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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:	Lifford Accommodation
Name of provider:	The Rehab Group
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	17 June 2024
Centre ID:	OSV-0002678
Fieldwork ID:	MON-0043489

About the designated centre

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

Lifford Accommodation provides full-time residential care and support for up to eight adults with intellectual disability. The designated centre comprises two interconnected semi-detached houses. Residents in each house have their own bedrooms and also have access to shared bathroom facilities on both the ground and first floors. In addition, the house includes a communal sitting room, kitchen dining room and laundry room for residents' use. The centre is located in a residential housing estate in a town and is close to local amenities such as shops, cinema and cafes. Residents are supported by a team of support workers, with daytime staffing arrangements based on residents' assessed needs. Night-time staffing arrangements included a waking night and a sleep over staff member. Management support is available to staff outside of office hours through the provider's on call system.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 17 June 2024	09:30hrs to 18:00hrs	Úna McDermott	Lead
Monday 17 June 2024	09:30hrs to 18:00hrs	Angela McCormack	Support

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor and review the arrangements that the provider had in place to ensure compliance with the Care and Support Regulations (2013). It followed the receipt of solicited and unsolicited information which was submitted for the attention of the Chief Inspector. The inspection was completed by two inspectors over the course of one day.

This designated centre comprises two interconnected semi-detached properties located in a residential estate and close to a busy town. The houses were two-story and linked by an internal door. Both houses were renovated and significantly improved since the last inspection. This included refurbishment of the kitchens, utility rooms and bathrooms. The inspectors found the premises provided were well equipped and well presented. They were clean and tidy, and communal areas were homely and welcoming. The bedrooms visited were personally decorated in accordance with resident's wishes.

On arrival, the inspectors met with the team leader. The acting manager arrived at the centre later and assisted with the facilitation of the inspection. The person in charge was not based locally as they had other responsibilities with the provider. However, they said that they were available if required and maintained regular telephone contact during the day. At the outset, the inspectors extended an invitation to meet with staff and family representatives should they wish to do so. Discussions were held with seven members of the staff team during the day and with one family member. In addition, inspectors met with all residents living at both properties.

A resident in property A agreed to show an inspector around their home. They pointed out various notices on display and also spoke about a visual schedule that they had, which supported them to plan activities and make choices. They showed the utility room and spoke about household tasks such as laundry, and jobs that they liked to do, and household tasks that they didn't enjoy doing and liked to get help with. Later, they were observed completing activities at the kitchen table.

The second resident living at this property was sleeping on the morning of inspection. The inspectors observed a day service staff member who called to the house to enquire if this resident wished to go out for the day. The staff on duty explained that the resident wished to make a change to the original plan and to go later in the week. This request was acknowledged and respected. Later, the resident was observing sitting by the window in the sitting room with the television on, which is what they wished to do that day.

The third resident was at home with their family on the morning of inspection. However, they made arrangements to come and meet with the inspector accompanied by a family member. This resident was the most recent admission to the service. They agreed to have a chat and they told the inspector about

disagreements with another person that they lived with and that this caused them upset. However, they said that it was getting a bit better, that they liked their new house and that they were happy as it was close to their family home. The family member said that the transition from home to a designated centre was difficult. They said that there were compatibility issues, but felt that they were gradually improving. Later, the two residents concerned were observed in the kitchen of their home. A high level of staff support was noted. One resident was looking at a music video on their phone while the second was enjoying a snack at the table. They discussed a music concert and the artist that was preforming. The atmosphere was jovial and the residents were laughing together at that time.

There was one resident in property B on the morning of inspection. They were sitting in a comfortable chair while waiting to go on a trip to their family home later that day. They told the inspector that they were happy in their home and that they liked the staff. If they had a worry, they said that they would speak to their family or to staff.

In the evening, two residents returned from their day service. One resident agreed to talk with an inspector and invited them into the sitting-room. When asked, they said that although they felt safe, they did not like living in the centre. They explained that they had lived there a long time and would like a change. They spoke about various options that they would like, including staff supporting them in a new home and living with new friends. They also said that at times, the heating and doors closing loudly caused them upset. A review of the complaints folder demonstrated that the resident had been supported to make a complaint about this and was acknowledged and documented. In addition, a review of documentation demonstrated that the resident was consulted and updated through 'key-working' sessions about the progress of their application for a new home. In addition, the support of an advocate was available for resident living here. Following a discussion with the local management team it was agreed that a visual document would assist with the resident's understanding of the housing application process and reduce any potential confusion.

