.

Safeguarding plans were not consistently implemented where these would have been necessary and these actions may place residents at risk.

Individual residents' intimate care plans, which indicated that a high level of support was necessary did not take account of the individual vulnerabilities presented despite the potential risks to residents in this instance.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Nenagh Residential Service OSV-0003420

Inspection ID: MON-0026433

Date of inspection: 18/06/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Action 1: The organisation's internal six monthly unannounced audit process is currently under review to ensure a more robust audit system is in place. The new process will be rolled out by 30/09/2019. Action 2: The PIC will ensure immediate consultation takes place with Designated Officer regarding any incident of safeguarding which requires notification to HIQA, The PIC and Designated Officer will ensure that Preliminary Screening is completed and submitted to the HSE safeguarding team. Action 3: Going forward a monthly review of incidents will be completed and submitted to the Designated Officer and Behaviour Therapist for consultation/review. Information for this report will be extracted from the incident management system and reviewed. The monthly report for July will be completed by 05/08/2019. Action 4: PIC will review current local audits completed within the service and make enhancements to same, this will be completed by 31/08/2019.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive	

behavioural support:
Action 1: A review of Behaviour Management Guidelines for all residents was completed by 27/06/19

Action 2: The Behaviour Therapist will provide a briefing session for staff team following review of BMG's – Scheduled 31/07/19

Action 3: Going forward the PIC will ensure that each incident is reviewed by PIC and actions identified are brought to the monthly team meeting or direction issued if immediate implementation is required. Already commenced June 2019 team meeting and on-going.

Action 4: The PIC will ensure immediate consultation with Designated Officer takes place for any incident of safeguarding nature which requires notification to HIQA, Ensure Preliminary Screening is completed and submitted to the HSE safeguarding team.

Action 5: The PIC will ensure that a monthly review of incidents takes place and reviews are submitted to Designated Officer and Behaviour Therapist for consultation/review. Information for this report will be extracted from the incident management system and reviewed. The monthly review for July is completed by 05/08/2019.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Action 1: The PIC will ensure each incident is reviewed by PIC and actions identified are brought to the monthly team meetings for discussion or direction issued if immediate implementation is required. Complete by the 27/06/19 and on-going.

Action 2: The PIC will ensure the centre has the Organisational Risk Management Policy in place which informs practice and specifies the frequency of review required depending on individual risk rating. All risk assessments are in the service are currently being review to ensure all risks are identified with appropriate control measures in place, this will be completed by 15/08/2019.Thereafter all risk assessments completed or revised as required following review of incidents.

Action 3: Organisational Business Continuity and Emergency Planning Policy in place. Nenagh Residential Service has an individualised contingency plan in place which specifies emergency accommodation/maintenance/electrical/management contacts to be used for this service if required.

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:
Action 1: An Assessment of need will be completed and be in place for each resident with identified requirements addressed in support plans. This will be complete by 31/07/19.

Action 2: In the event of a resident being proposed for admission to the service moving forward a comprehensive assessment of need will be completed along with compatibility assessments and consultation with the resident and their circle of support to ascertain if the service is suitable to meet the needs of the resident. Only when the service has been deemed appropriate will a transition plan be developed.

Action 3: A transition plan is currently being facilitated progress for one resident identified as requiring a different type of service model that will more appropriately meet their needs. The transition will be completed by 31/08/19

Action 4: An update/review of all residents support plans is currently taking place. Thereafter Support plans will be reviewed at least annually or more often if required. Complete by 31/07/19.

Action 5: The PIC will follow up with relevant professional to ensure all residents have access to relevant allied health professionals as required. This will be completed by 15/09/2019.

Action 6: Annual health screening document in place which tracks all access to health professionals throughout the year.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Action 1: Individual safeguarding plans have been developed and implemented for each individual. Complete 27/06/19

Action 2: All staff attend have Safeguarding training with RehabCare on commencement of employment and complete refreshers as required. Currently all staff are trained.

Action 3: Safeguarding is agenda item for each team meeting. All staff familiar with protocol to be followed in the event that a safeguarding incident occurs. Commenced June 2019 and on-going.

Action 4: Organisational Policy on Safeguarding Vulnerable Adults is in place which incorporates national procedures on the management of safeguarding incidents. Staff team have read and signed most up to date version of policy and work in adherence to same. Completed by 30/07/19

Action 5: Following the occurrence of any safeguarding incident national procedures are followed i.e. consultation with Designated Officer, completion of Preliminary Screening, submission to HSE safeguarding team within 3 working days and notification to HIQA also within 3 working days. Commenced 22/06/19 and on occurrence going forward.

Action 6: Personal and intimate care plans reviewed and updated to provide detailed and accurate guidance for staff in providing personal care to residents who require support in a manner that respects the resident's dignity and bodily integrity. The review of plans will focus on ensuring maximum independence for residents. This review will be completed by 15/08/2019.

Action 7: Training will be provided to staff team in the delivery of personal care to residents. 30/09/19

Action 8: Guidance for staff to plan shifts has been developed by the PIC and discussed with staff at team meeting during the first week in July. The purpose of this guidance is to ensure that activities are planned in a manner that reduces the potential for safeguarding incidents to occur. This guidance was developed followed a review of incidents and trends and since implementation there has been a reduction in 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	31/08/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and	Not Compliant	Orange	30/09/2019

	quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	15/08/2019
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 out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	15/09/2019
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,	Not Compliant	Orange	31/08/2019

	as assessed in accordance with paragraph (1).			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	23/07/2019
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.	Substantially Compliant	Yellow	05/08/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	27/06/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers	Not Compliant	Orange	22/06/2019

	abuse.			
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Orange	15/08/2019