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:	Tulla House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	15 November 2023
Centre ID:	OSV-0005323
Fieldwork ID:	MON-0035520

About the designated centre

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

This is a service providing full-time residential care and support to four adults with disabilities. It consists of a large two storey, five bedroom house, located in a rural location on the outskirts of a small town in county Westmeath. Each resident has their own large bedroom (all of which are en-suite) and are decorated to their individual style and preference. Communal facilities include a large well equipped kitchen/dining room, a utility room, a living room, a small conservatory, staff sleepover facilities, a downstairs bathroom and an open area TV space. There are spacious well maintained grounds surrounding the centre with adequate private car parking space to the front and rear of the building. The centre is staffed on a 24/7 basis with a full time person in charge,a team leader, a deputy team leader, a team of social care workers and assistant support workers. Transport is provided so as residents can attend day service placements and access community based activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 15 November 2023	11:00hrs to 17:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted in order to monitor on-going compliance with regulations and standards.

On arrival at the centre the inspector found that residents were engaged in morning activities with the support of staff. Throughout the course of the inspection, some residents chose to invite the inspector to their rooms, and some people preferred to interact with their familiar staff members.

Each resident had their own spacious room with an in-suite bathroom, and their rooms were kept in the way that they chose, with was many or as few items as each resident preferred. Each person had their own personal possessions, photographs, pictures and furniture as they chose.

Two bedrooms were upstairs, and on the landing of this floor was a seating and tv area. This was frequently the preferred area of the house for one of the residents who preferred to spend some of their time alone watching the television.

One of the residents showed the inspector their room, and showed various items relating to their hobbies and their collections. The resident was very clear about making their own choices, and told the staff about the shop they wanted to go to later. During the course of the conversation the resident indicated that they did not want a wall chart relating to communication and activities, and this was removed by the staff during the day. The resident spoke about a recent event they has attended and spoke about how they had enjoyed the outing, and described the things they had done at it. This resident had a job in the local community, and spoke about this with enthusiasm.

Another resident was relaxing in the living area with a morning drink, and did not choose to engage with the inspector other than an acknowledgement. The resident was supported throughout the day to engage in activities, and staff supported them to manage behaviours that might be detrimental to their health, whilst also facilitating choice as far as possible.

There were some restrictive interventions in place in the centre, and these were kept under constant review to ensure that they were the least restrictive to ensure the safety and wellbeing of residents.

Another resident who did not interact with the inspector was also observed to be supported in a caring way by staff throughout the day. The inspector saw them watching a favourite tv show in the afternoon, and the resident could be heard vocalising along to it.

Another resident, who was on an outing returned to the centre, and came to show the person in charge a new item that had been purchased during the trip which they

were clearly very excited and happy about. Another resident spoke with staff about their hobby of playing pool, they spoke about joining in at the local pub where they had entered a pool tournament.

Throughout the inspection staff were observed to be communicating effectively with residents, and it was clear from the response of residents that they were comfortable in the presence of their supporting staff team, and were keen to interact with the person in charge.

There various aids to communication in place to support residents, and accessible information had been made available.

Residents were supported in a range of activities, including daily activities, and also special occasions. There were multiple examples of events and outings, and both management and staff prioritised the support for a meaningful day for each resident.

The next two sections of this report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

There was a well-defined management structure with clear lines of accountability. Various monitoring strategies were in place, and these were noted by the inspector to be effective in both ensuring safe services, and in supporting quality improvement in the designated centre. An annual review and six-monthly unannounced visits on behalf of the provider had taken place, and there was a suite of audits undertaken in the centre and overseen by the person in charge.

There was a consistent and competent staff team, and effective communication strategies between staff members, and between staff and management were in place. Staff training was up-to-date, and staff were knowledgeable about the care and support needs of residents.

There was a clear and transparent complaints procedure, and although there were no current complaints, the process was readily available to residents and their representatives.

The centre was adequately resourced, and all required equipment was made available to residents.

Regulation 14: Persons in charge

There was an appropriately skilled and qualified person in charge who had clear oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual staffing roster was maintained as required by the regulations and there were sufficient numbers of staff to meet the needs of residents both day and night, and residents had access to registered nurse who attended the centre once a week, or more frequently if required.

Recruitment was had recently been completed in relation to employing nurses full time in the designated centre due to the identified changing healthcare needs of one of the residents.

Staff engaged by the inspector were knowledgeable about the care and support needs of all residents, and were observed to be offering care and support in a kind and respectful manner, and to be supporting residents to make their own decisions.

Judgment: Compliant

Regulation 16: Training and staff development

All mandatory training was up-to-date, and the person in charge had oversight of training needs. Additional on-site training had been provided to staff in relation to the specific needs of residents

There were regular staff supervision conversations held with each staff member, and records of these conversations indicated that they were meaningful, and allowed for a two way conversation between staff and their supervisor.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained which included all the information required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure whereby the person in charge was supported by two team leaders so that there was always a manager on duty in the designated centre.

