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:	The Haven
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	09 December 2019
Centre ID:	OSV-0005236
Fieldwork ID:	MON-0028245

About the designated centre

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

The Haven is located in a rural area of County Kildare and provides 24 hour residential supports to five adults with an intellectual disability. The centre consists of a large two storey, five bedroom house with an adjacent self-contained one bedroom apartment. In the main house the ground floor consists of a kitchen, utility area, living room, sitting room and bathroom and four bedrooms, one of which is the staff sleepover room/office. Two of the residents' bedrooms downstairs are ensuite. There are two bedrooms upstairs both of which have an ensuite bathroom, there is also a staff office and games room/staff sleepover room. The apartment contains a kitchen come dining room, a sitting room, a sensory room, bedroom and large bathroom. There is also a spacious garden for recreational use and spacious grounds surrounding the house and apartment. The staff team is made up of social care workers, assistant social care workers, deputy managers, and a person in charge. Nursing input is available from a nurse employed in the wider organisation.

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
09 December 2019	09:35hrs to 17:20hrs	Marie Byrne	Lead
09 December 2019	09:35hrs to 17:20hrs	Valerie Power	Support

What residents told us and what inspectors observed

On the day of the inspection, the inspectors of social services met briefly with three of the five residents who lived in the designated centre. One of the residents was not present in the centre for the majority of the inspection and inspectors did not get an opportunity to talk to them on their return, and another resident preferred to stay in their room rather than meet the inspectors.

Residents were observed participating in a range of activities throughout the day, with the support of staff, both in the centre and in the community. For example, one resident was seen creating artwork at the kitchen table; another resident was supported by staff to attend a medical appointment in the community.

One resident was accompanied by two staff members to go on a morning walk in a quiet countryside area. On their return, the resident appeared content and staff reported that they enjoyed this outing. The registered provider had made arrangements for an external music therapist to attend the centre for the benefit of two residents, and on the day of inspection, the inspectors saw one resident relaxing and enjoying the live music and singing provided. The resident appeared very calm and comfortable, and the music could be heard throughout the house, creating a pleasant atmosphere.

The inspectors saw staff interacting positively with residents throughout the day. One resident was seen to engage in repetitive behaviours on multiple occasions, and staff were seen to be patient and gentle, and to afford this resident time to move on to other planned activities.

Capacity and capability

This inspection was completed in response to an increase in the receipt of information from the centre relating to allegations of misconduct by staff members. Prior to this inspection, the Chief Inspector had issued a provider assurance report which the provider had completed outlining steps they had taken and additional control measures they had put in place, to ensure they were monitoring the quality and safety of care and support for residents in the centre. Following the return of this provider assurance report, the Chief Inspector received a further notification relating to the alleged misconduct.

This inspection was facilitated by the person in charge and Director of Operations (DOO) for the centre. During this inspection, the inspectors reviewed the steps the provider had taken in response to the increase in notifications and found that there was clear evidence that they were putting additional control measures in

place to keep residents safe. These control measures included an increased management presence in the centre both day and night, a visit by a member of the organisations human resources team to talk to staff about the importance of performing their duties in line with the organisation's policies and procedures, discussions at staff meetings relating to the organisation's escalation policy and on-call system and a review of the supports systems in place and staffing arrangements in the centre at night time. However, despite these additional control measures, concerns remained in relation to staffing numbers and the supervision and performance management of staff in the centre. They required review to ensure that staff were being supported to carry out their roles and responsibilities to the best of their abilities.

At the time of the inspection, there was a full time person in charge a two deputy team leaders employed in the centre. The DOO outlined additional measures planned to increase the monitoring and oversight in the centre. They had just received approval from the executive management team to recruit a further two deputy team leaders for the centre to ensure that they had a member of the local management team on duty 24 hours a day, seven days a week.

The inspectors acknowledge that improvements had been made in the centre since the last inspection in relation to safeguarding, risk management, auditing, the agenda items at staff meetings and the sharing of learning following incidents and adverse events in the centre. There had also been a marked decrease in the number of incidents and in the use of some restrictive practices in the centre. There had been a review and update of a number of residents' support plans leading to additional supports and control measures being implemented. There was evidence that these changes had resulted in increased opportunities for residents and an overall decrease in the the number of incidents and safeguarding concerns in the centre.

In line with the findings of the last inspection, there were clearly defined management structures and systems in place to monitor the quality of care and support for residents in the centre. These included an annual review and 6 monthly reviews by the provider, regular audits in the centre and regular contact and meetings between the person in charge and DOO. The person in charge was completing weekly and monthly reports and sending them to the DOO. The findings from these reports were shared with the executive management team and actions developed as required. There was evidence that actions identified in these reports and reviews were being followed up on and completed in line with the timeframes identified by the provider. There was also evidence that these actions were positively impacting on the quality of residents' care and support.

