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:	Radharc Nua
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	15 May 2024
Centre ID:	OSV-0002633
Fieldwork ID:	MON-0043618

About the designated centre

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

Radharc Nua is a designated centre located in a rural area in Co.Wexford. The centre provides long-term residential care to five adult residents, with intellectual disability, dual diagnosis and significant high support physical and behavioural support needs. Residents living in the centre require full-time nursing care. The staff team consists of nursing staff and support workers. The residents attend day-services attached to the organisation and also have in-house individualised activities. The centre comprises of a large two-story house located in rural location. It has five single bedrooms with two living rooms, a kitchen, dining room, sensory room, five bedrooms, adapted bathrooms and a large accessible garden.

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 15 May 2024	10:10hrs to 17:30hrs	Sarah Mockler	Lead
Wednesday 15 May 2024	10:10hrs to 17:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This was a risk based inspection completed to review progress against actions set by the provider in both an urgent action plan and provider assurance report submitted to the Chief Inspector of Social Services. These assurances were sought following an inspection in April 2024, whereby serious concerns were identified in relation to the provider's ability to manage risk, identify and investigate safeguarding concerns and operate a service that promoted a safe and rights based approach to care and support.

Overall the findings of this inspection indicated that some immediate risks had been addressed to improve resident safety in specific areas. However many of the issues that were identified in April 2024, remained a concern. Inspectors found that the provider was in the process of making system changes to enhance their oversight of the service and make further quality and safety improvements.

On arrival at the centre the inspectors were greeted by the clinical nurse manager (CNM1) and brought into the hall way. This was a large open plan space that contained some seating and a table. One resident was observed leaving the centre with a staff member to help with shopping. Later in the day when they returned they were observed sitting at the table in the hallway and engaged in some painting.

Two other residents were present in the hall when the inspectors arrived. One resident approached an inspector and stood in very close proximity to them and the other resident remained on the couch. Over the course of the day all residents were observed moving between their bedrooms and the hall way.

Just after the inspectors arrival, a fourth resident entered the hallway carrying a drink and moved around the room observing the activity. This resident grasped the Clinical Nurse Manager (CNM1) by the arm and moved them towards the kitchen. This action was interpreted as a request for a drink. This resident over the course of the day was observed sitting on a sofa in the hallway. Standing in the garden looking in the kitchen window for a number of minutes on three occasions and then moving into their 'sensory garden' and moving around the shed structure present there. The inspectors observed that the resident was outside in the garden area independently for 10 minutes in total over the course of the day.

The fifth resident was being supported with personal care in a bathroom when the inspectors arrived. They were observed over the course of the day moving rapidly through the centre, walking from one end to another. They sat on their bed to listen to music or sat on one of the sofas in the hallway.

Residents in the home mainly communicated their immediate needs by leading staff members by the hand to the areas of the home were their needs could be met. All residents in the home were assessed to need a low arousal environment. However,

due to the assessed needs of residents and number of staff present this was not possible. On the walk around of the home there was loud music and televisions on in areas of the home. Although this may have been some residents' preference the impact of this was not considered for other residents.

The residents lived in a large detached dormer bungalow in a rural area in Co. Wexford. The home was subject to a high level of restrictive practices which were evident on the walk around of the premises. This included key pad locks on doors, bedroom doors locked, kitchen door on key pad lock and a hatch with a shutter, water access restricted in showers and baths and toiletries and chemicals locked away. Inspectors found that one restriction, in relation to the locking of a bathroom door had ceased since the last inspection.

Premises works had commenced in the kitchen/dining area and were ongoing on the day of inspection. It was explained to inspectors that new storage was going to be installed to store medication and other equipment in a more suitable manner. This would reduce the clinical presentation of this area as the medication trolley and other equipment would not be on display.

While one vehicle was available for residents to use as was observed with the resident going to the shop in the morning, the other vehicle was still not available for use for all residents. For one resident, who used a specific safety harness when travelling, the second vehicle present could not accommodate the use of the harness. This meant that they had now not left the centre for six weeks unless a family member attended to take them for a drive.

