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:	Belltree
Name of provider:	Resilience Healthcare Limited
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	21 November 2022
Centre ID:	OSV-0005635
Fieldwork ID:	MON-0037591

About the designated centre

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

This designated centre is located in a mature residential area on the outskirts of the city. The premises is a two-storey detached house where residents have access to a choice of sitting rooms, a kitchen and dining area, utility room and, their own bedroom. Two of these bedrooms have en-suite facilities. There is a pleasant garden and paved area to the rear of the property. A residential service is provided and residents have access to an external day service or, receive an integrated type service from their home. A maximum of four residents can be accommodated. The designated centre is open seven days a week and the model of support is social. The house is always staffed and there are a minimum of two staff members on duty at all times. The management and oversight of the service is delegated to the person in charge supported by a team leader.

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
Monday 21 November 2022	10:00hrs to 16:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to follow-up on the findings of the inspection completed in April 2022 and information submitted by the provider to HIQA (Health Information and Quality Authority) in the interim such as the notification of certain events and an overarching safeguarding plan. Improvement was noted and the provider demonstrated an improved level of compliance with the regulations. However, the safeguarding of residents was an active component of the day-to-day operation and management of this service and while there was evidence of good safeguarding practices there were residual controls that were not fully completed or implemented so as to improve the quality and safety of the service.

This inspection was unannounced and on arrival the person in charge advised the inspector that all four residents had left that morning for a trip to Disneyland, Paris. Therefore, the inspector did not meet with residents, observe their interactions with each other and with the staff team or observe the care and support provided. However, both the person in charge and the team leader were available and there was good opportunity to discuss the management arrangements of the centre, staffing and staff supervision arrangements and, the arrangements in place to safeguard residents from harm and abuse. The residents' voice was well represented by the management team and in records seen by the inspector.

The individual needs of the residents presented safeguarding challenges in what is effectively a shared living arrangement. This has resulted in a pattern of notifications submitted to HIQA where these individual safeguarding challenges have impacted on the resident themselves, on their peers and on the overall safety and quality of the service. The provider had concluded that residents were compatible to live together but with the appropriate supports and interventions.

This compatibility with appropriate interventions was reflected in the arrangements put in place for the holiday. For example, the inspector was advised that it was each resident's choice and wish to holiday together, one resident was reported to have said that it was their dream holiday. However, each resident had their own accommodation, individualised support from a staff member and somewhat different itineraries. The team leader who had accompanied the residents and the staff team to the airport reported that all four residents had departed happy and excited.

Compatibility and the quality of life that residents enjoyed in this service was also evident from other records seen such as the weekly house meetings and feedback residents and their representatives had provided for example to inform the personal plan and internal reviews of the service. Residents said that they liked and were happy living in the house and with their peers. Representative feedback was also positive. Residents could and did express how they felt, what they liked and did not like. The person in charge told the inspector that no resident was actively reporting that they did not like living in the house or living with their peers. Each resident had good opportunity to engage in a broad range of activities at home and in the

community.

However, managing the challenges and conflicts that had the potential to develop between residents was also as stated above, part of the day-to-day operation of this service. This was evident from the pattern of notifications submitted to HIQA and the active safeguarding plans in the centre. Based on what was discussed with the management team and the records reviewed by the inspector there was evidence of improved governance and management, improved oversight and management of incidents and risk and, improved guidance for staff and supervision of staff so that the safeguarding plan and safeguarding interventions were adhered to. This was a necessary prerequisite to any conclusion that residents could and would live well and safely together in the longer-term. However, there was still scope to improve the centres staffing levels and arrangements and the arrangements for monitoring staff training. Completion of the minor modifications to the house was outstanding. These improvements were needed to better support and assure the safeguarding of residents.

The next two sections of this report will present the focused findings of this inspection and details of the governance and management arrangements in place and how these impacted on the quality and safety of the service.

Capacity and capability

The management structure was clear as were individual roles, responsibilities and reporting relationships. Based on these inspection findings the management arrangements in the centre were ensuring that the quality and safety of the service was consistently monitored. While there was scope for further improvement the provider demonstrated improved compliance with the regulations.

The person in charge worked full-time and had responsibility for two designated centres. The person in charge endeavored to be present in this centre a minimum of two days each week. The person in charge was supported in the management and oversight of the service by the team leader who was present in the centre Monday to Friday. The provider was currently piloting the role of assistant team leader in the person in charges other designated centre. The team leader provided a handover to the staff team each Friday and there was a structured on-call service that staff could access if needed. The person in charge was alerted if the on-call support was accessed. The person in charge reported good access to and good support from their line manager who also attended the verbal feedback of these inspection findings.