Staff meetings were occurring monthly. The agenda items were found to be resident focused and there was evidence that incidents were reviewed and learning shared amongst the team. However, the numbers of staff attending these meetings was low and over the past number of months, two were cancelled due to low attendance and one was cut short for the same reason. Plans were in place to hold the meetings bi-weekly moving forward to ensure staff on different shifts could attend. There was a process in place for staff handover daily. There was a comprehensive

template in place and staff were assigned specific duties and responsibilities during each shift. For example, it was clearly identified which staff were supporting residents both at home and during activities in their local community. In addition, it identified who the shift lead was in the absence of the person in charge or deputy team leaders. However, the inspectors reviewed a sample of these handover sheets and found that they were not been consistently completed, particularly on days when the person in charge and deputy team leaders were not on duty.

Information received from the centre, indicated that there had been considerable disruption to the staff team in the preceding months, with high levels of staff turnover. In the nine months prior to this inspection, the provider had notified the Chief Inspector of nine allegations of misconduct by staff in the centre. On the day of inspection, six staff members were engaged in the provider's disciplinary procedure, and the person in charge confirmed that there were 2.5 whole-time equivalent (WTE) staff vacancies in the centre. This was an increase from the time of the last inspection, when there was one WTE vacancy. The person in charge reported that recruitment was ongoing and a number of new staff members had commenced working in the centre over the previous two months.

The inspectors reviewed a sample of planned and actual staff rotas and found that cover provided by relief staff was frequently required in order to maintain appropriate staffing levels. Members of the centre's management team acknowledged to the inspectors that the number of relief staff employed in the centre in recent months had been greater than planned. Review of the staff rota for a recent sample month showed that relief staff worked in the centre on 25 out of 31 days. Forty-three unique staff members were named on the rota throughout that month, approximately 40% of whom were categorised as relief staff. The person in charge described arrangements put in place by the registered provider to minimise the number of unfamiliar relief staff working in the centre: a panel of relief staff was specifically assigned to this centre, and additional cover could be sought, as required, from a centralised panel of relief staff maintained by the provider. However, due to the high turnover of staff in the centre at this time, these arrangements did not ensure continuity of care and support for the residents at all times.

Furthermore, aspects of the planned and actual staff rotas had not been properly maintained. For example, names of relief staff were not recorded on the rota in places, and the full names of staff were not always listed. Staff handover documents were reviewed in line with the rota for a sample month and, on two days, the staff members named on the rota were not consistent with the staff named on the handover documents. In addition, it appeared as if a number of shifts had not been covered. However, assurances were provided during the inspection, that these shifts did not require cover as some residents were not present in the centre and therefore the usual number of staff were not required to cover these shifts. This was not clear on the planned or actual rosters.

In the provider assurance report submitted to the Chief Inspector approximately two weeks prior to the inspection, it stated that all staff were in receipt of professional supervision every month for their first six months and then every two months

following this. Inspectors reviewed supervision meeting records for a sample of staff members and found that meetings were not consistently taking place at the specified frequency for all staff. In addition, sample meeting records indicated that the quality of supervision and appraisal was variable. Specifically, not all supervision records demonstrated an appropriate focus on shared learning and professional development, and a sample appraisal record did not document discussion of some key elements of staff performance. For example, records were reviewed for one staff member who was on a performance improvement plan for a specified period. Once this process was completed satisfactorily, the inspectors found that there was no documentary evidence to show that they had any further supervision meetings until 12 months later. There was documentary evidence of annual performance appraisals and mediation meetings with staff to support them to work together. Through discussions with staff it was also evident that additional supports had been put in place in an effort to retain staff. However, there was no documentary evidence that these supports has been put in place.

Regulation 15: Staffing

There were 2.5 WTE staffing vacancies in the centre at the time of the inspection. There was evidence that the provider was attempting to minimise the impact of these vacancies and provide continuity for residents while they were in the process of recruiting to fill these vacancies. For example, they were attempting to utilise regular relief staff to fill the required shifts. However, this was not always proving possible due to the volume of shifts being covered by different relief staff. In addition, planned and actual staff rotas had not always been properly maintained in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not in receipt of professional supervision, in line with plans outlined by the provider following a number of allegations of misconduct by a staff member. From reviewing records, it was not clear that staff were being supported to carry out their roles and responsibilities to the best of their abilities.

Judgment: Not compliant

Regulation 23: Governance and management

There were clearly defined management structures and systems in place to monitor the quality and safety of care and support for residents in the centre. In response to an increase in concerns relating to staff performing their duties, the provider had put additional control measures in place to monitor the the quality and safety of care and support for residents. This included an increased management presence in the centre, increased auditing and monitoring both day and night. The provider had recognised that the needed to further increase the management presence in the centre and plans were in place to recruit a further two deputy team leader to make sure there was a management presence in the centre 24/7. However, areas for improvement remained in relation to staffing numbers, documentation and the supervision and performance management of the workforce.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre is maintained. Notifications are submitted to the Chief Inspector in line with the timeframes identified in the regulation.