As part of the walk around the centre inspectors went to the outside areas. The majority of the garden was surrounded by a large metal fence. Areas of the garden were sectioned off into different parts with gates with locks. One area of the garden was used to separate/isolate a resident from their peers and the home during periods of engagement in behaviours of concern and self-injurious behaviours. In this part of the garden there was a metal structure. This was a three sided shed that the resident could use if it was raining or for other poor weather conditions. The previous inspection had identified significant risks in relation to this structure as one resident had engaged in self-injurious behaviour in this area. As part of the urgent action plan issued to the provider they had committed to making this structure safe. On the day of the current inspection it was found that padding material had been installed to minimise the risk of injury if self-injurious behaviour occurred in this area. However, additional risks remained in the garden area this will be discussed further under Regulation 26.

The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care.

Capacity and capability

The findings of the current inspection indicated that the provider had identified the need to improve governance and oversight arrangements in the centre and were in the process of adopting and implementing new systems. Further time was required to allow the system changes to take effect and determine if they were effective in driving quality improvement and identifying areas for improvement. Concerns remained in relation to the provider's response and identification of safeguarding matters and risk within the centre including their ability to respond in a timely and effective manner.

Regulation 23: Governance and management

The previous inspection of this centre had identified that the provider's oversight arrangements did not consistently identify risks, safety and safeguarding concerns. Also the previous inspection found that systems available in the centre were not utilised in an effective manner. On this inspection the inspectors found that the provider had reviewed it's systems and had prioritised a number of these areas with a focus on change and were implementing some new systems of oversight. For example, more frequent reviews of actions generated from audits were now in place. Some safety issues identified on the previous inspection had been addressed or were in the process of being addressed.

The senior management team were to review actions on a quarterly basis as opposed to a six monthly basis. As these systems or timings of previously used systems were new they had not yet been embedded into practice and it was not yet possible to state their full effectiveness.

The inspectors found that some of the stated actions by the provider in their submitted responses to the Chief Inspector were not based on factually accurate information. For example, that 'all staff had been in receipt of three specifically named training courses'. The inspectors found that five staff for example, at the point of submitting the provider assurance plan, did not in fact have safeguarding training with one having been due refresher training since August 2018. This was a concern for inspectors.

Inspectors also found that while some provider's systems were identifying areas that required action, the timeliness of response to these actions was poor. For instance in an audit of resident finances conducted in March 2024 a number of areas of concern were identified by the person in charge. These audit findings were next reviewed by the person participating in management in the beginning of May 2024 and this review stated that these 'were concerning'. However, on the day of inspection no actions had as yet been put in place to address the matters found. This did not demonstrate robust nor responsive governance and oversight.

Judgment: Not compliant

Quality and safety

Concerns in relation to the safety and quality of care being delivered to residents was identified on inspection in April 2024. The purpose of the current inspection was to follow up on very specific actions as identified by the provider. Some immediate safety concerns had been addressed in relation to a resident's use of a garden space. However, the provider's systems to identify, assess and mange risk and safeguarding concerns were not comprehensive or effective. Concerns remained in both these areas. In addition, significant improvements were required to ensure a rights based approach to care and support was delivered

Regulation 26: Risk management procedures

Following the inspection in April 2024 the provider had completed a review of their risk procedures and was endeavouring to put in place a more effective system for the identification, assessment and management of risk. However, the inspectors found that there remained gaps in the recognition of and assessment of risk within this centre. In addition, the timeliness of provider response as stated in Regulation 23 was contributing to continued poor risk management.

The provider had for instance formally assessed the risk of use of the metal structure in the garden for one resident however, the control measures in place did not consider the need to review the integrity of the structure or to spot check it's effectiveness. For example, although the structure was inspected as per daily works schedule this system was not robust in terms of identifying defects. On the day of inspection some of the outer safety padding was coming away from the structure. This had not been identified by the provider as there was an absence of systems in relation to ongoing reviews of the condition of the structure.

In addition, there were additional risks in the garden that had not been identified. For example, an incident form dated 26 April 2024, described an incident whereby a resident utilised part of a metal fence to engage in self-injurious behaviour. This risk had not been assessed through the provider's risk management systems. Although discussions had taken place in relation to aspects of this risk. For example, in minutes from an on-site review meeting that took place 24 and 25 of April, the action was agreed that 'hedging would be planted to help reduce the force/impact of the resident hitting the fence structures'. While a landscape company was to visit the centre this had not yet occurred as per the date of inspection. Other notes, such as Rights Review Committee notes dated 07 May 2024 incorrectly stated that the hedging had been installed. The risks posed in the garden area required careful consideration, assessment and effective control measures due to the fact the resident had received injuries while in this area.