The inspector noted that the person in charge and the team leader worked well-together. They were both well informed as to the individual and collective needs of the residents and the arrangements in place to support these needs including the

safeguarding plans. Records were readily made available to the inspector to support and validate what was discussed. For example, the provider had completed an internal review of the quality and safety of the service in July 2022 and the reviewer had actively sought feedback from residents, a representative and staff members. The recorded feedback was positive but where concerns were raised these were also reported. For example, concerns raised as to the effectiveness of the ongoing reliance on agency staffing arrangements. The person in charge said that the quality improvement plan was still in progress and this was clearly stated on the hard copy service improvement plan provided to the inspector.

Monthly staff meetings were held and based on the records of these meetings there was good discussion of each resident's needs and supports and feedback was provided to the staff team where the need for learning or improvement has been identified. For example, staffs role and responsibilities on receipt of any allegations or disclosures received were reiterated at a recent staff meeting.

Formal staff supervisions were completed and arrangements such as allocated key-workers, allocated daily staff responsibilities and a daily visual schedule where staff members were assigned to a particular resident or residents each day were in place. These arrangements promoted supervision, accountability and responsibility for the support provided. It also ensured that there was accountability for the supervision of residents as described in the safeguarding plan. Both the person in charge and the team leader were confident in describing the day-to-day oversight and supervision of the service to assure that the support provided was as set out in the positive behaviour support plan and the safeguarding plans.

Prior to the inspector reviewing the staff rota the person in charge confirmed that there was ongoing reliance on agency staffing arrangements. The person in charge said that there had been a recent successful recruitment campaign and staff were currently going through the recruitment process. The rota was clearly presented and it showed the staff members on duty by day and by night. It was evident from the staff rota that there was ongoing reliance on agency staff to maintain the staffing levels in the centre. The inspector's review of a sample of staff rotas indicated that each week an average of seven to eight agency staff were listed. In general however, the same agency staff were listed indicating that the provider did seek to ensure the continuity and consistency of support needed in this service. However, feedback provided during the internal review, discussion at a recent staff meeting and recent MDT records all referenced the challenge posed by agency staffing arrangements and how one resident in particular found this staffing arrangement difficult. In addition, the person in charge confirmed that a reassessment of needs and data collated such as from incidents had identified the need for additional staffing resources to provide one-to-one staff support for a resident. Preliminary discussions had been held with the funding body in relation to this requirement.

There were better arrangements in place for monitoring and ensuring staff had completed mandatory and required training. For example, a record was maintained of the training completed by all of the agency staff who worked in the centre. This record reflected the staff listed on the staff rota and indicated in-house induction was also provided on fire safety and safeguarding plans. However, while

improvement was noted in ensuring all persons supporting residents had completed the training required, there was a number of staff who had to complete training in de-escalation and interventions techniques if needed when behaviour posed a risk to self or others.

Regulation 14: Persons in charge

The person in charge worked full-time and had the experience, skills and qualifications needed for the role. The person in charge facilitated this inspection and their knowledge of the service, residents needs, staffing matters and safeguarding plans confirmed they were consistently engaged in the management and oversight of the service. The person in charge was satisfied as to the effectiveness of the current management arrangements and had good support from an experienced team leader and their own line manager.

Judgment: Compliant

Regulation 15: Staffing

The provider was in the process of recruiting staff. The provider did still rely on agency staffing arrangements to maintain the staffing levels in the house and while the provider sought to ensure that the same agency staff worked in the centre an average of seven to eight agency staff were required each week. Based on records seen there was some concern as to the effectiveness of these staffing arrangements and their suitability in particular to the needs of one resident. A recent reassessment of needs had also identified the need for and the benefit to all residents of the provision of additional one-to-one staffing for one resident.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Overall, improvement was noted in the monitoring and evidencing of the training completed by staff and agency staff. However, the inspector noted that training in de-escalation and intervention techniques was not listed on the training matrix. A review of individual training records found evidence of up-to-date appropriate training in only four of seven files reviewed. The person in charge confirmed that a recent audit had identified deficits in the completion of this training for a number of staff. There was evidence that the provider was in the process of arranging for all staff to complete this training. However, this gap in training was an oversight given

the specific needs of the residents. While the approach endorsed in this service was therapeutic, one behaviour support plan did identify the possible need for safety interventions such as blocking techniques.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the inspector was assured that there were management systems in place to ensure that the service provided to residents was safe, appropriate to their needs, consistently and effectively monitored. The provider was effectively using the data that it collected, for example from incidents that occurred, to monitor and improve the support provided to each resident and the safety of the service. The provider had completed an internal review of the service since the last HIQA inspection. It was evident from the report of that review that the reviewer was informed of the risks and challenges in the service and actively sought feedback from residents, representatives and staff so as to ascertain the safety and quality of the service. There were good arrangements in place for supervising, supporting and guiding staff so that they developed their responsibilities for the quality and safety of the support that they delivered.

