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:	Winterfell
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	01 December 2022
Centre ID:	OSV-0005350
Fieldwork ID:	MON-0038303

About the designated centre

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

This centre provides full-time residential support for up to four adults. The centre supports individuals who may require support with mental health, intellectual disabilities and/or acquired brain injuries. The centre is a detached dormer style house split over two floors. Each resident has their own bedroom decorated to their own choice. There is a large garden to the back of the property. Some residents attend a formal day service and some residents plan their activities on a daily or weekly basis in line with their own wishes. Transport is provided so residents can access their local community. The centre is staffed on a full time basis by social care staff with one staff on duty at night for a sleepover shift. The person in charge is supported by a team leader in order to ensure effective oversight of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 1 December 2022	11:00hrs to 17:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During this inspection, the inspector had the opportunity to meet and speak with all four residents living in the designated centre, as well as speak with support staff members, and observe some of the routines and interactions in the house.

The residents were supported in a two-storey house in the outskirts of a town in North Dublin. Downstairs was a comfortable sitting room which was decorated for Christmas, and a suitable kitchen and dining area which led onto another TV lounge. Residents had access to a spacious garden area which included one resident's pet rabbits in a large enclosure. Each resident had a private bedroom which had sufficient space for belongings and was decorated based on their preferences and interests. Residents had the option to lock their bedroom when out of the house. Three of the four bedrooms had appropriate en-suite facilities. The service had exclusive use of multiple suitable vehicles.

Residents for the most part were supported to be active and retain good links with the community, meet with friends and peers at day services and social groups, and pursue hobbies and interests in the community. When the inspector arrived to the house, three of the residents were out engaging with their planned activities. One resident told the inspector about their involvement in a Christmas choir and was at rehearsals in the afternoon. Some residents went to the local shopping centres to buy presents for their families, and two residents were planning Christmas dinner in their favourite restaurant together. One resident had recently returned from a holiday in Spain and was already planning out their next trip for the coming months. Another resident told the inspector how they made regular visits to spend time with their family.

At the time of the inspection and for the majority of the time they had lived in this designated centre, one resident had stopped engaging with their planned activities. This included not attending appointments or social links, not attending to activities of daily personal living or upkeep of their living space, and spending the majority of their day in bed. The inspector found evidence to indicate that the front-line staff team were trying to engage and activate the resident, with months of diligent notes kept to demonstrate the team's offer for support and encouragement to participate, and the refusal by the resident. The service provider had identified that the designated centre and support structure of the service were not appropriate to meet this person's needs, and had initiated plans to transition this person to a centre more appropriate for their assessed needs. This had been discussed with this resident who was happy with the plan to move to a new house.

The inspector observed positive and respectful interactions from staff members with the residents, and the residents commented positively on their opinions of their support staff. Residents got along well together overall, though residents commented to the inspector that they were at times upset or annoyed by behaviours of their peers in shared spaces. However, residents were confident that

they could speak with the staff or management if there was anything bothering them and that it would be taken seriously. Residents also appreciated having quiet private bedrooms to distance themselves from busy areas if needed. The inspector found examples of debriefs taking place after complaints or incidents had occurred, in which residents were supported to have mutual respect for the shared house and the privacy and dignity of their housemates.

While not far from local amenities, the house was located down a rural road, and the service had sufficient vehicles, and staff who could drive, to facilitate resident access to the community and attend their personal and social engagements. On the previous inspection one resident who did not have allocated staffing commented that their transport opportunities were limited when the weather was bad or days got dark early, affecting their independent travel with mobility equipment. While staffing arrangements had not changed since, the resident commented that their transport options had improved because the staff allocated to one of their peers were often available to provide them lifts. In the main, residents were happy that reductions in community access necessitated due to the COVID-19 pandemic had been reduced to allow them more varied and enjoyable activities.

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 these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This unannounced inspection was carried out in response to information brought to the attention of the Chief Inspector relating to the quality of care and support delivered in this designated centre. The inspector spoke with all staff on shift in the centre individually, as well as to all residents in the house, and reviewed minutes of meetings and governance and oversight reports.

Staff told the inspector that overall they felt supported in their roles by their respective managers and their colleagues, however commented where there were challenges in delivering on their duties. Members of the team gave examples of where staff felt uncomfortable or unsafe in their work, and described examples of where additional safety precautions had to be taken, or planned daily structures changed, to keep people safe. These concerns were frequently discussed at team meetings with the local management. Staff were also supported through scheduled formal one-to-one supervision meetings and performance appraisals by their manager through the year.

In the main, the inspector found evidence that the provider was aware of the risks and challenges present in the designated centre and had concluded that the designated centre was not suitable to provide the required supports for some assessed needs. However, the inspector reviewed the most recent quality and safety

of care report (dated July 2022) and the most recent annual review (dated June 2022) and found little to no reference to the experiences through 2022 as described during the inspection by the residents, front-line staff and person in charge.

The provider maintained a log of complaints raised in the service and how they were assured that the complainant was satisfied with the outcomes or actions taken. Residents told the inspector they knew to whom they would speak if they were unhappy about something in their home and would be confident in doing so.

Regulation 16: Training and staff development

The inspector was provided evidence to indicate that staff were supported in their roles and met formally and informally with their managers on a regular basis. Current and ongoing risks, incidents and objectives, and updates relevant to the team were discussed in team meetings.

