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:	Lifford Accommodation
Name of provider:	RehabCare
Address of centre:	Donegal
Type of inspection:	Announced
Date of inspection:	30 November 2021
Centre ID:	OSV-0002678
Fieldwork ID:	MON-0027197

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 to eight adults (male and female) with a disability. The designated centre comprises of 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 staffing arrangements in each house being based on residents' assessed needs. In house one, during the week staff support is provided at set times in the evening to assist residents to maintain their independence skills. Whereas in house two, a staff member is available in the morning and evening to support residents when they are not at their day placements. In addition, the support worker will undertake a sleep over duty in house two in order that they are available to support residents at night if required. The sleep over staff are also available to residents in house one and accessed through the operation of a buzzer system. At the weekend, residents in both houses are supported by one staff member who undertakes a sleep over duty, with an additional staff member being available at set times during the day and evening. In addition, management support is available to staff outside of office hours through the provider's on call system if required.
Residents can access a number of amenities in the local community including an equine centre, cinema, community garden and shops.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 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
Tuesday 30 November 2021	10:00hrs to 16:30hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

The service provided in this centre respected the rights of residents and supported them to be as independent as possible. Residents were active participants in the running of the centre. Staff interacted with residents in a respectful manner and were knowledgeable of the residents needs. As part of this inspection, significant issues in relation to fire safety were identified. As a result, the provider was required to submit an urgent compliance plan outlining how theses issues would be addressed to minimise the risk to residents. This will be further discussed in the 'Quality and Safety' section of the report.

This was an announced inspection and, throughout the inspection, the inspector adhered to the public health guidelines on the prevention of infection from COVID-19.

The centre consisted of two interconnected semi-detached houses located on the edge of a town. The houses were two-storey and linked by an internal door between the two kitchens. Each resident had their own bedroom. One bedroom in each house was located downstairs and the rest were located upstairs. The bedrooms were decorated in line with residents' tastes and contained personal photographs and objects. Residents' personal photographs and art work were on display throughout the centre. Each house had a sitting room, kitchen-dining room and utility room for use by all residents. There was a bathroom downstairs in each house that had a level access shower and the bathrooms upstairs had a bath and over-bath shower. One house had an upstairs room that was used by a resident to relax and do their arts and crafts. One house contained a room used by sleepover staff. There was a buzzer system in the centre so residents could ring to alert the sleepover staff if they needed attention during the night. The house was clean and welcoming. There were areas of wear noted throughout the house; for example missing tiles and kick-board in the kitchen, a hole in a utility room wall, cracks in the bathtub. The provider had identified these and a number of further repairs and refurbishments that needed to be addressed. These included significant refitting of fire doors, new kitchens and bathrooms. This will be discussed later in the report.

The inspector met with three residents who talked about their lives and opinions on living in the centre. They were going about their daily routines; some remained in the centre during the day, some left to attend day services and others had appointments to attend. One resident was noted completing an art project in the centre. Residents reported that they were happy in their home and that they liked the staff. They talked about the activities that they engage in at their day services. These included dancing, art and working on the computer. In the centre, residents talked about participating in household chores and activities, including grocery shopping, cooking meals, and general cleaning. They talked about recent outings to the cinema, to go clothes shopping and for beauty treatments. Some residents had plans to attend concerts in the near future and one had a night away booked that week. They talked about resident meetings that occurred regularly and reported that

staff will write down their requests at these meetings. Residents knew the names of members of management and said that they met them regularly and that they could talk to them about the service. Residents said that they would be comfortable making a complaint and that staff helped when they had any problems. They talked about maintaining contact with family through phone calls and visits. Some residents had their own mobile phones. Residents said that they liked the people that they lived with but talked about some disagreements that had happened in recent times. One resident talked about a request to move to a new house that had been submitted previously. This will be discussed later in the report.

The inspector reviewed satisfaction questionnaires that had been completed by residents. Overall, they indicated that residents were happy in their home. Some had made requests for refurbishments to be completed in the centre. The inspector spoke with a family member of one of the residents. They reported that they were very happy with the service and had no concerns about their family member residing there. They said that the staff were very helpful and good.