Judgment: Compliant

Quality and safety

The primary focus of this inspection was to review the arrangements and, the effectiveness of the arrangements that the provider had in place to ensure that each resident had the support that they needed and to ensure appropriate procedures were in place for preventing and responding to safeguarding risks.

The inspector saw that residents and the staff team had ongoing access to the behaviour support team. This meant that the positive behaviour support plan was reviewed and amended as needed so as to best support the resident. Residents were directly consulted with so as to better inform the strategies needed to support them. These discussions had, based on records seen confirmed the potential for incidents to happen between peers. For example, the annoyance caused if a peer was talking too much. The review of incidents and the learning from incidents also informed the review of the plan. Preventative and responsive strategies were in general therapeutic and evidenced in practice and other records seen. For example, a suite of social stories (a tool that supports the meaningful exchange of information and promotes resident understanding) was available to staff. Visual schedules were in use. The importance of not placing too many demands on residents such as

asking residents to complete two tasks in quick succession was reiterated at staff meetings. Records of key-working meetings with residents reflected the guidance of the positive behaviour support plan.

However, the positive behaviour support plan also identified that there were times when one-to-one staff support was needed for the safety and wellbeing of the resident and their peers for example in times of crisis and, there were times when only two staff were on duty generally after 20:00hrs. This clinical recommendation and data from the analysis of incidents supported the identified need for additional staff supports.

As stated in the opening section of this report safeguarding residents from the risk of harm and abuse was part of the day-to-day management and oversight of this service. The risk that presented was multi-factorial. For example, the interpretation of a peer's facial expression or a conversation between peers could trigger an incident. There had been incidents where individual anxiety had resulted in extended periods of distress that had impacted on the resident but also their peers. There were times when residents said that they felt their safety and personal space was compromised. The inspector was assured that the person in charge and the team leader had sound knowledge of the range of safeguarding risks and safeguarding plans in place. The internal reviewer had established and was happy as to staffs knowledge of the safeguarding plans. Incidents of alleged abuse or negative interactions between peers were screened and investigated and reported to HIQA and to the local safeguarding and protection team. The local safeguarding and protection team were reported to work closely with the service and visited the service. There was documentary evidence on file where safeguarding plans were submitted, accepted, closed off or still open to the safeguarding team. This inspector reviewed and saw evidence of how the provider ensured these safeguarding plans and the safeguarding actions it said it would take were in place. For example, the daily staff allocations, the analysis of incidents by the behaviour support team, key-working meetings with residents and weekly house meetings.

However, the safeguarding of residents and the management of possible allegations were active ongoing risks in this service. The risk rating for one type of behaviour of risk to others including staff had actually increased slightly due to two recent incidents. There were additional controls outstanding such as the completion of the modifications to the house to promote privacy and reduce the impact of seeing or hearing incidents when they occurred. These controls were needed to see how they reduced the risk of incidents and further protected residents from the risk of harm and abuse.

Regulation 10: Communication

While residents had good communication skills there were also risks and challenges that arose due to perhaps how residents communicated how they were feeling or how they interpreted the communications of peers and staff. This was recognised in

the plans and tools in place to support better and more effective communication while still recognising the validity of how residents felt or had perceived the communications of others. The plan of support detailed specific communication needs such as the importance of choice and managing the requests made of the resident. Residents had good access to a range of media, personal devices and the Internet. Justifiable controls were in place to safeguard residents based on the findings of risk assessments.

Judgment: Compliant

Regulation 13: General welfare and development

While challenges arose to the safety of this service, based on the evidence available to the inspector residents did enjoy a good quality of life. Residents did conflict at times but there was no evidence to indicate that residents were unhappy living in this centre. For example, residents and representatives had provided positive feedback during the internal review. Residents reported that they liked living in the house and liked their peers. Weekly house meetings were held where staff recorded each residents contribution and preferences for the coming week or upcoming events such as Halloween. There was no recorded discontent and residents were evidently happy to sit together and discuss the general operation of the service. Each resident continued to engage in a broad range of activities in the house and in the community such as a number of sporting activities, social events, meeting with peers and friends and, the experience of work. Residents had access to family and their network of support as appropriate to their individual circumstances.