Judgment: Compliant

Regulation 23: Governance and management

In the main, the provider had sufficient centre resources and management arrangements to operate the services and ensure that procedures were followed per the regulations and provider policy. Some ongoing concerns which had been in place throughout 2022, or the experiences of the residents and front-line staff over the past year, had not been identified in the service's six-monthly audit or the annual review, with any strategy set out to address the risks following said reports.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider maintained a log of complaints, actions taken, and notes on how they were assured as to whether or not the complainant was satisfied with the result.

Judgment: Compliant

Quality and safety

In the main, the provider and the staff team were supporting the residents to retain active and busy lives in their home, in the community and through their social activities. The residents were supported to stay safe and measures were in place to respond to allegation or concerns related to resident safeguarding. Development was required in ensuring that guidance to staff and control measures related to some risks in the service were kept under continuous review and revised when required.

The inspector reviewed a sample of investigation records related to instances of suspected or reported safeguarding concerns. The inspector found evidence that matters of concern were reported to the designated officer and An Garda Síochána as required, and that debriefs took place to ensure that staff and residents were encouraged to report any events with which they were concerned.

The centre maintained a register of risks related to the designated centre, and risks related to each resident. The inspector found examples of where risks had been rated before and after control measures were taken, and actions set out with the view to reducing to an acceptable level of risk where possible. Some risks identified in the designated centre had not been accounted for in the register.

Personal plans were detailed and informed by a comprehensive assessment of need carried out before and during time of admission. Overall, plans were person-centred and included relevant input from the multidisciplinary team. However, in the sample of plans reviewed, the inspector identified staff guidance which had not been implemented in practice for many months because the measures described did not work. Some plans had not been updated to reflect supports which had been implemented in practice following incidents, including measures to protect the safety of staff members, which was particularly important in light of the weeks before this inspection having staff members from a relief panel who were working alone at night. While meetings and reviews by the multidisciplinary team were taking place, the majority of the minutes of these meetings related to the assessments of the reason behind identified risks, with limited evidence that the support plans were evaluated for their effectiveness and amended accordingly.

Regulation 13: General welfare and development

Residents were facilitated and supported to participate in social and community activities and maintain personal relationships in accordance with their needs and wishes. Where activities and outings were offered and not availed of, this was clearly documented.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, risks were identified, rated and had appropriate control measures or actions to reduce the relevant risk outlined. Some risks which had been identified during this inspection through observations and from speaking with staff had not been accounted for in the risk register.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall, residents' health, personal and social care needs are met, however, there were deficits in personal plans and staff guidance on the delivery of resident support for identified needs. This included guidance which had not been updated to reflect current practices implemented, information which was inaccurate, elements of support structures which were not used in some time due to them not working, and gaps in evidence indicating that the effectiveness of plans was evaluated and changes made where appropriate.

Judgment: Not compliant

Regulation 6: Health care

Appropriate health care was made available for each resident having regard to their assessed needs. The inspector found evidence of referrals and reviews with allied health professionals relevant to ongoing support needs.

Judgment: Compliant

Regulation 8: Protection

Where alleged, suspected or witnessed incidents of safeguarding concern were raised in the service, timely investigation procedures took place to establish the facts and identify grounds for further investigation. The provider had reported matters to the Gardaí and the designated officer where required.

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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Winterfell OSV-0005350

Inspection ID: MON-0038303

Date of inspection: 01/12/2022

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 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 (2)(a) Registered Provider and The Person in Charge will ensure 6 monthly unannounced reports and Designated Centre annual review is reflective of plans in place and any concerns in relations to any individuals. 1. PIC will update the current Annual Review report in place to ensure it reflects the experiences of all Individuals and front-line staff over the past year. (Due Date 12/01/2023) 2. Quality Assurance Department will conduct an unannounced visit on behalf of the Registered Provider and will ensure 6 monthly report reflects the current experiences of Individuals and front-line staff. (Due Date 31/01/2023) 3. Following the 6 monthly audit an action plan will be completed by the PIC as required and closed out within required time frame. (Due Date 24/02/2023)	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: To demonstrate that the Designated Centre is line with Regulation 26(2) The person in charge shall ensure risk assessments reflect management and ongoing review of risk, including a system for responding to emergencies. 1. PIC will ensure Risk Assessments are updated to reflect all current risks and controls	

are documented including systems for responding to emergencies. (Due Date 09/01/2023)
2. Following the review of all Risk Assessments these will be communicated and signed off by all Team Members. (Due Date 23/01/2023)
3. Test of Knowledge will be completed with all Team Members to ensure all fully understand all controls in place (Due Date 06/02/2023)

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 5 (6)(c), (7)(a) and (8) PIC will ensure that the assessed needs of Individuals are reflective in their comprehensive needs assessment and personal plan. Any supporting documents will be maintained in line with their assessed needs to guide staff on the support required for the Individual.

1. PIC will ensure all Comprehensive Needs Assessments are updated to ensure they are in line with Individuals assessed needs.(Due Date 09/01/2023)
2. Following the review of all Comprehensive Needs Assessment all Personal Plans will be updated to ensure they are reflective of all individuals presentations. (Due Date 18/01/2023)
3. All Plans will be communicated to all Team Members to ensure they provide full guidance on how to support Individuals. (Due Date 18/01/2023)
4. Behavioual Specialist will complete full review of all Personal Plans and feedback willl be provided to the PIC and action plans will be created and closed out as required for PIC final sign off (Due Date 06/02/2023)

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 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	24/02/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	06/02/2023

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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 effectiveness of the plan.	Not Compliant	Orange	07/02/2023
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	07/02/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	07/02/2023