Staff were noted talking to residents in a friendly and respectful manner. Staff offered residents choices throughout the inspection and these choices were respected. Staff were knowledgeable on the needs and preferences of residents. Residents were supported by staff to be as independent as possible and their rights were upheld. Staff respected the residents' privacy and were observed knocking on doors before entering rooms.

Overall, residents received a good service in this centre that supported them to live as independently as possible. Staff were responsive to residents and knowledgeable of their needs.

The next two sections of the report will outline the inspection findings regarding the governance and management of the centre, and how this impacts on the quality and safety of the service delivered.

Capacity and capability

There was good oversight of this service and clear lines of accountability. This ensured that the service provided was consistent and appropriate to the needs of the residents. However, improvements were required in relation to the recording of audit findings and the documentation of staff on rosters.

The inspection was facilitated by the person in charge who had good knowledge of the service and what was required to address the needs of residents. The service had a complement of regular staff who were familiar to residents. There had been recent changes to staffing arrangements in the centre in response to safeguarding issues with staff from day services attending the centre in the mornings. This was to support residents prepare for their day and to ensure that there were no adverse incidents due to compatibility concerns between residents. Some of these staff

members had been added to the regular team rota. However, a staff member who regularly attended the centre in the morning was not listed on the staff rota. Therefore the rota was not reflective of the staffing arrangement in the centre.

Staff training was largely up to date. The provider had identified a number of mandatory training areas for all staff. Regular staff were up to date in all areas with two members of staff due to attend the third day of a fire safety course later in the week. The training needs for new staff who had been added to the rota were identified by the person in charge and training for these individuals had been scheduled for the coming weeks. Staff received supervision and team meetings were held regularly.

The provider had completed a number of audits to ensure that there was good oversight of the service. The provider had completed an annual review and six-monthly unannounced audits in line with the regulations. Findings from these audits were added to an online system, with actions plans and completion dates listed. Issues identified on these reports could be closed when completed. In addition, the provider had implemented weekly and monthly audits in the centre. A review of documentation found that these audits were completed within the timeframe set by the provider. The audits identified issues that were specific to residents; for example, a review of a resident's daily notes. They also examined issues that related to the running of the service as a whole; for example, a review of any complaints or daily chores check. The person in charge reported that findings from these audits were actioned immediately and delegated to staff who had responsibility for their completion. This was done through direct contact with staff or by adding items to the team meeting agenda. However, there was no formal system or documentation in place to record findings from weekly and monthly audits and to ensure than any issues identified were actioned and resolved.

The provider had a complaints procedure in the centre that was available in an easy-to-read format. Complaints were reviewed and audited. A review of documentation found that complaints were acted upon quickly and resolved. Residents were kept informed of how to make a complaint and who they could contact in order to make a complaint.

Regulation 15: Staffing

There was a core team in this centre who were familiar to residents. Staff numbers were sufficient to meet the assessed needs of residents and staffing arrangements had recently been altered to ensure the safety of residents. However, not all staff working in the centre were listed on the staff rota.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff training in the areas that were deemed mandatory by the provider were up to date for all regular staff members. The training needs of additional staff, who had recently been added to the rota, had been identified and there were dates planned to address their training needs.

Judgment: Compliant

Regulation 23: Governance and management

The provider had good oversight of the service. There were clear lines of accountability in the centre. The provider had implemented annual reports and six-monthly unannounced audits in line with the regulations. Findings from these audits were recorded and addressed within a specific time frame. Additional audits were completed weekly and monthly. However, there was no formal method of recording these findings, identifying actions that needed to be taken to address the findings and identifying when the actions had been completed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints procedure in the centre. Complaints were routinely audited. A review of documentation found that complaints were acted upon quickly and resolved.

Judgment: Compliant

Quality and safety

The service in the centre addressed the needs of residents and supported them to be as independent as possible. Their wellbeing and welfare was supported by a good standard of care. However, significant improvements were required in relation to fire precautions and there were improvements necessary regarding the premises and infection prevention.