In terms of risks identified around residents' engagement in sexualised behaviours in communal areas and other peer bedrooms risk assessments were now in place and associated control measures. As part of the provider's response they had identified the need of the input of a psychologist in relation to managing this risk. An initial meeting had occurred on the 02 May 2024. It was identified on this date as an outcome of the expert recommendation that specific external specialist risk assessments were required in relation to managing the risk appropriately. No actions or action plan had been put in place in relation to this recommendation.

Judgment: Not compliant

Regulation 8: Protection

Since the last inspection the provider had engaged with the safeguarding and protection team and had sought advice in relation to specific incidents occurring in the centre.

As stated above in Regulation 23 concerns related to financial practices and concern on the implementation of financial oversight systems had been identified during centre audits of resident finances in March 2024. It was not clear if these had been identified as potential financial safeguarding and whether there had been appropriate measures put in place. These audit findings were subsequently reviewed by the person participating in management in the beginning of May 2024. In this audit the provider noted that findings 'were concerning'. However, on the day of inspection no actions had as yet been put in place to address the matters found. These findings included no clear structures for staff when purchasing items, for instance, when residents purchased takeaways. Staff at times obtained a joint receipt rather than individual receipts, thus residents contributions were unclear as it could not be identified who had ordered and paid for which items. Also when residents purchased items of value these were not recorded and there were no records kept of their personal possessions.

The inspectors found that the provider had failed to identify a potential safeguarding concern and it was unclear if necessary reporting, investigation and measures were in place in relation to this. The provider had put in place temporary physical measures but not demonstrated that the risk and safeguarding concerns associated with the practice outlined below had been carefully considered. A resident in the home would go into the bathroom and sit on the floor. They would remain on the floor and staff described how they could not move or redirect the resident from this area. If another resident entered the bathroom at this time to use the facilities the second resident would remain in this space. Although as stated some measures were taken in relation to this such as installing a temporary privacy screen. There was no guidance for staff in relation to safety measures to be taken in this instance, it was unclear if this incidents were being recorded as required and therefore there

was limited evidence to indicate if they had been considered from a safeguarding perspective. This was a repeated failure on part of the provider.

Judgment: Not compliant

Regulation 9: Residents' rights

The previous inspection of this centre stated that deficits in this Regulation had been found in all inspections since 2019. In addition the previous inspection summarised that despite written assurances the rights of the individuals living in this centre continue not to be met. This remains the position during this inspection.

Resident compatibility in this centre remained a serious concern for the inspectors due the levels, complexity and frequency of the behaviours displayed and the vulnerabilities of the residents living in the centre. This also directly impacted choice available to residents as for example meal times and activities had to be staggered. This concern had also been identified by the provider. An additional table and location for this for instance, had been identified which while it went some way to mitigating incidents at mealtimes also further highlighted that residents were not compatible and could not easily share everyday routines and environments.

The provider had completed risk assessments which accounted for the need to explore alternative accommodation for some residents. For example, two risk assessments reviewed by the inspectors indicated that alternative accommodation was an additional control required in order to reduce the level of risk in the centre. While the provider gave some verbal assurances regarding potential proposals these were in line with previous written assurances and no definitive confirmations or time lines were available.

Due to a lack of resources in terms of transport one resident had not had the choice to leave the centre in a six week period. The residents' behaviour support plan indicated the need for them to access a 'robust activity schedule'. This had not occurred in recent weeks and inspectors were told that this was not currently possible. Therefore the resident was not being supported in line with the requirements of their specific plan.

On a review of one resident's health care file, there was personal information found on this file relating to all residents within the organisation. This was not best practice in ensuring residents' right to privacy around their documentation was upheld.

Staff described to the inspectors that one resident had no family or other legal representative in place due to bereavements. This had been the position for the resident for approximately 12 months. Although the provider was aware of this, the resident not been referred to advocacy services or other relevant services such as supports around the Assisted Decision Making Act (2015) despite the fact they had no nominated person to help them make decisions around finances, healthcare or

other care related matters including restrictive practices. It was unclear how this resident was supported to make decisions.

Judgment: Not 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 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Radharc Nua OSV-0002633

Inspection ID: MON-0043618

Date of inspection: 15/05/2024

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider has reviewed the overarching systems for Governance and Management within the Centre. A governance and oversight team has been established, chaired by the Head of Service with terms of reference agreed to ensure the residents experience a good quality of life and specifically address the issues raised in the inspection report. The team will meet weekly initially for 6 weeks after which the frequency of meetings will be reviewed and potentially progress to monthly meetings with a further review of frequency in 6 months.

