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:	Belfry House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Cavan
Type of inspection:	Unannounced
Date of inspection:	11 April 2023
Centre ID:	OSV-0008157
Fieldwork ID:	MON-0035328

About the designated centre

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

This centre comprises of a large detached house in a tranquil rural setting in County Cavan. There are four stand alone apartments each consisting of a sitting room/living room and a large ensuite bedroom. The main part of the house consists of a kitchen, staff office, a utility facility, a bathroom, sitting room and a double ensuite bedroom. To the rear of the property there is a games room/relaxation room/visitors room and a laundry facility. There are well maintained gardens to the front and rear of the property with adequate private care parking space. The centre is staffed by a person in charge, a team leader, two deputy team leaders and a large team of assistant support workers. Transport is provided to the residents for social outings, drives and trips to nearby towns and villages.

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 (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
Tuesday 11 April 2023	11:30hrs to 19:30hrs	Raymond Lynch	Lead

What residents told us and what inspectors observed

This inspection was unannounced so as to monitor the service against the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and adults) with disabilities) Regulations 2013 (the Regulations). The inspection was completed over one day and the inspector met and spoke briefly with two residents living in this service.

This centre comprised of a large detached house in a rural setting. The main house consisted of a kitchen, staff office, a utility facility, a bathroom, sitting room and a double ensuite bedroom. There were also four stand alone apartments each consisting of a sitting room/living room and a large ensuite bedroom. To the rear of the property a visitors room and a laundry facility were available to the residents.

On arrival to the centre the inspector was met with by the team leader and was invited to sanitize their hands and had their temperature taken prior to entering the main premises. It was observed that all staff were wearing appropriate personal protective equipment (PPE) over the course of the day. The inspector was shown around the premises by the team leader and observed that they were modern, clean and well maintained.

On the day of this inspection one of the residents were visiting their family and the inspector did not get to meet with them. However, another resident invited the inspector to view their apartment and it was observed to be decorated to their individual style and preference. For example, they had put up Easter decorations on their sitting room wall. The resident was relaxing watching television and had the support of two staff members. They said that they liked animals and they had a pet budgie which they took care of themselves. While the resident appeared comfortable in their surroundings they said to the inspector that they might like to move service sometime in the future.

Four vehicles were available to the residents for ease of access to the community. The team leader informed the inspector that residents liked to go for drives, have coffee out, go to the pub or get their nails done. However, it was observed that none of the residents were attending a day service and the process of individual planning with them required review so as to ensure they had more opportunities to experience a meaningful day, based on activities of their choosing and preference.

Another resident was observed having a cigarette outside their home. They didn't interact with the inspector but spoke to the team leader with the inspector present. The team leader was observed to be kind, caring and reassuring in their interactions with the resident. However, on the day of this inspection it was raining heavily and the inspector observed that there was no designated sheltered area available for the resident to smoke in comfort.

Later in the inspection process another resident spoke briefly with the inspector.

They reported that they liked their home and the inspector observed positive interactions between this resident and staff members present. However, when asked what they were going to do with their evening they told the inspector that they didn't know and that there wasn't much to do.

The inspector spoke with two staff members over the course of this inspection. Both were observed to speak positively about the one resident they were supporting and were able to talk the inspector through one of the residents care plans. Additionally, both informed the inspector that they had received training in safeguarding and would have no issues with reporting any concerns (if they had any) to a member of the management team.

Overall, staff were observed to be caring in their interactions with the residents and residents appeared comfortable in the company and presence of staff. However, the supervision process for staff required review so as to ensure all staff were receiving timely and adequate supervision.

The above is discussed in more detail in the next two sections of this report.

Capacity and capability

While systems and staff were in place to meet the needs of the residents, the governance and management arrangements and the process of staff supervision required review.

Four weeks before this inspection the service had deployed a new person in charge and team leader to manage the centre. The person in charge was not met with as part of this inspection process as they were on leave however, they were a qualified professional with relevant experience of managing services for people with disabilities. The team leader was also a qualified professional and they facilitated the inspection process with support from senior management.

The team leader explained the staffing arrangements in place for each apartment that made up the designated centre and having viewing a sample of rosters from March 2023, the inspector found that there were adequate staffing numbers in place as described by the team lead.

