Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Rathdearg House
Name of provider:	Nua Healthcare Services Unlimited Company
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	02 October 2018
Centre ID:	OSV-0005449
Fieldwork ID:	MON-0024916

About the designated centre

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

The service provided was described in the providers statement of purpose, dated May 2018. The centre was registered to provide residential care for up to five adults. At the time of inspection, there were four adult residents living in the centre. The centre consisted of a large two storey house which had spacious gardens surrounding the house. There were five bedrooms for residents use, two of which had ensuite facilities. Each of the residents had their own bedroom which they had personalised to their own taste. The last inspection in the centre had been completed in May 2017. The purpose of this inspection was to monitor compliance with the regulations and to followed up on the actions from the previous inspection.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

To prepare for this inspection the inspector or 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
02 October 2018	12:00hrs to 18:30hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with one of the four residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. This resident told the inspector that overall they enjoyed living in the centre. It was evident that the resident had a close relationship with staff caring for them on the day of inspection. The inspector observed warm interactions between the resident and staff caring for them and that the resident was in good spirits. The inspector did not have an opportunity to meet with the relatives of any of the residents but it was reported that relatives were happy with the care being provided for their loved one.

The inspector found that residents were enabled and assisted to communicate their needs, wishes and choices which supported and promoted residents to make decisions about their care. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits.

Staff spoken with outlined how they advocated on behalf of the residents and how they felt that each of the residents enjoyed living in the centre.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to the resident's needs.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge had taken up the position in June 2018. Prior to this and within the previous two year period, the governance and management arrangements in place were not consistent with a total of five different persons in charge having been appointed and resigned during this period. The current person in charge was interviewed at the time of his appointment and found to meet the requirements of the regulations and to have a sound knowledge of the care and support requirements for each of the residents. He was in a full time post but was also responsible for one other centre located a distance away. He was supported by a deputy team leader in this centre and in the other centre for which he held responsibility. Staff members spoken with told the inspector that, since taking up the position, the person in charge had supported them in their role and was considered to be approachable and person centred. There was evidence that the person in charge had regular formal and informal contact with his manager.

There was a clearly defined management structure in place that identified lines of

accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the director of operations who in turn reported to the chief operations officer. There was evidence that the director of operations visited the centre at regular intervals.

The provider had completed an annual review of the quality and safety of care in the centre and six monthly unannounced visits to assess the quality and safety of the service as required by the regulations. The providers quality department had undertaken a number of other audits in the centre and there was evidence that appropriate actions had been taken to address issues identified. The centres operations manager completed two weekly audits in the centre on operational matters. The person in charge submitted a weekly governance matrix report to the director of operations. This included information on matters such as incidents, restrictive practices, safeguarding concerns and risks. The person in charge also submitted a weekly report regarding house budgets, audits, behaviours of concern and notifications.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were in place at the time of inspection but it was noted that there head been a changeover of a number of staff in the preceding period. A staff communication book and staff handover sheets were completed on a daily basis. On-call arrangements were in place for staff.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the providers training department. Training records showed that staff were up-to-date with mandatory training requirements. Other training to meet specific needs of residents had been provided. There were no volunteers working in the centre at the time of inspection.

There were staff supervision arrangements in place. However, supervision for some staff was not being undertaken in line with the frequency proposed in the providers policy and some of the supervision was deemed not to be of a good quality. This meant that staff may not be adequately supported to perform their duties to the best of their abilities.

There was a written statement of purpose, dated May 2018. It set out the aims, objectives and ethos of the designated centre. It also stated the facilities and services which were provided for residents. It contained all of the information required in schedule 1 of the regulations.

A directory of residents was maintained in the centre. However, it did not include the name and address of the organisation or body, which arranged each residents admission to the centre as required by the regulations.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and ensure it meets its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

The full complement of staff were in place and considered to have the required skills and competencies to meet the needs of the residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, some staff were not receiving formal supervision in line with the frequency specified in the providers policy.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents did not include the name and address of the organisation or body, which arranged each residents admission to the centre as required by the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre had a publicly available statement of purpose, dated May 2018 that accurately and clearly described the services provided.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre were maintained and where required, notified to the Chief Inspector and within the timelines required in the regulations.

Judgment: Compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality, safe, person centred and which promoted their rights.

