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:	Steadfast House Residential Service - Group Home
Name of provider:	Steadfast House Company Limited By Guarantee
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	02 November 2022 and 06 December 2022
Centre ID:	OSV-0001631
Fieldwork ID:	MON-0038340

About the designated centre

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

Steadfast house residential service provides care and support to five female residents on a full time basis. Residents are supported on a individual basis in line with their assessed needs, wishes and preferences. The centre has a staff team consisting of a person in charge, a social care worker, and healthcare assistants. The person in charge is supported in their role by the chief executive officer.
The centre is located within walking distance of a town, and residents can access a range of amenities and activities in the local community. Residents are supported by one to two staff during the day and one staff overnight. Four residents attend day services every day, and one resident is supported with activities in the centre and in the community, as is their preference. The premises is laid out to meet the individual and collective needs of residents in a homely environment.

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
Wednesday 2 November 2022	10:00hrs to 18:35hrs	Caroline Meehan	Lead
Tuesday 6 December 2022	10:15hrs to 16:45hrs	Caroline Meehan	Lead
Tuesday 6 December 2022	10:15hrs to 15:00hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

From meeting residents and observations during the inspection, residents appeared content living in the centre, and had varied choices regarding how they wished to spend their day. Most residents attended day services, and for one resident who had retired, they chose where they would like to go, and what they preferred to do on a daily basis.

The inspectors met with the five residents over the course of the inspection. On arrival to the centre, an inspector spoke with a resident, who seemed in good spirits, and told the inspector they had retired, but still visited the day centre once a week. Later in the day an inspector spoke to two other residents, both of whom had attended day services that day. One resident was supported by staff to chat with an inspector and they stated they had enjoyed a coffee out during the day, and that they were looking forward to visiting relatives at home the week following the inspection.

Another resident told an inspector that things were good in the centre, and spoke positively about the support they had been given when they were feeling unwell the previous week. The resident also told the inspector about the support they received from an allied health care professional and the staff to manage their mobility, and how they had received timely support when a recent concern regarding their mobility had presented. The resident told an inspector they felt safe in the centre. The resident also spoke about going to their preferred hairdresser in the local town, and enjoys getting their hair done there.

Staff were seen to be kind and respectful when helping and talking to residents. For example, asking residents what they would prefer to do that day, and sensitively offering a resident support to attend to their personal care, as well as helping a resident chat with an inspector. A staff member had supported a resident to do some Christmas shopping, and the resident showed an inspector some of the purchases they had made. Residents said they were looking forward to Christmas, and were going on a seasonal outing the following day.

The centre was located on the outskirts of a large town, and transport was provided in order for residents to go on social outings and to access the community for appointments or to attend day services. The premises was well laid out to meet the needs of residents, and each of the residents had their own room, with assistive equipment provided to meet their specific needs.

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

Capacity and capability

This centre was last inspected in August 2022, the purpose of which was assess if the provider had sustained improvements in the centre. Significant issues of concern were identified during this inspection and as a result the provider had been issued with a notice of proposal to cancel the registration of this centre in September 2022. The provider subsequently submitted written representation to the Health Information and Quality Authority (HIQA) in October 2022, which outlined the measures the provider was taking to bring the centre into compliance. This inspection was carried out to inspect against the representation received from the provider.

The inspection took place over two days, one day in November 2022, and a second day in December 2022. Initially concerns were identified with the governance and management of the centre, specifically in relation to the remit of the person in charge, safeguarding residents and incident management, however, the provider had taken actions to mitigate these risks by the second day of inspection.

Additional support had been provided to the person in charge to manage two designated centres, and a full-time clinical nurse manager 1, as well as two team leaders had been appointed in the service. The provider had put in place revised systems for monitoring the centre, including the development of a quality improvement plan, and enhanced review mechanisms between the person in charge and the registered provider representative. In addition two new members had been appointed to the board of directors, and there were improved reporting systems put in place to report any deficits to the board. Staff had also been provided with clear information on their roles and responsibilities particularly in relation to risks and incidents, and this was supported with the development of a revised incident and risk policy.

There were sufficient staff employed in the centre, and additional staff could be provided in the event of an adverse incident or if more staff support was needed in the centre.

Regulation 14: Persons in charge

The provider had initially employed a clinical nurse manager 1 on a part time basis to support the person in charge in their role, and subsequently employed a full time clinical nurse manager, who was based in the second designated centre under the remit of the person in charge. The inspectors met with the clinical nurse manager, who described their role, responsibilities, and reporting mechanisms in order to review and escalate issues as they arose, with the person in charge. The clinical nurse manager also described the recent implementation of the quality improvement plan, and the on- call arrangements should staff require assistance in the absence of

the person in charge, or during out of hours. This meant there were arrangements to support the person in charge with the operational management and administrative functions of the centre.