From viewing a sample of files the inspector also saw that staff were receiving training so as to meet the assessed needs of the residents. For example, staff had training in safe administration of medication, basic first aid, protection and welfare, how to manage behaviours of concern and how to take blood pressure. Additionally, from speaking with staff over the course of this inspection, the inspector observed that they were aware of care plans in place for the resident they were supporting.

However, staff supervision was not up-to-date and some staff had yet to receive supervision. This was concerning as the inspector observed that some staff practices

required review with regard to the reporting of adverse incidents and behaviours of concern occurring in the centre. While the person in charge and team leader were aware of these issues and had plans in place to address them (to include developing a schedule to provide timely supervision to all staff as a way to review work related practices and provide support), they had not been fully addressed at the time of this inspection.

The statement of purpose was reviewed by the inspector and found to meet the requirements of the regulations. It detailed the aim and objectives of the service and the facilities to be provided to the residents. The team leader and management team were also found to be aware of their legal remit to S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations) and were responsive to the inspection and regulation process. Additionally, the person in charge was notifying the Chief Inspector of any adverse incident occurring in the centre as required by the regulations.

The were clear lines of authority and accountability in the centre and the provider had systems in place to monitor the service as required by the regulations. An annual review of the quality and safety of care for 2022 was completed and a six monthly unannounced visit to the centre had been carried out in November 2022. On completion of these audits, plans of action were being implemented so as to address any issues or concerns highlighted. For example, the auditing process highlighted the need to include a set of floor plans in each residents emergency evacuation plans. This issue had been addressed by the at the time of this inspection.

However, aspects of the auditing process required review so as to ensure the service was at all times appropriate to the needs of the residents and effectively monitored.

Regulation 15: Staffing

The team leader explained the staffing arrangements in place for each apartment that comprised the designated centre.

Three residents were on a 2:1 staffing ratio and the other two residents were on a 1:1 staffing ratio.

Additionally, there was one additional staff member to provide support if required to the two residents on the 1:1 staffing ratio and, a floating staff member was also available to provide support where or if required.

From viewing a sample of rosters from March 2023, the inspector saw that staffing arrangements in place were as described by the team leader and ten staff provided care and support during the day with eight waking staff at night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision was not up-to-date and some staff had yet to received supervision. This was concerning as the inspector observed that some staff practices required review with regard to the reporting of adverse incidents and behaviours of concern occurring in the centre.

For example, two days before this inspection a resident had presented with behaviours of concern to include self injurious behaviour. While this issue was reported to management by the relevant staff, no detailed information on the incident was documented. In turn, the team leader had to contact the relevant staff to find out the details of the incident and enquire if a body chart needed to be completed for the resident.

While the person in charge and team leader were aware of these issues and had plans in place to address them, they had not been adequately addressed at the time of this inspection.

Judgment: Not compliant

Regulation 23: Governance and management

At the time of this inspection there were clear lines of authority and accountability in the centre. A new experienced qualified person in charge had commenced working in the centre in March 2023 who was supported in their role by an experienced and qualified team leader.

However, aspects of the auditing process required review so as to ensure the service was at all times appropriate to the needs of the residents and effectively monitored.

For example:

- the auditing process was not timely in addressing some of the issues as found in this inspection regarding the process of staff supervision and issues related to the individual planning process/assessment of need
- additionally, a resident was observed having a cigarette outside their home. On the day of this inspection it was raining heavily and the inspector observed that there was no designated sheltered area available for the resident to smoke in comfort.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector and found to meet the requirements of the regulations. It detailed the aim and objectives of the service and the facilities to be provided to the residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was notifying the Chief Inspector of any adverse incident occurring in the centre as required by the regulations.

Judgment: Compliant

Quality and safety

While residents appeared comfortable in their home, the individual planning process required review so as to ensure residents had adequate opportunities to experience a meaningful day based on their expressed interests and preferences.

The individual needs of the residents were being supported however, their assessment of need and personal plans required review. For example, residents goals were not being adequately documented or updated and, some goals identified in residents individual personal plans on the computer system were different to the goals filed in the hard copies of their plans. In turn, it was difficult to ascertain what goals had been achieved and in what time frame. Additionally, none of the residents attended a day service and one family member had recently expressed dissatisfaction regarding the level of opportunities available to the residents to engage in social and recreational activities of their choice and preference. On the day of this inspection the inspector observed that one resident remained in bed for most of the day. When they got up later on the inspector asked them had they any plans for the evening and they responded by saying that there wasn't much to do.