The service has two PPIM's who provide oversight of all Designated Centre's. The Registered Provider has allocated the PPIM's to specific Centre's and their remit has been clearly defined via a process to support comprehensive oversight. The Registered Provider will ensure oversight of the Centre through enhanced supervision arrangements between the PPIM and PIC. A supervision schedule has commenced where the PPIM is carrying out weekly Governance visits to the Centre for an initial period of 8 weeks before this is reviewed and adjusted as required.
The PPIM will carry out monthly supervision meetings with the PIC for an initial period of 6 months following which the frequency of these supervision meetings will be reviewed

The provider has reviewed the audit reporting format for training and a revised matrix will be developed to ensure a red flag is used to identify those modules near expiration for all staff. The PPIM has reviewed the process for actioning of Audit findings, the methods used to communication same with staff team and follow up will be reviewed in supervision meetings and at Senior Nurse Management Team Meetings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider has ensured the development of a risk assessment in line with the HSE Enterprise Risk Management Policy to support the resident's safety while using the secure garden area which includes the internal padding and external cladding.

The Provider has reviewed the process used to identify risk to ensure no further incidents of oversight occur. Enhanced PPIM / PIC supervision meetings and enhanced Senior Nurse Management Review Group (SNMRG) meeting agenda is in place.

The Senior Nurse Management Team have developed an enhanced approach to reviewing the Risk Register as part of their Review Group (SNMRG), QPS Agenda.

The PIC will incorporate a review of Residents Risk Assessments pertaining to their safety with the ANP on a quarterly basis.

The delays in completing the installation of the hedging have been addressed by the supplier and work commenced on site.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The provider has sought assurance that the audit findings did not meet the threshold for concern. The provider and PPIM have met with staff and reviewed the resident's weekly activities incorporating meal planning and food purchases. Taking consideration of the RSSMAC contributions paid by each resident and their waivers. The provider will ensure audit findings are actioned in both a timely and appropriate manner in conjunction with the PIC and PPIM.

The provider has arranged for the service based lead in Health and Wellbeing to audit resident's diet and associated expenditure with a view to developing individualized plans to support a healthy balance reflecting individual choices.

The provider will ensure that all residents have an up-to-date property list reflecting any purchases of significant value which is monitored and updated as required. This list will be audited as part of the residents file.

The ANP has worked with the residents and staff to develop support plans to ensure that access / use of communal spaces like bathrooms does not impede anyone's rights to

privacy and dignity.

The use of visual aids is currently being trialed to deter residents from encroaching on each other's space while using bathrooms.
Support and input from the ADM leads is ongoing with educational sessions scheduled for staff with a member of the Social Work team.

Assisted Decision Making (ADM) / Consent support is being provided to staff by members of the ADM Team focusing on resident rights and safeguarding. The PPIM met with the leads on 22/05/2024 and a follow up workshop is scheduled for 25/06/2024 after which the ADM lead will meet the SNMT and then will follow up with further training for the staff team on 16/07/2024.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The planned reconfiguration of communal spaces are near completion with the installation of one final storage press required. The bedroom relocation is due to happen by 21/06/2024 after which the new pieces of furniture purchased will be placed in the vacant room and it will be an additional available space for residents to relax or enjoy an activity.

4 of the compatibility assessments have been completed and the findings will inform future planning for the residents.

The vehicle has been repaired and the harnesses used assessed by the supplier with a devise ordered which will support its transfer of use between vehicles. This will ensure no further restrictions as a result of a vehicle breaking down and a requirement to borrow from another area.

The reconfiguration and enhancement of internal spaces within the Centre will ensure that all areas are functionally accessible while being tastefully decorated and maintained.

Door holds are currently being manufactured to support resident's independent access to external spaces.

The replacement fire hatch is due for installation.

Access to a local accessible swimming pool has been secured with a plan for some of the residents to enjoy.

The PPIM and PIC are working with ADM and HSE Legal to make appropriate referrals to ensure the resident secures all appropriate representation and support following the

death of a Guardian.
In the interim the resident is allocated a Key worker and the PIC / PPIM to support him in completing any functional assessments or make decisions. The ADM lead will advise as required.

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 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.	Not Compliant	Orange	16/07/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	16/07/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of	Not Compliant	Orange	16/07/2024

	abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/07/2024