During the course of the inspection, the inspector spoke with the acting manager, the team leader and person in charge and five staff members. Overall, staff were content in their roles and felt supported by managers. They said that improvements in staffing had a positive impact on resident's quality of life. They added that staff were more consistent now, they knew what to do, and this reduced safeguarding concerns. However, while other staff acknowledged a reduction in safeguarding issues, they expressed concern about resident compatibility and about the supports provided to staff by management. They said that working in Lifford Supported Accommodation could be very challenging.

Overall, the inspectors found that residents living at this designated centre had a range of support needs. Their independence was a priority for the provider and residents were supported to take managed risks. This included accessing their local community autonomously or with additional supports if required. Residents had active lives and they spent time with their families and friends. They told the inspectors about weekly cinema trips, dancing, going to concerts and going on

holidays. One resident spoke about a trip to Spain later in the year where they would be attending a country music concert.

From what the inspectors observed and from discussions with staff members, it was clear that this designated centre experienced challenges, however, the provider had taken action to address these. For example, a new resident was admitted and there was an increase in safeguarding concerns. In response, the provider completed a compatibility assessment and has a range of positive behaviour supports in place. In addition, renovations were required which were reported to cause disruption to the routine from time to time. These were completed and reported as very positive. Furthermore, there were ongoing changes to the leadership and management arrangements in place. Interim systems were used and a recruitment campaign was ongoing.

These matters will be expanded on in the next two sections of this report which will outline the findings of this inspection in relation to the governance and arrangements in place in the centre and how these impacted on the quality and safety of care.

Capacity and capability

The provider had a governance structure in place and staff were aware of their responsibilities and who they were accountable to. Sufficient staff were recruited and trained to work in the centre and there were good systems and processes in place. Improvements to the governance and management arrangements would enhance the quality and safety of the service provided.

The staffing arrangements in place at the time of inspection were in line with the needs of the service and the statement of purpose. The management team were responsive to changing needs of the service and consistency of care and support was provided. This was an improvement on previous inspections as a full core staff team was in place. Where additional staff were required, familiar staff were available.

Staff were provided with a range of mandatory and refresher training courses which provided them with the skills and competencies to support resident's care needs. In addition, bespoke training modules were provided. Where refresher training was due, a plan was in place. In addition, staff had regular supervision meetings with their line manager. A record of each meeting was maintained and where concerns were raised by staff, a range of supportive actions were offered. This was in line with the provider's staff supervision policy.

As outlined, the governance, management and oversight arrangements at the centre were subject to ongoing change. The provider was aware of the challenges facing this service and were taking action to address the concerns relating to compatibility of residents and consistency of management. Ongoing work was required to ensure

that these actions were effective and this will expanded on under the regulation below. The number of incidents occurring had reduced in frequency and a review found that they were reported to the Chief Inspector in line with the requirements of the regulation.

The provider had a system in place to respond to complaints. This included a complaints policy, however, it required review. In the interim, residents had access to an easy to read version and posters of the complaints officers were displayed in each house. A review of a sample of complaints found that they were responded to effectively and in line with the provider's policy.

Overall, improvements were evident in this centre. However, ongoing work in relation to the governance, management and oversight of the service was required in order to provide consistency of support to the staff team and sustain the improvements found in the service.

Regulation 15: Staffing

The staffing arrangements in place at the time of inspection were in line with the needs of the service and the statement of purpose.

- A review of the planned and actual roster for the period 30/04/2024 to 16/06/2024 was completed. It was well maintained and provided an accurate reflection of the staff employed on the day of inspection.
- In addition, the management team were responsive to changing needs of the service. For example, there was a waking night staff in house A to support resident's healthcare needs and a second staff was in place at times to support residents to have 1:1 time to help reduce safeguarding risks.
- Furthermore, consistency of care and support was provided. This was an improvement on previous inspections as a full core staff team was in place. Where additional staff were required, familiar staff were available.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with a range of mandatory training courses which provided them with the skills and competencies to support resident's care needs. For example, training in fire safety, positive behaviour support, safeguarding and protection, and medicines management was provided. Where refresher training was due, a plan was in place to support this.

- In addition, staff had access to bespoke training modules which provided additional guidance on the specific assessed needs of some residents. For

example, training in epilepsy management and personal and intimate care was provided.
- Inspectors found that supervision meetings were happening regularly. A review of the supervision records for five staff members found that comprehensive minutes were held. Where staff raised concerns, a range of supportive actions were suggested including additional breaks and enhanced weekly opportunities to meet with the line manager. This was in line with the provider's staff supervision policy.

Judgment: Compliant

Regulation 23: Governance and management

The provider had a governance structure in place and staff were aware of their responsibilities and who they were accountable to. In addition, the provider had systems and oversight arrangements in place in order to monitor the quality of the service. These included an audit system which was reviewed by inspectors. The annual review of care and support which was completed on 04/12/2023 and a six monthly provider-led audit which was completed on 12/03/2024.