Systems were in place to meet and support the healthcare needs of the residents. Residents had access to general practitioner (GP) services and a range of other allied healthcare professionals to include occupational therapy, optician, dentist and dietitian. Care plans were also in place to guide practice however, one care plan for

a resident with epilepsy required review and updating. This issue was actioned under regulation 5: individual personal planning. Residents were also supported to experience positive mental health and where required, access to psychotherapy and psychiatry support was provided for.

Systems were in place to safeguard the residents and where or/if required, safeguarding plans were in place. At the time of this inspection, there were two open safeguarding plans. The inspector reviewed one of these and saw that as per the safeguarding policy, the issue had been reported to the designated officer, safeguarding team, the police and to HIQA. Two staff members spoken with said, if they had any concerns about the welfare of any of the residents they would report them to the person in charge or management team immediately. Additionally, from a small sample of files viewed staff had training in safeguarding of vulnerable adults and information on how to contact the designated safeguarding officer was available in the centre.

Systems were in place to manage and mitigate risk and keep residents safe in the centre. There was a policy on risk management available and each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. For example, where a resident may be at risk in the community, they were provided with 2:1 staff support so as to ensure their safety.

There were systems in place to mitigate against the risk of an outbreak of COVID-19. For example, from a small sample of files viewed, staff had training in IPC. Staff also had as required access to PPE to include face masks which they used in line with public health guidance on the day of this inspection. Adequate hand sanitising gels were available throughout the centre as was COVID-19 related signage.

The premises were laid out to meet the needs of the residents and were found to be generally well maintained, clean and homely on the day of this inspection. An issue to do with a designated smoking area was identified however, this was actioned under regulation 23: governance and management.

From a review and walkabout of the main house only, it was found that adequate fire fighting systems were in place to include a fire alarm, fire extinguishers, fire doors and emergency lighting. Equipment was being serviced as required by the regulations. From a sample of files viewed, staff also had training in fire safety. Fire drills were being conducted in the centre and each resident had a personal emergency evacuation plan in place.

Regulation 17: Premises

The premises were laid out to meet the needs of the residents and were found to be generally well maintained, clean and homely on the day of this inspection. An issue to do with a designated smoking area was identified as part of this inspection however, was actioned under regulation 23: governance and management.

Judgment: Compliant

Regulation 26: Risk management procedures

Systems were in place to manage and mitigate risk and keep residents safe in the centre. There was a policy on risk management available and each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. For example, where a resident may be at risk in the community, they were provided with 2:1 staff support so as to ensure their safety.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place to mitigate against the risk of an outbreak of COVID-19. For example, from a small sample of files viewed, staff had training in IPC. Staff had as required access to PPE to include face masks which they used in line with public health guidance on the day of this inspection. Adequate hand sanitising gels were available throughout the centre as was COVID-19 related signage.

Judgment: Compliant

Regulation 28: Fire precautions

From a review of one of the houses it was found that adequate fire fighting systems were in place to include a fire alarm, fire extinguishers, fire doors and emergency lighting. Equipment was being serviced as required by the regulations. From a sample of files viewed, staff also had training in fire safety. Fire drills were being conducted in the centre and each resident had a personal emergency evacuation plan in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

While the individual needs of the residents were being supported, their assessment of need and personal plans required review so as to ensure their goals were being adequately documented and achieved and to ensure that adequate opportunities to

engage in social, learning and recreational opportunities of their preference were provided for. For example:

- monthly goals required review so as to ensure they were being documented and recorded accurately providing explicit information on what goals had been achieved and in what time frame. Additionally, more information on the supports required to assist residents in achieving their goals was required
- where a goal had not been achieved there was insufficient information recorded as to why this was the case
- none of the residents attended a day service and one parent had recently expressed dissatisfaction regarding level of social and recreational activities available to the residents.

Additionally:

- some residents could make allegations however, there was insufficient information in their individual personal plans/risk assessments as to how this issue should be managed
- some residents could refuse to attend their medical appointments and there was insufficient information available in their personal plans/key working notes as to how the service was supporting the residents to understand the consequences of their decisions or if their GPs were informed
- one resident's individual epilepsy care plan required updating so as to ensure it reflected relevant updates and changes regarding a referral to neurology.