Two social care workers had also been employed as team leads within the current staffing capacity, and the clinical nurse manager told inspectors the social care workers were supporting the person in charge with mentorship for health care assistants, social care activities for residents, and the development of residents' personal plans. Overall the inspector found the revised arrangements could ensure that the arrangement for the person in charge to manage two designated centre, with the support of a full time clinical nurse manager, and two team leaders, could ensure the effective management of the centre.

Judgment: Compliant

Regulation 15: Staffing

The inspectors reviewed the staffing arrangements in line with the details set out in the provider's compliance plan and the representation. The provider had employed a clinical nurse manager 1, and while two social care workers had also been employed, these were not additional posts as stated in the provider's compliance plan. The inspectors reviewed rosters for the two preceding months and found the whole time equivalents in the centre had increased by 0.2 of a post overall to 6.2 whole time equivalents.

There were sufficient staff employed with the appropriate skills, experience and knowledge to meet the needs of the residents. There was one staff on duty at night time from 9pm until 9.15am the following morning, and one staff worked Monday to Friday from 7.30am to 10.00 am. An additional staff member also worked from 9.00am to 9.15pm. This meant there were three staff on duty in the morning to support residents with their morning routine. One staff member was in the centre from 10am to 3:30pm, and a second staff member worked from 3.30pm to 9pm. At the weekends there were two staff on duty all day, and one staff at night time.

Arrangements were in place by the end of the inspection, for additional staff support to be made available should the need arise, and staff were clear on the process for requesting these resources.

Judgment: Compliant

Regulation 23: Governance and management

Improved arrangements were either in place, or in the process of being

implemented in the centre, and the provider had responded to risks which had been identified through the inspection process, and their own auditing systems, to ensure the services residents received were safe and consistent. These had included responding to safeguarding risks, and to inadequate risk and incident management systems. As a result, all safeguarding risks had been identified, with clear plans in place to reduce the risk of harm to residents. Similarly, the incidents and risk management systems had been reviewed, and staff had received instruction on their responsibilities, and on the procedure for reporting incidents.

Over the course of the inspection, the inspectors interviewed the registered provider representative, the clinical nurse manager deputising in the absence of the person in charge, and a recently appointed clinical nurse manager 1, who all described the revised governance and management arrangements. The provider had developed and implemented a quality improvement plan which took account of issues identified through self assessment, and through previous inspections. The provider outlined their intention to continually review the quality improvement plan, as well as safeguarding and adverse incidents, and weekly meetings with the person in charge and registered provider representative were scheduled to take place.

The inspectors reviewed the quality improvement plan, and actions were developed for all identified issues. Actions were either completed within the specified timeframe, or not due for completion yet.

Team and management communication was also identified by the provider as an issue of concern, and the provider had taken actions to mitigate these issues. An external consultant employed by the provider, facilitated staff meetings, where roles and responsibilities were discussed. Staff were also provided with information on the quality improvement plan implemented by the provider and their role in its implementation was clearly outlined.

The external consultant also met with the board of directors, chief executive, and person in charge on a number of occasions. The provider had outlined in their compliance plan that the role of the external consultant would be to support the board of directors in their roles and responsibilities, agree an improvement plan, and oversee it's implementation. A representative from the funder was also in attendance at these meeting, and had provided support directly to the person in charge in relation to their oversight in the centre. While initially inspectors found safeguarding risks and incidents were not being escalated to the board of directors as recommended by the external consultant, the provider had responded by the second day of inspection. In the interim a revised incident and risk management policy had been developed which outlined that all active and new risks were to be reviewed at monthly Board of Director meetings, and the person in charge outlined that safeguarding incidents had all been reviewed at the most recent board meeting.

The inspectors met with the chairperson of the board of directors and discussed changes to the governance structure, including the recruitment of two additional board members, and a recruitment campaign for an operational manager, who will also be on the board of directors. The chairperson confirmed that improved communication systems had been implemented and the quality improvement plan

would be available to all staff and the board of directors for information sharing and review purposes. The chairperson was in the process of sourcing training for the board of directors in relation to their regulatory responsibilities.

Judgment: Compliant

Quality and safety

The inspectors found the provider had implemented the necessary changes to ensure residents were provided with safe services, which met their needs.

There had been a number of safeguarding and adverse incidents since the last inspection which had initially not been adequately followed up on; however, the provider subsequently ensured these incidents were reported and investigated, with actions taken to ensure residents were protected.

Improvements were noted in the assessment of need and personal plan process, and in the provision of positive behavioural support. The provider had outlined their plan to ensure residents' personal plans informed by up-to-date assessments of need were up to date, and these were in place on the day of inspection.