An annual review of the care and support offered to residents had been developed in accordance with the regulations, and six monthly unannounced visits on behalf of the provider had taken place as required. These were detailed documents, and there was an easy read version of the annual review made available to residents.

There was some ambiguity in the records of the six monthly visits, where under a heading of 'findings' there was reference to issues that did not relate to the designated centre. For example, there was reference to the menstrual cycle, and none of the residents in the centre had menstrual cycles. However, it was clear from further sections in the reports that there was a meaningful and centre specific audit undertaken in various areas. This anomaly was explained by the audit tool having a drop-down menu whereby the auditor selected the areas examined, and was misnamed as 'findings'. The inspector was satisfied that this was an error in documentation, and that the audits and reports provided clear oversight of the care and support offered to residents. There were clearly defined required actions identified through this process, and a system of oversight to ensure that actions were completed. All of the actions reviewed by the inspector had been completed, or were within their agreed timeframes.

Further local audits had been completed, including audits of medication management, personal plans and residents' finances. Areas for improvement were identified in these audits, and required actions were monitored. For example the audits of personal plans resulted in a quality checklist, and these were overseen by the appropriate members of the multi-disciplinary team (MDT). The keyworker for each resident was responsible for ensuring that actions identified in the checklist were completed, and once completed there was a system whereby the person in charge was alerted to the completion of the actions for sign off. The actions taken were further reviewed by members of the MDT prior to a final close off.

There were various strategies to ensure effective communication with the staff team, including regular staff team meetings. Some of these staff meetings were attended by members of the MDT in order to give a first-hand account of any changes required in the support of residents, for example the speech and language therapist had attended the last meeting and had given a presentation in relation the changing needs of one of the residents.

These team meetings included a detailed update on each resident, and discussions were held in relation to their goals, activities and safeguarding. A review of any actions required in terms of quality improvements were also discussed a these

meetings.

In addition there was a detailed daily handover, and any issues that required action or new information remained on this document for until each staff member had been on duty.

There were also quarterly meetings of the persons in charge in the area to share learning and to offer peer support to persons in charge.

Accidents and incidents were recorded and reported appropriately, and there was a clear system of escalation to senior management or to the MDT of any incidents that could not be managed locally.

All the findings of the previous inspection relating to some infection and control issues found in relation to the premises had been actioned, and had resulted in improvements for residents, for example one of the issues identified in an en-suite bathroom of one of the residents had been rectified to a high standard, and the bathroom was tiled and refurbished.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were contracts of care in place for each resident which included all the required information. These contracts had been made available to residents in an easy read version, and had been signed either by the resident of by their representative.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place, and the information in relation to raising a complaint was made available to residents and their friends and families. There were no current complaints, however the complaints log included detail of any outcomes and a record of the satisfaction of the complainant.

Judgment: Compliant

Regulation 21: Records

All required records required by the regulations under Schedule 2 in relation to staff were all in place, including garda vetting, references and employment history.

All required records required by the regulations under Schedule 3 in relation to information in respect of each resident was in place including personal information, including the required care and support of residents, the information in relation to healthcare, and a record of any belongings of the residents.

All required records required by the regulations under Schedule 4 were in place including a Statement of Purpose and Function, a Residents' Guide, and copies of previous inspection reports were maintained in the centre.

All records or documents that were required to be available in the centre were in place.

Judgment: Compliant

Quality and safety

Overall residents were supported to have a comfortable life, and to have their needs met. There were multiple activities made available to residents, and support for quiet times and restful periods as preferred.

Healthcare was well managed, and behaviour support was provided as required, both in relation to the safety of residents, and to the availability of opportunities.

Communication with residents had been prioritised, particularly where residents had difficulty in this area, and effective communication was observed through the course of the inspection.

Both risk management and fire safety measures were appropriate, and it was clear that all efforts were in place to ensure the safety and comfort of residents.

The rights of residents were supported, and various examples of the ways in which the rights residents were upheld were evident.

Regulation 12: Personal possessions

There were clear records of the possessions of each resident, and these records and had been regularly reviewed and updated on a monthly basis.

Personal spending money held by each resident in the designated centre was well managed and monitored, and there were consistent checks in place. Two staff

members checked the amount of money held by each resident twice a day, and any purchases were accurately recorded. There was an entry for each purchase that was signed by two staff members, and a receipt was available. A reducing balance was maintained following each purchase, and balances checked by the inspector were correct.

Residents had accounts, for example a post office account, and a sample of the records relating to these accounts was checked and found to be correct. There was a weekly audit of each resident's finances which included cross reference to their accounts.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were supported to have a balanced and varied diet, and where residents required modified diets these were in accordance with their assessed medical needs and had been recommended by the speech and language therapist. Staff were knowledgeable in relation to any such requirements, and it was evident that the choices of residents in relation to their meals and snacks was respected. Meals were planned at a weekly residents' meeting, although residents made changing choices on a daily basis.

On the day of the inspection each resident had a different lunch, and there were two different dinners prepared as requested by residents.

There were frequent outings for meals and snacks, and residents enjoyed takeaways at the weekends.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy in place which included all the information required by the regulations. There was a risk register in place, and all identified risks to residents had a risk assessment and risk management plan in place.