Judgment: Compliant

Regulation 17: Premises

The refurbishment of the main bathroom was complete. Privacy locks had been provided to the downstairs bathroom that could be accessed from the main hallway but also served as an ensuite bathroom for one resident. The recommended environmental modifications are addressed in Regulation 8: Protection.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector found improved systems for the identification and management of

risks that reflected the specific risks arising in this centre. For example, there were active open risks for the risk of behaviours and the impact on others. The person in charge was satisfied that there was a culture in the centre that supported the reporting of incidents. There was a good link between the review of incidents that had occurred and the review of the relevant risk assessment and controls. Where learning from incidents was identified this was communicated to the staff team. The wider MDT provided support to the local staff and management team. The process of managing risk was not just focused on or reactive to risks such as safeguarding but also supported residents to safely pursue personal goals and objectives such as having their own bike and cycling. Controls included staff accompaniment and the use of designated cycle lanes. The person in charge was satisfied that risk control measures such as staff supervision were proportional and did not impact on residents' quality of life.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan was informed by the leaning from incidents that had occurred and consultation with the resident themselves so as to gain insight into their behaviours and how best to prevent and respond to them. The local management and staff teams were supported by the wider MDT so as to ensure the evidence base of interventions. Interventions that had a restrictive dimension were in use largely in response to other risks that presented such as a risk for falls or seizure activity. Oversight was maintained of these interventions. The behaviour support plan did identify the possible need for safety interventions in a crisis; this has been addressed in Regulation 16: Training and staff development.

Judgment: Compliant

Regulation 8: Protection

There was good evidence as to how the provider sought to protect residents from harm and abuse. For example, a range of social stories were used as staff sought to develop resident understanding and skills in areas such as respecting personal space and expressing their emotions. All staff had completed safeguarding training, learning from incidents and staff safeguarding responsibilities were reiterated at a recent staff meeting. However, in this service safeguarding, protecting residents from the risk of harm and abuse and, the management of possible disclosures required ongoing and active management and oversight. The providers own active risk rating was medium. There were additional controls that had the potential to improve the compatibility of residents to live together and promote the safeguarding of residents such as the completion of the modifications to the premises and

progressing the case for additional staffing resources.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Belltree OSV-0005635

Inspection ID: MON-0037591

Date of inspection: 21/11/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: It is well documented nationally the shortage of a skilled work force in the Social Care sector this has been very challenging in 2022. Resilience has a policy of ongoing recruitment, and it is always the providers preference to have staff employed on a full time basis. The provider has two agency partners to access staff in the event of staff vacancies not being filled of for short term cover in the event of other leave. Regular agency staff are utilised they are regular. The commitment seen from the dedicated agency staff who regularly work in Beltree has been very positive. On the date of inspection, Beltree House had only one open position for an FTE. There were 5 people in compliance. Garda vetting has significantly delayed starters at this time. The recent Assessment of Needs review for a SU has identified the requirement for 1:1 staffing this is strongly supported by external professionals working closely alongside this SU- in particular the safeguarding team, as it is recognized that this increase will support reduced safeguarding concerns. The strategies, plans and responses in place are far more successful with focused staff for the SU.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A full two day course has been booked for the entire team on the 24th & 25th January 2023. This will include all aspects of postive behaviour support including de-esclation and interventios required. Traingin will include specifics relating to any residents behaviour support plan. The training matrix is reviewed regularly by the PIC to ensure that all training including refresher training is identified and planned.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: It is recognised that the ongoing management and oversight in every element related to protection and safeguarding of the current residents needs to remain strong and consistent. Oversight and good governance will continue, ensuring this is embedded in every element of service delivery. A cohesive and experienced management team, with	

longer term SSW's has supported the responses being active and comprehensive. The compatibility of the residents has been assessed and is considered positive. As with many situations where mobile, verbal young adults living in one location, there may remain a level of risk comparable to expected family situations and group dynamics. The ongoing investment in strong processes and strategies, devised in consultation with our multi-disciplinary team, will support these young adults to achieve great things in their lives, in a safe, supported way. Their recent successful trip as a group to Disneyland Paris, demonstrates the progress since they moved in together, and the relationships and bonding evident in their lives. Their relationships are not without incident but maintaining very low to low level risk in this area is targeted.

The recent Assessment of Needs review for a SU has identified the requirement for 1:1 staffing and this is strongly supported by external professionals working closely alongside this SU- in particular the safeguarding team, as it is recognized that this increase will support reduced safeguarding concerns. The strategies, plans and responses in place are far more successful with focused staff for the SU.

The adaptations for the premises are progressing, which will support minimizing of noise throughout the property, enhancing privacy and also creating additional spaces. The contractor has been identified, a quote approved, and scheduling is occurring for January 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/03/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	28/02/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/03/2023