Personal support plans were in place which reflected the assessed needs of the individual residents. Overall, these outlined the support required to maximise individual residents personal development in accordance with their individual health, personal and social care needs and choices. Monthly outcomes were identified for individual residents and records were maintained at the end of each month on progress made in achieving the outcomes identified. The majority of personal plans in place were reviewed at regular intervals with the involvement of the resident's multidisciplinary team. However, there was limited evidence that personal plan reviews involved residents families or their representatives. Some reviews undertaken did not assess the overall effectiveness of the plan in place. One of the resident's personal plans had not been reviewed in the previous 12 month period as required by the regulations and a date for a review had not yet been identified.

The residents were supported to engage in meaningful activities in the centre and within the community. Only one of the residents attended a formal day service. The other residents engaged in an individual programme within the centre which was tailored to meet their needs. Staff facilitated and supported the residents to

participate in activities that promoted community inclusion such as, a social group, cinema, theatre shows, bowling, gym, visits to local shops, restaurants and walks in a local community park. Individual daily and weekly schedules were in place for residents.

The centre was found to be suitable to meet the resident's individual and collective needs in a comfortable and homely way. Each of the residents had their own bedrooms which had been personalised to their tastes and choices. A sensory room on the first floor area was in the early stages of being developed with some sensory items purchased. Overall, the centre was nicely decorated and in a good state of repair.

Residents' communication needs were met. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. Communication passports were on file for residents who required same.

The residents were provided with a nutritious, appetizing and a varied diet. The timing of meals and snacks throughout the day were planned to fit around the needs of the resident. A weekly menu was agreed with residents at a weekly meeting. A healthy eating programme was being encouraged in the centre and a successful weight loss had been achieved for one of the residents to improve their health and quality of life. Nutritional intake records were maintained for residents identified to require same.

There were systems in place to ensure the safe management and administration of medications. The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. A medication management policy was in place. There was a secure cupboard for the storage of all medicines. All staff had received appropriate training in the safe administration of medications. Assessments had been completed to assess the ability of individual residents to self manage and administer medications. However, at the time of inspection it was not suitable for any of the residents to be responsible for their own medications. Individual medication management plans were in place. There were some systems in place to review and monitor safe medication management practices which included regular counts of all medications and audits. There were procedures for the handling and disposal of unused and out of date drugs. A record was maintained of all unused and out of date medications returned to pharmacy.

Overall, the health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences.

Precautions were in place against the risk of fire. There was documentary evidence

that fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified in an area to the front of the centre. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training. Fire drills involving residents had been undertaken at regular intervals.

Residents were provided with appropriate emotional and behavioural support. The inspector found that the assessed needs of residents were being appropriately responded to. Multi-element behaviour support plans had been put in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual residents. There was evidence that the providers behaviour support specialist visited the centre at regular intervals to provide support for residents and the staff caring for them. There had been a number of peer to peer incidents in the centre but these were found to have been appropriately managed.

Regulation 10: Communication

Residents' communication needs were met.

Judgment: Compliant

Regulation 17: Premises

The centre was homely, accessible and promoted the privacy, dignity and safety of each resident.

Judgment: Compliant

Regulation 18: Food and nutrition

The residents were provided with a nutritious, appetizing and a varied diet.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire safety arrangements were in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal support plans were in place which reflected the assessed needs of the individual residents. However, there was limited evidence that personal plan reviews involved residents families or their representatives. Some reviews undertaken did not assess the overall effectiveness of the plan in place. One of the resident's personal plans had not been reviewed in the previous 12 month period as required by the regulations and a date for a review had not yet been identified.

Judgment: Not compliant

Regulation 6: Health care

Resident's healthcare needs were being met in line with their personal plans and assessments.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Rathdearg House OSV-0005449

Inspection ID: MON-0024916

Date of inspection: 02/10/2018

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · The PIC to conduct a full review of the Supervision which has taken place in the Centre and review schedule to ensure it is in line with the Supervision Policy [30 Nov 2018]	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: PIC will ensure Directory of residents is updated to include the name and address of the organisation or body, which arranged each residents admission to the Centre as required by the regulations. [14 Nov]	
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: · The PIC and Behavioural Specialist Manager to facilitated a review of all Personal Plans	

within Designated Centre. [14 Dec 2018]
· PIC will ensure all Personal Plans are reviewed 12 monthly and Annual Reviews are held within required timeframe. Outstanding Review was completed on the 12 Nov 2018.
· PIC will ensure there is evidence that Residents Families and Representatives are involved in Residents Personal Plan Reviews. This will be reflective in the review Minutes of each Resident. [12 Nov 2018]

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/11/2018
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	14/11/2018
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in	Substantially Compliant	Yellow	14/12/2018

	accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	14/12/2018