Judgment: Not compliant

Regulation 6: Health care

Systems were in place to meet and support the healthcare needs of the residents. Residents had access to general practitioner (GP) services and a range of other allied healthcare professionals to include occupational therapy, optician, dentist and dietitian. Care plans were also in place to guide practice however, one care plan for a resident with epilepsy required review and updating. This issue was actioned under regulation 5: individual personal planning.

Judgment: Compliant

Regulation 8: Protection

Systems were in place to safeguard the residents and where or/if required, safeguarding plans were in place. At the time of this inspection, there were two open safeguarding plans. The inspector reviewed one of these and saw that as per

the safeguarding policy, the issue had been reported to the designated officer, safeguarding team, the police and to HIQA. Additionally, staff spoken with said they would have no issue reporting any concern they had regarding the quality or safety of care to the management team.
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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Belfry House OSV-0008157

Inspection ID: MON-0035328

Date of inspection: 11/04/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To demonstrate that the Designated Centre is in line with Regulation 16(1)(b) The person in charge shall ensure that staff are appropriately supervised. 1. PIC has completed a supervision schedule in place to ensure all Team Members receive supervision in line with Policy given change of Management in Centre. (Due Date 30 June 2023) 2. PIC and Management Team will continue to complete on the floor mentoring forms with all Team Members and this will be an ongoing process going forward (Due Date 30 June 2023) 3. Tests of Knowledge was created by PIC on Behavioral Plans and Escalation Policy and is being used ensuring Team Members knowledge of plans. (Due Dates 31 May 2023) 4. PIC has arranged Report Writing Training for all Team Members. (Due Date 30 June 2023) 5. PIC has arranged Key working Training for All Team Members (Due Date 30 June 2023)	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To demonstrate that the Designated Centre is in line with Regulation 23(1)(c) The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. 1. Quality Assurance Department will conduct an unannounced visit on behalf of the Registered Provider and will ensure 6 monthly report which will include audit of current	

experiences of Individuals and Supervision. (Due Date 31 May 2023)
2. Following the 6 monthly audit the PIC will complete an action plan as required and closed out within required time frame. (Due Date 30 June 2023)
3. PIC has completed a supervision schedule in place to ensure all Team Members receive supervision in line with Policy given change of Management in Centre. (Due Date 30 June 2023)
4. PIC will ensure all Incidents and Accident Reports are recorded and closed out in a timely manner (Completed)
5. Smoking Shed is being install by the Maintenance Team (Due Date 18 May 2023)

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:
To demonstrate that the Designated Centre is in line with Regulation 05(6)(c) and Regulation 05 (6)(d), 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 plans

1. PIC will ensure all Comprehensive Needs Assessments are updated to ensure they are in line with Individuals Assessed Needs.(Due Date 31 May 2023)
2. PIC will ensure all Personal Plans are updated following the review of the Comprehensive Needs Asssesments to ensure goals are meaningful and inturn these will be comunicated to all Team Members (Due Date 31 May 2023)
3. PIC will completed a full Review of Individuals Risk Assessement to ensure all present control measures are in place and in turn these will be communicated to all Team Members (Due Date 31 May 2023)
4. Following the review of all Comprehensive Needs Assessment all Personal Plans will be updated to ensure they are reflective of all individuals goals and ensure they have a meaninful goals. (Due Date 31 May 2023)
5. PIC will complete a review of all Individual Planners and ensure meaninful activities are being offerd and any refusials will be documented. (Due Date 31 May 2023)
6. PIC has reviewed and updated Individuals Health Specific Epilepsy Manangement Plan (Completed)
7. PIC and Clinic Nurse will ensure all Health Specific Management Plans are reviewed and updated to ensure they include updated information as per assessed needs and these are communcated to all Team Members.(Due Date 09 June 2023)
8. PIC will ensure where Individuals refuse to attend medical appointments a Key Working session will be documented outlining risks of not attending(Completed)
9. MDT to be held in May and June to discuss all Individuals in Centre to review all assessed needs and appointment refusals to ensure all controls in place to support Individuals. (Due Date 30 June 2023)
10. Behaviour Specialist will completed a review of all Individuals Personal Plan and assign actions where required. (Due date 21 June 2023)
Following review of Individual Personal Plans PIC will ensure all action plans are closed out. (Due Date 30 June 2023)

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.	Not Compliant	Orange	30/06/2023
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	30/06/2023
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	Not Compliant	Orange	30/06/2023

	effectiveness of the plan.			
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Not Compliant	Orange	30/06/2023