However, the following required improvement;

- The governance, management and oversight arrangements at the centre were subject to ongoing change. The current person in charge held additional responsibilities with the employer and while they had a local support structure in place, ongoing effort was required to ensure that a permanent management team was recruited to support the service.
- While the provider had a policy on dealing with complaints, it was not in date and required review.
- While the provider had some good audit systems, others required strengthening. For example, the monitoring of fire safety systems to ensure that risk were identified promptly and removed if required. This includes where keys are left in doors that if locked, would block an evacuation pathway.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents occurring found that they were reported to the Chief Inspector in line with the requirements of the regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a system in place to respond to complaints. This included the following;

- Residents had access to an easy to read complaints process and posters of the complaints officers were displayed in each house.
- This was reviewed at residents' meetings, the most recent of which took place on 10/06/24.
- The inspectors reviewed a sample of three complaints and found that they were responded to effectively. For example: a resident raised a concern on 29/02/2024 in relation to a noise that was disturbing their sleep. This was addressed promptly, an alternative plan was put in place and the resident was satisfied.
- A concern raised by a family member on 06/05/2024 was reviewed. This was resolved at stage 1 and within a two day time frame with the outcome documented on 08/05/2024.

Judgment: Compliant

Quality and safety

The residents living at Lifford Supported Accommodation had a high level of staff support and good quality care was provided. Improvements to both houses meant that residents were living in comfortable homes that met with their assessed needs at that time. Improvements to the governance and management systems and arrangements would further strengthen the service.

As outlined, the provider was aware of the compatibility issues arising at this centre and where required, the support of positive behaviour support specialists was provided. Policies, procedures and guidelines were available to guide staff on what to do if an incident arose and staff training in behaviour support was up to date. Restrictive practices were used in this centre, however, they were the least restrictive option for the shortest duration.

A rights' based approach to care was evident in this centre. Residents were consulted with about the running of the centre through regular residents' meetings where their views and input on the centre was sought. In addition, each resident had a named staff called a 'key-worker' who supported their understanding of their rights, their finances, their privacy, advocacy and assisted decision-making.

The provider, the person in charge and the staff team were responsive to the safeguarding and protection risks at this centre which were linked to compatibility concerns previously outlined. A compatibility assessment was completed and placement options were reviewed in consultation with residents and the multi-disciplinary team. The safeguarding policy was up to date and staff training was provided. Where a safeguarding concern arose, this was addressed in line with national guidelines and ongoing contact with the local safeguarding and protection team was maintained. Pictures of the designated officers were displayed in the centre and residents spoken with were aware of what to do if they had a concern.

There was an up-to-date policy and procedure for risk management and a process for risk escalation. Where risks were identified, they were documented on a risk register, assessed, risk rated and control measures were put in place. Risk assessments were under regular review.

A walk around of both houses found significant improvement on previous inspections. The kitchens, dining rooms, utility rooms and bathrooms were refurbished. They houses were freshly painted, had new flooring and new kitchen units. The bathrooms and utility rooms were tiled and had accessible fixtures and fittings for showing and bathing provided.

The provider had good fire safety arrangement in place including systems to detect, contain and extinguish fire. The fire safety policy was up to date and staff training in fire safety was provided. Residents were supported to understand fire risks and had personal emergency evacuation plans (PEEPS) to guide staff on what to do if required. Fire drills occurred regularly and evacuation plans were updated to reflect learning.

Regulation 17: Premises

A walk around of both houses found significant improvement on previous inspections.

- The kitchens, dining rooms, utility rooms and bathrooms were refurbished. They houses were freshly painted, had new flooring and new kitchen units.
- The bathrooms and utility rooms were tiled and had accessible fixtures and fittings for showing and bathing provided.
- Residents spoken with told inspectors that they were very pleased with the upgrades which enhanced their independence and improved their quality of life.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had good systems and process for risk management at this centre. This included an up-to-date policy and procedure for risk management and a process for risk escalation.

- The service had a risk register which contained the risks identified. These were reviewed regularly intervals based on the changing needs of residents and the risk scoring.
- On discussion with the local management team about the risks that were highest in the centre, it was clear that control measures to mitigate identified risks were kept under ongoing review and all options to reduce risks to a tolerable level were reviewed. For example; one medium rated risk involved a resident not evacuating in the event of a fire if they were in their bedroom. The provider used a number of control measures such as educating the resident, input from allied healthcare professionals, involving the resident in fire checks, and involving health and safety personnel for input. This was effective in supporting the resident's understanding of the risk as they raised this in a conversation with an inspector and said that they were aware of what to do if required.

Judgment: Compliant

Regulation 28: Fire precautions

There were good arrangements in place for fire safety including, a fire alert system, a fire alarm panel, emergency lights, fire doors and firefighting equipment.

