



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

## Issued by the Chief Inspector

Name of designated centre:	Larassa
Name of provider:	RehabCare
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	20 June 2022
Centre ID:	OSV-0002687
Fieldwork ID:	MON-0028148

## About the designated centre

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

Larassa provides full-time residential support to four adults with an intellectual disability. Residents may also have a secondary diagnosis of mental health difficulties. The service at Larassa is based on a social care support model and provides low to medium support to residents. Larassa is located in a residential area on the outskirts of a town, but close to local amenities such as shops and leisure facilities. The centre is a purpose built bungalow with five bedrooms of which four are used by residents. Residents' bedrooms have access to en-suite bathroom facilities and an additional communal toilet is also available. In addition, residents have access to a kitchen, dining and sitting room area as well as a separate sun room and small conservatory. The centre also has a rear garden with an accessible patio area. Residents are supported by a team of support workers, with one support worker being available at all times, and increasing to two workers dependent on residents' needs and planned activities. Night-time support is provided by a sleep over staff member who is provides on call cover if required.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	2
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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 (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
Monday 20 June 2022	09:00hrs to 13:00hrs	Úna McDermott	Lead

## What residents told us and what inspectors observed

From what the inspector observed on the day of inspection, it was clear that residents in Larassa had a good quality of life where they were supported to be active participants in the running of the centre and be involved in their communities.

This designated service had experienced significant change since the last inspection. This was due to the death of two residents, one recently.

This meant that there were two residents living at Larassa and two vacancies. Furthermore, it meant that the care and support provided in the designated centre was changing. This was based on the assessed needs of the residents and will be expanded on later in this report.

On the day of inspection, both residents were attending their day service and unable to meet with the inspector. However, the person in charge provided resident surveys for review. These provided information on residents' day to day experience of living in Larassa. Residents described feeling happy about living in their home, being happy with the activities that they were involved in and that they felt supported by staff. Furthermore, they said that they knew who to contact if they had a concern, for example; their keyworker or "the staff".

Larassa was a large accessible bungalow close to a busy town. The entrance hallway was bright and welcoming and the atmosphere was homely. There was a communal kitchen, dining and living area with a sun room close by. Furthermore, there was a sitting room to the rear of the property which was very pleasant. This meant that residents had a number of rooms to host visitors, watch television or relax in private if required. There were 5 bedrooms in this house, one of which was a staff office and sleepover room. The inspector did not view the resident's bedrooms on the day of inspection. There was a large accessible shower room, a shared shower room and toilet at the rear of the property. These were clean and in good repair. The back garden was very well presented. There was a patio area and ramped access to the lawn. Garden furniture was provided and there were raised beds for residents use. The bins were stored neatly and were closed.

There were a number of notice boards and posters displayed throughout the centre. Most were easy-to-read to support residents' understanding. These included a picture of the complaints officer and their contact number, and for the advocacy officer, the designated officer and the confidential recipient. Information was displayed in relation to the risks associated with the COVID-19 pandemic. In the kitchen, there was an easy-to-read menu displayed so that residents were aware of what meal was planned and who was to assist with cooking.

The person in charge told the inspector that residents had good contact with their friends and families. This was supported through visits home, hosting visitors, telephone calls and video calls. Furthermore, it was clear that the residents living in

Larassa were active members of their community. Activities included, going for coffee, going shopping, going to the spa, going to the hair dresser and going horse riding. The person in charge explained that residents had decided not to attend their day service on Fridays as they preferred to stay at home or to plan activities of their choosing.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

## Capacity and capability

The inspector found that there were management systems in place in Larassa which ensured that the service provided was safe, consistent and appropriate to residents' needs. As previously mentioned, some of these systems and processes were changing due to the reduced number of residents residing in Larassa at the time of inspection. Furthermore, the provider was subject to a cyber-attack this year. This had a significant impact on the service and the person in charge told the inspector that efforts to resume normal working computer systems were ongoing.

The provider had prepared a statement of purpose which was available in writing and contained the information set out in Schedule 1 of the regulations. There was evidence of regular review and a copy of the statement was available in easy-to-read format in the residents' bedrooms.

A review of policies and procedures as required under Schedule 5 of the regulations was completed. This was an action from the previous inspection and for the most part, the policies reviewed were up to date. However, the person in charge explained that some policies and procedures were not updated and this was due to the ongoing impact of the cyber-attack. A process was in place to address this.