Judgment: Compliant

Quality and safety

The inspectors found that the provider was striving to ensure that the quality of service for residents was good and safe. Improvements had been made since the last inspection in relation to risk management and further improvements had been made in relation to safeguarding procedures and plans and positive behaviour support. Residents had opportunities to take part in activities in line with their wishes and goals. The provider was completing regular audits and reviews and implementing supports to ensure residents were safe. These included relevant risk assessments, safeguarding plans and regular review of restrictive practices to ensure they were appropriate and the least restrictive, for the shortest duration. As a result of these reviews, there was evidence of both a reduction in incidents in the centre, evidence of the consistent implementation of behaviour support plans to support residents and evidence of a reduction in the number and frequency of use of restrictive practices in the centre.

The premises was warm, clean, comfortable and decorated in line with residents preferences. The provider was identifying through their audits that there were a number of areas which required repair or redecoration. Plans were in place to complete these required works. Improvements had been made in relation to the

driveways in the centre since the last inspection and further improvements were planned in relation to one residents' outdoor space. The inspectors viewed evidence that areas for improvement identified during the inspection had been reported to the maintenance department. A representative from the maintenance department was on site on the day of the inspection to complete a number of the jobs from the maintenance list in the centre. There were a number of pieces of furniture which required replacement and removal from the centre and the person in charge outlined plans for this to be completed and plans to further develop a number of rooms to provide space for residents to engage in activities which they enjoyed such as sensory play and table top activities.

Residents were protected by the risk management policies, procedure and practices in the centre. There was a risk register in place and evidence that it was regularly reviewed and updated in line with learning following accidents and incidents. Each resident has an individual risk management plan which was reviewed and updated in line with their changing needs. There was an emergency plan in place which clearly guided staff to support residents in the event of an emergency. There were systems in place for reviewing accidents and incidents which included review by the management team. There was evidence that following review of these incidents, documentation was updated and learning was shared across the team at handover and during staff meetings.

Residents were also protected by the polices, procedures and practices in the centre in relation to safeguarding. Staff were in receipt of training to support them to be aware of and know the steps to follow, if they were to become aware of any allegation or suspicion of abuse in the centre. From reviewing incident reports and notifications for the centre, it was evident that allegations or suspicions of abuse were reported and followed up on in line with the organisation's and national policy. There was a centre specific safeguarding plan and safeguarding plans were developed and reviewed as required. In response to a number of safeguarding concerns in the centre, the provider had put additional control measure in place in relation to support residents such as; staffing supports, the review of support plans, the implementation of monitoring systems and documentation relating to these monitoring systems, and additional controls relating to residents' possessions and finances. These area specific safeguarding plan for the centre and individual safeguarding plans were reviewed and discussed at shift handover and during staff meetings.

Regulation 17: Premises

The centre was clean, comfortable and designed and laid out to meet the number and needs of residents in the centre. There were a number of areas for maintenance and repair and the provider was aware of these and had plans in place to complete the required works.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by the systems in place for the assessment, management and ongoing review of risk in the centre. There was evidence that there were systems in place for responding to emergencies. There was a risk register in place and residents had individual risk management plans. There was evidence that these were reviewed and updated regularly in line with learning following incidents and that this learning was shared across the team.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. All allegations and suspicions of abuse are reported and followed up on in line with the organisation's and national policy. Immediate actions were implemented to keep residents safe and then interim safeguarding plans were put in place as required.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Haven OSV-0005236

Inspection ID: MON-0028245

Date of inspection: 09/12/2019

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: 1. The Person in Charge will ensure that relief staff assigned to the Centre will be regular relief staff and in line with the Designated Centre's Statement of Purpose. 2. The PIC shall ensure that planned and actual staff rosters will be properly maintained in the Centre by conducting a daily review of the staff roster to ensure that and all information is correct and accurate.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in Charge to ensure that a supervision schedule is implemented and adhered to. 2. The Person in Charge shall review staff supervisions in with the Designated Centre's policy to ensure that any performance issues within the Centre are being addressed through this pathway and that appropriate support is being provided to staff to carry out their roles and responsibilities to the best of their abilities.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. Additional Deputy Team Leaders have been implemented in the Designated Centre since 12 December 2019 to ensure 24/7 governance. 2. The Person in Charge shall ensure that any performance management processes with the Designated workforce is in line with all relevant policies and procedures. 3. Where staff supervisions occur, the Person in Charge shall ensure appropriate support is being provided to staff to carry out their roles and responsibilities to the best of their abilities.	

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.	Substantially Compliant	Yellow	14/03/2020
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	14/03/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	14/03/2020

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	14/03/2020
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.	Substantially Compliant	Yellow	29/02/2020
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Substantially Compliant	Yellow	29/02/2020
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for	Substantially Compliant	Yellow	14/03/2020

	the quality and safety of the services that they are delivering.			