- Residents had personal emergency evacuation plans (PEEPS) to guide staff on what to do if required. Fire drills occurred regularly and evacuation plans were updated to reflect learning.
- Residents were supported to understand fire safety and those spoken with talked about what they would do in the vent of a fire, including going to the assembly point.
- In the main, fire safety audit systems were working well. For example, an issue with a fire sensor was identified and was under repair on the day of inspection. However, inspectors observed that there was a key in a sitting-room door on the hall side. If locked, this would prevent evacuation from this door to the front exit. Staff and residents were unsure of the reason for this and the key was removed. Ongoing monitoring was required which is included under regulation 23 above.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider was aware of the compatibility issues arising at this centre and had taken action to support these concerns.

- Access to the support of positive behaviour support specialists was provided. An integrated approach was used which involved members of the multi-disciplinary team and the plans used were subject to regular review.
- Policies, procedures and guidelines were available to guide staff on what to do if an incident arose and staff training in behaviour support was up to date.
- Restrictive practices were used in this centre. Protocols were in place and inspectors found that they were they were the least restrictive option, used for the shortest duration possible.
- In addition, it was clear from speaking with residents that they were consulted about the supports given. For example; one resident showed inspectors an easy-to-read guide to support them if they felt like they were getting upset with peers and they said that they found it useful

Judgment: Compliant

Regulation 8: Protection

The provider, the person in charge and the staff team were responsive to the safeguarding and protection risks at this centre most of which were linked to compatibility concerns previously outlined.

- A compatibility assessment was completed and the provider had examined placement options in consultation with residents and the multi-disciplinary team.
- Where a safeguarding concern arose, this was addressed in line with national guidelines.
- The service worked closely with the local safeguarding and protection team and a robust safeguarding and protection plan was in place. This included enhanced staff supports and opportunities to participate in regular individual activities. Evidence of this was found on the day of inspection.
- All residents were supported to understand safeguarding and how to protect themselves from abuse, through easy-to-read documents and discussion at residents' meetings. For example, the different types of abuse were outlined and problem-solving scenarios were discussed.
- Individual residents were supported to understand the impact of their behaviours on others. A easy to read document called 'Living Well with Others' was in place and was reported to work well.
- The safeguarding policy was up to date and staff training was provided. Pictures of the designated officers were displayed in the centre and residents spoken with were aware of what to do if they had a worry or concern.
- Residents spoken with said that they felt safe, one resident said that they did not like living in the centre because they were there a long time and it was

noisy at times at night. This was being addressed by the provider.

Judgment: Compliant

Regulation 9: Residents' rights

A rights' based approach to care was evident in this centre. Residents participated in decisions about the running of the centre and had opportunities to make decisions about their daily lives.

- Residents were consulted with about the running of the centre through regular residents' meetings where their views and input on the centre was sought. For example; a resident told the inspector that they had requested outdoor furniture for the garden. This was discussed at a recent residents' meeting and documented in the minutes.
- Residents made choices about their daily lives. As outlined, one resident did not wish to attend their day service on the day of inspection. They asked for an alternative plan and this decision was respected.
- Each resident had the support of a named staff called a 'key-worker'. They met together and discussed topics such as their rights and their privacy, managing their finances, making assisted decisions, and understanding advocacy and how that could support them in their lives.
- Residents were supported to practice their faith, and visit religious amenities in line with their preferences.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lifford Accommodation OSV-0002678

Inspection ID: MON-0043489

Date of inspection: 17/06/2024

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The Rehab Care Complaints and Compliments policy v5 was reviewed and issued in June 2024. This is now available in the service for all staff to read and understand. All staff are to have read and signed this policy by the 26/07/2024.

• The key referred to as being in the door is now labelled and in the key box situated in the staff room and available to residents and staff should they need this at any time.

• Checks for all doors and any keys that may obstruct a fire exit pathway if locked has been included in the daily chores checklist. This has been put in place on 16/07/2024. This practice will be by the Team Leader as part of the weekly audit.

• An additional Team Leader post 35 hours per week has been recruited and appointed since the inspection took place. This will increase to 70 hours per week the local governance and management of the service with availability daily on site for leadership, supervision and support to staff.

• A supporting Manager continues to provide oversight daily and is on sight 2-3 days per week for governance and management. This person reports directly to the PIC. The organization will continue to actively review this arrangement.

• Regular governance meetings and support and supervision sessions are held with the covering Manger and the Regional Manager (PIC) to ensure adequate on-going governance and monitoring of the service.

• Rehab Care will notify the Regulator of the permanent arrangements for the PIC for this center by the 30th December 2024.

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.	Substantially Compliant	Yellow	30/12/2024