There were no staff on duty in Larassa during the time of inspection as they were due to work later that afternoon. The person in charge was present as was a team leader. This showed that there was a defined management system in place, with clear lines of authority and support available. The inspector viewed the staff rota and found that it was an accurate reflection of the staff due to work that day. As previously referred to the staff rota was amended recently and this was due to the change in the assessed needs of the residents living in Larassa. For example; the waking night staff member was discontinued and a sleep over staff remained. Furthermore, there was a change in the number of staff members on duty during the daytime and evening hours. These changes were in line with the number of residents living there, their assessed needs, the statement of purpose and the size and layout of the designated centre. An on-call arrangement was in place which provided relief staff if required. The person in charge told the inspection that for the

most part, relief staff members were familiar with the residents, their support needs and with the designated centre. This ensured that consistency of care was provided.

Staff had access to training as part of a continuous professional development programme. A training matrix was in place and a sample of training modules were reviewed. The inspector found that these were up-to-date. Furthermore, staff supervision sessions were taking place for staff members in line with the providers policy and staff meetings were held regularly.

The provider ensured that an annual review of the service occurred each year, which provided for consultation with residents and their families and the unannounced six-monthly provider led audit was up to date. There were systems in place for regular internal audits to occur and these took place daily, weekly and monthly. Audits included cleaning audits, health and safety, fire safety and medication management.

Overall, Larassa was found to provide good quality, person-centred care to residents and the management and staff team were responsive to the individual needs of residents. However, some improvements in the oversight of infection prevention and control measures were required and these will be expanded upon in the following section of this report.

### Regulation 15: Staffing

The provider had ensured that the number, qualifications and skills mix of staff was appropriate to the number of residents, their assessed needs, the statement of purpose and the size and layout of the designated centre. An on-call arrangement was in place which provided relief staff if required. The person in charge told the inspection that for the most part, relief staff members were familiar with the residents, their support needs and with the designated centre. This ensured that consistency of care was provided.

Judgment: Compliant

### Regulation 16: Training and staff development

Staff had access to training as part of a continuous professional development programme. A training matrix was in place and a sample of training modules were reviewed. The inspector found that these were up-to-date. Furthermore, staff supervision sessions were taking place for staff members in line with the providers policy and staff meetings were held regularly.

Judgment: Compliant

### Regulation 23: Governance and management

The provider ensured that an annual review of the service occurred each year, which provided for consultation with residents and their families and the unannounced six-monthly provider led audit was up to date. There were systems in place for regular internal audits to occur and these took place daily, weekly and monthly.

Judgment: Compliant

### Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which was available in writing and contained the information set out in Schedule 1 of the regulations. There was evidence of regular review and a copy of the statement was available in easy-to-read format for the residents use.

Judgment: Compliant

### Regulation 4: Written policies and procedures

The provider had ensured that written policies and procedures in line with requirements of Schedule 5 were available for staff. For the most part, the policies were up to date. However, some policies and procedures were not updated and this was due to the ongoing impact of the cyber-attack. A process was in place to address this.

Judgment: Compliant

## Quality and safety

This centre provided a good quality and safe service where the care and welfare needs of residents was supported. There was evidence of residents' involvement in decision making and the centre was found to actively promote their rights. It was evident throughout the documentation review that residents were consulted about



the running of the house and about their day-to-day activities. However, some improvements were required in the measures in place to prevent and control the spread of infection in order to further improve the quality of care and support provided.

The inspector found that the facilities and supports provided at Larassa met with the assessed needs of the residents. Residents had an individual assessments of needs completed and these were up-to-date. Person-centred plans were in place and there was evidence of residents' participation in personal goal setting. For example; to plant flowers and onions in the garden, to enrol in a jewellery making course and to have a night away.

The provider and the person in charge had ensured that that the individual healthcare needs of residents were assessed and supported. Residents had access to a range of allied healthcare professionals, with evidence of appointments with physiotherapy, occupational therapy, chiropody, dental care, opticians, audiology and consultant lead services as required. Each resident has a hospital passport which outlined their individual needs in the event of a hospital admission. The inspector found that where a resident choose to decline medical support that this was respected, for example; it was documented that one resident choose not to attend dietetic services as they felt that they 'already knew what to do'.

Residents who required support with behaviours of concern had up-to-date support plans in place. These support plans were reviewed regularly by the staff team and the relevant members of the multidisciplinary support team and included comprehensive detail on the proactive strategies in place. For example; social stories and relaxation techniques. Furthermore, there was evidence that staff were trained in how to use the positive behaviour support plans correctly. Restrictive practices were in use in this centre and were found to be assessed in terms of the risks involved, to consider the impact on the resident and to ensure that they were the least restrictive measure for the shortest duration of time.

There were systems in place for the identification, assessment and management of risk, including a site specific safety statement and emergency plans in the event of adverse events. Risks that had been identified at service and resident level had been assessed and kept under regular review. For example; risk assessments on money management, spending time alone and risks associated with individual healthcare conditions. A positive risk taking approach was used which will be expanded on in the next paragraph.