Overall residents had been provided with support to manage their behavioural needs; however, some improvement was required to ensure the recommendations outlined in behaviour support plans were consistently implemented. Restrictive practices had been reviewed by a behaviour support specialist and plans were progressing to establish a rights review committee to oversee the use of restrictive practices in the centre.

Regulation 5: Individual assessment and personal plan

Since the previous inspection a review of residents' assessments of need and personal plans had been completed. The inspectors reviewed documentation pertaining to three residents, and found all assessments were up to date and were informed by the identified and emerging needs of residents, and by the most recent reviews by healthcare professionals, the staff team, and by the personal preferences of residents themselves.

Personal plans were also up to date, and guided practice in the care and support residents required to meet their health, social and personal care needs. Plans were implemented in practice, for example, monitoring interventions were completed in the centre, and residents were supported to attend scheduled appointments with a range of healthcare professionals. Residents were also supported with their social care needs, through both activities in the centre, attending day services, and regular

social outings.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors reviewed two behaviour support plans and corresponding behaviour and incidents records, and found improvements had been made in the provision of behavioural support. Up to date behaviour support plans had been reviewed by the behaviour support specialist, and included proactive and reactive supports to help residents manage their emotions, and to respond to identified and emerging risks. Some improvement was required to ensure staff were providing behavioural support consistent with behavioural support recommendations, specifically relating to reactive strategies.

A restrictive practice had been reviewed by the clinical nurse manager and the behaviour support specialist. The clinical nurse manager outlined the provider's intention to reintroduce the establishment of a right review committee, the purpose of which was to oversee all restrictive practices in the service. From a review of correspondence it was evident this plan was progressing, with the committee due to meet in the next 3 months, and quarterly thereafter.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had implemented the actions in their compliance plan and representation, and while initially there were concerns regarding the identification and response to safeguarding incidents in the centre, the provider subsequently put measures in place to ensure these risks were mitigated. The inspectors reviewed incident records and behaviour records since the last inspection. The provider response had included a review of all behavioural and incident records, to ensure safeguarding incidents were identified, and subsequently reported to the relevant authorities. Staff described the safeguarding plan in place following a recent incident, and also described the process for responding to safeguarding incidents in line with the centre policy.

Since the previous inspection, a specific safeguarding risk had been included on the risk register, and a safeguarding plan and control measures were in place to minimise the risk of reoccurrence. Staff had been provided with refresher training in safeguarding, and a specific safeguarding incident had been reported to the relevant authorities.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place to identify and respond to presenting risks in the centre, which effectively responded to adverse incidents, to prevent reoccurrence, and to ensure residents were safely and appropriately supported.

Since the previous inspection the provider had reviewed the risk register and most risk management plans were up-to-date, with the control measures in place. For example, a specific staffing requirements was now included on the risk register, and an individual risk management plan had been developed in response to a new environmental restriction.

Initially, inspectors found the provider was not appropriately, efficiently and effectively responding to some risks in the centre, relating to behaviour of concern. However, the provider responded to this risk, and the inspectors found a revised policy and procedure, which meant that there were clear guidelines on the roles and responsibilities of all staff and management in responding to incidents. For example, the provider had updated an incident and risk management policy in November 2022, which clearly set out the roles and responsibilities of all personnel up to and including the board of directors. The policy also included step by step guidance on the response to and reporting of adverse incidents, and two staff spoken with described this process to the inspectors. From reviewing the most recent incident forms, the inspectors were satisfied that this revised policy was being implemented. For example, incidents had immediately been reported to the clinical nurse manager, who had reviewed the incidents, and where required had put additional control measures in place to prevent reoccurrence.

Improved oversight of risks from a board of management level were proposed and these arrangements were discussed with the registered provider representative. Plans included a weekly reviewed of risks and incidents by the person in charge and operations manager, and a monthly review with the operations manager and the board of directors. Improvement actions which could not be resolved at a local level, were to be escalated to the board of directors at monthly meetings or in the case of a significant risk, escalated immediately.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 26: Risk management procedures	Compliant

Compliance Plan for Steadfast House Residential Service - Group Home OSV-0001631

Inspection ID: MON-0038340

Date of inspection: 02/11/2022 and 06/12/2022

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 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Postitive Behaviour Support refresher training was organized for and completed by all staff on 19/10/22. On 02/11/2022, all PBSPs were reviewed by Sinead Smyth, CNS Behaviour Support. All staff read and signed off on resident PBSPs and had an opportunity to raise questions on same. Positive behavior support was added to the team meeting agenda going forward.	

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(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	15/11/2022