Risk management plans were appropriately risk rated, and included the required control measures to mitigate the identified risk. Control measures identified as being required to mitigate the healthcare risk related to the behaviour of one of the residents was observed by the inspector to be implemented appropriately and safely, while still allowing the resident to make choices.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre. All equipment had been maintained, and there was a current fire safety certificate. Regular fire drills had been undertaken, and each resident had been involved in a fire drill. The records of fire drills included information as to how each resident responded to the drill. There was a record that indicated that each staff member had been involved in fire drills.

There was an up-to-date personal evacuation plan in place for each resident, giving clear guidance as to how they would respond in the event of an emergency and how staff should respond to ensure their safety.

Staff were all in receipt of fire safety training, and staff could describe the actions they would take in the event of an emergency.

Judgment: Compliant

Regulation 6: Health care

Health care was well managed and monitored, so that both long term and changing needs were met by the staff team.

Any changes in the presentation of residents was responded to in a timely manner. There had been a recent deterioration in health for one of the residents, and all the required supports had been put in place, with additional nursing support in the process of being arranged by the provider.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. Proactive strategies were clearly identified, and all staff were aware of these strategies, and were able to describe the ways in which they minimised the risks posed by behaviours of concern for each resident.

Reactive strategies were clearly documented, and were regularly reviewed. Where

some restrictive practices had been identified as being necessary to ensure the safety of residents, these were well defined and there was detailed guidance in place to ensure that they were applied appropriately, and that they were always the least restrictive required to ensure the safety of residents. They were regularly reviewed, and again staff were knowledgeable in relation to all of the requirements.

Where restrictive interventions were identified as being required to ensure the safety of residents, these were kept under regular review, and one such restriction had recently been removed following a detailed review of all restrictive practices.

However, not all restrictions were recorded appropriately. Where restrictions were applied and removed intermittently there were no detailed records of each occasion of use.

Judgment: Substantially compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were aware of the content of this policy, and knew their responsibilities in relation to safeguarding residents. Staff were in receipt of up-to-date training in safeguarding, and could discuss the learning from this training.

Where safeguarding issues had been identified there were clear and detailed safeguarding plans in place which outlined the measures to be taken to mitigate any risks to residents. Any safeguarding plans had been implemented effectively and were closed.

Judgment: Compliant

Regulation 9: Residents' rights

There was an ethos of upholding and supporting the rights of residents, and of ensuring on-going consultation with residents. A weekly 'service users forum' was held at which various aspects of daily life were discussed, and at which residents were encouraged to express their views and choices.

The person in charge had undertaken training in the rights of residents in relation to decision making, and this issue was under discussion at the regular meetings of persons in charge. The person in charge outlined plans to present information to the staff team at a forthcoming staff meeting.

Residents had the keys to their own rooms, and staff respected their privacy by not

entering the rooms without permission.

However, when the inspector visited the bedroom of one of the residents it was immediately obvious that there was a pervasive and unpleasant odour. Staff explained that the bin in the corner of the room was used to dispose of incontinence wear, and that the disposal of these items took place every two weeks, and that the bin disposal date was due. It was therefore clear that used incontinence wear was kept in the bin in the bedroom for two weeks, and on the day of the inspection the bin was so full that the lid did not close. The person in charge immediately undertook to make alternative arrangements to ensure that used incontinence wear was not stored in the resident's bedroom.

Residents were engaged in various activities of their choice, and there was an emphasis in the designated centre of supporting residents to have a meaningful life. Residents were supported in various ways to engage in meaningful activities. Each resident had a meaningful activities review document which was submitted by the person in charge to the area director every six weeks, so as to ensure continual oversight of activities. A daily planner was in place for each resident, and a record of the implementation of this planner was maintained.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Tulla House OSV-0005323

Inspection ID: MON-0035520

Date of inspection: 15/11/2023

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 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: To demonstrate that the designated Centre is in line with Regulation 7 (4), the registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based by: 1. PIC and Behavioural Specialist completed a review of the Centre Specific Restrictive Practice Register on the 20th of November to review all restrictions in place in Centre (Completed). 2. PIC has updated the Register of all restrictions and the date they were reduced and or removed is in place to ensure that all restrictions are documented accurately (Completed). 3. Log to be implemented where buckle boss/harness is prescribed for Service Users which clearly indicates intermittent use and length of time it was used for (Due Date: 12th January 2024). 4. Restrictive Procedure Policy to be updated to reflect implementation of Log in Transport which clearly indicates intermittent use and length of time it was used for (Due Date: 12th January 2024).	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: To demonstrate that the designated Centre is in line with Regulation 9 (3), the registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations, and personal information by:

1. PIC to ensure daily safety walks are in place to ensure incontinence bin are checked and they are stored appropriately (Completed).

2. PIC has arranged for the frequency of the Waste Disposal Company to increase bin collections to weekly (Completed).

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 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	12/01/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and	Substantially Compliant	Yellow	18/12/2023

	personal information.			