The provider ensured that the designated centre was operated in a manner that respected the rights of the individuals living there. The person in charge told the inspector that residents "valued their independence" and that a positive risk taking policy was in place. A review of the documentation provided evidence of residents telling staff about their hopes and wishes. For example, one resident wished to travel to their day service independently. A risk assessment was completed, control measures were identified and a step-by-step programme of support was put in place. This was regularly reviewed and gradually reduced over time. Another example included a residents wish to attend medical consultations in private and

there was evidence that these wishes were respected.

The provider ensured that there were systems in place for the prevention and control of infection including COVID-19. These included a safety pause which was used on entry to the house, staff training, guidance in the form of posters on display and availability of hand sanitisers and personal protective equipment (PPE). The COVID-19 self assessment tool was available and up to date. There was a COVID-19 local response plan in place and this included person specific isolation plans if required. However, although regular cleaning schedules and audits were in place, the inspector noted that many doors, door handles and the railings outside were lined with reflective tape which had evidence of wear and tear. Furthermore, some doors and walls had velcro tape attached. This meant that it was not possible to clean these high-touch areas effectively in order to prevent and control the spread of infection. Secondly, some guidance information and posters displayed required review to ensure that they were up-to-date with current public health guidelines. These included the posters and stickers displayed on some entrances and the guidance used as part of the safety pause folder. Finally, the inspector found that the process in place to support a residents use of a sharps box were not effective as it was found to be blood stained and required cleaning. The person in charge addressed this on the day of inspection and updated the risk assessment accordingly. A plan was put in place to support the resident with the safe completion of this task.

Overall, the inspector found that residents in this designated centre had a good level of care and support provided, where their individual rights were respected and their goals supported. Larassa was a well equipped and comfortable home which was welcoming, spacious and met with the assessed needs of the residents. Some improvements in the measures in place to prevent and control the spread of infection were required in order to further improve the quality of care and support provided.

## Regulation 26: Risk management procedures

There were systems in place for the identification, assessment and management of risk, including a site specific safety statement and emergency plans in the event of adverse events. Risks that had been identified at service and resident level had been assessed and kept under regular review. For example; risk assessments on money management, spending time alone and risks associated with individual healthcare conditions.

Judgment: Compliant

## Regulation 27: Protection against infection

The provider ensured that there were systems in place for the prevention and control of infection including COVID-19. These included a safety pause which was used on entry to the house, staff training, guidance in the form of posters on display and availability of hand sanitisers and personal protective equipment (PPE). The COVID-19 self assessment tool was available and up to date. There was a COVID-19 local response plan in place and this included person specific isolation plans if required. However, although regular cleaning schedules and audits were in place, the inspector found that the use of reflective tape and velcro tape on high touch surfaces required review. Furthermore, guidance required updating and the process in place to support a resident with their use of a sharps box required review.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

The inspector found that the facilities and supports provided at Larassa met with the assessed needs of the residents. Residents had an individual assessments of needs completed and these were up-to-date. Person-centred plans were in place and there was evidence of residents' participation in personal goal setting.

Judgment: Compliant

## Regulation 6: Health care

The provider and the person in charge had ensured that that the individual healthcare needs of residents were assessed and supported. Residents had access to a range of allied healthcare professionals as required. The inspector found that where a resident choose to decline medical support that this was respected, for example; it was documented that one resident choose not to attend dietetic services as they felt that they 'already knew what to do'.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Residents who required support with behaviours of concern had up-to-date support plans in place. These support plans were reviewed regularly by the staff team and

the relevant members of the multidisciplinary support team and included comprehensive detail on the proactive strategies in place.

Judgment: Compliant

### Regulation 9: Residents' rights

The provider ensured that the designated centre was operated in a manner that respected the rights of the individuals living there. The person in charge told the inspector that residents "valued their independence" and that a positive risk taking policy was in place. A review of the documentation provided evidence of residents telling staff about their hopes and wishes. For example, one resident wished to travel to their day service independently. A risk assessment was completed, control measures were identified and a step-by-step programme of support was put in place. This was regularly reviewed and gradually reduced over time.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
<b>Quality and safety</b>	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Larassa OSV-0002687

Inspection ID: MON-0028148

Date of inspection: 20/06/2022

## 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 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <ul style="list-style-type: none"> <li>• The PIC has arranged for the removal of Velcro and reflective tape from high touch surfaces by a professional cleaning company, this is scheduled to be completed by 20/07/22.</li> <li>• All COVID-19 guidance displayed in the service has now been updated to reflect current guidelines.</li> <li>• A risk management plan and cleaning check sheet has been implemented by the PIC in relation to supporting a resident to manage her sharps box. Staff are now adhering to her updated support plan for her sharps management. The PIC is going to review this during the monthly PIC audit and the TL will review this weekly when reviewing cleaning schedules.</li> </ul>	

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	20/07/2022