The centre itself was sufficient to meet the assessed needs of residents. Residents

had adequate space to be alone or to spend time together. Residents had their own privacy and their own rooms that they locked, if they so wished. The house had adequate facilities for residents in relation to cooking and laundry. The centre was personalised with the residents' photographs and belongings. However, there were a number of areas in the house that showed signs of wear and needed to be refurbished. This included missing tiles in the kitchen, missing grout beneath tiles at the kitchen sink, broken kick boards, cracks in bathroom tiles, damage to a wall in the utility room, discoloration and damage to floors, and an unpainted ceiling in one house that had been plastered following a leak. The person in charge reported that an agreement had been reached with the owner of the house to address the refurbishment issues and that this would occur in the first few months of 2022. However, no definite date had been given for these works to commence.

The plan for agreed works stated that the internal doors in the house could not be certified as fire doors, as the doors were not stamped and no documentation was available to certify that they were fire doors. The person in charge reported that intumescent strips had been put into the doors retrospectively. Although some doors in the house were fitted with self-closers, this was not the case on every door; for example, there were no self-closers on the doors between the kitchen and utility room. The interconnecting door between the two houses was fitted with a magnetic lock that kept the door open. On the day of inspection, the fire alarm was tested in both houses and it was noted that the magnetic lock did not release when the fire alarm sounded in one of the houses. Furthermore, the fire alarm system was not integrated throughout the entire centre. When activated in one of the houses, the alarm did not sound in the other house. This created a significant risk to residents' safety in the event of a fire and an urgent compliance plan was issued to the provider to address these issues. In response, the provider gave assurances that a fire safety consultant from an external fire company would reconfigure the alarm system to sound throughout the centre and include the release of the magnetic lock on the interconnecting door. Further assurances were given that a full fire detection and containment assessment would be completed by a competent professional and a schedule of remediation works, including the replacement of fire doors, would be drawn up from this assessment. A full health and safety audit would be conducted and staff were also to receive further training in relation to health and safety essentials. Until such time as these works could be completed, the provider rostered an additional member of staff on waking night duty.

It was noted that there was good practice in place in relation to other aspects of fire safety. All staff had up-to-date training in fire safety. An external fire company routinely checked the fire detection and fire fighting equipment. Each resident had a personal evacuation plan and fire drills were completed routinely under varying conditions. Learning from these drills was recorded and implemented. The provider had made special arrangements for one resident who did not participate in drills and had taken steps to ensure that the resident would be able to evacuate in the case of a fire.

There was also evidence of some good practice regarding infection prevention and control. The provider had a comprehensive cleaning schedule and an enhanced cleaning schedule had been devised since the beginning of the COVID-19 pandemic.

A review of documentation found that this cleaning was completed routinely. Temperature checks for staff and visitors, along with sign-in for contact tracing, was also in place in the centre. However, it was not possible to fully wipe clean certain surfaces due to structural damage; for example, cracks in tiles, and missing paint and rust on radiators. Also, a vent in one bathroom had significant black dust and coating causing an infection control risk.

As stated above, residents rights were respected in this centre. A review of documentation found that the wishes of residents in relation to their care and contact with next of kin was respected by staff. Each resident had an individual assessment that looked at their health, social and personal needs. This assessment was reviewed annually with input from the residents and their family member, if appropriate. It identified the care and support needs for the resident and outlined some goals for the coming year. Each resident had a named keyworker who also met with residents routinely throughout the year to review their needs and goals. Residents had a named general practitioner (GP) and their health records were maintained. There was evidence of input from a variety of health professionals as needed. Any identified health needs had a corresponding support plan. Where required, residents' plans also contained behaviour support guidelines that were devised by a behaviour support therapist. These outlined the issues that may cause distress to residents and how best to respond to support residents manage their behaviour. Residents were also aware of these guidelines and informed the inspector when they should be used. As mentioned previously, additional staff had been allocated to the service to address any issues relating to behaviour and reduce safeguarding risks to residents. The provider had additional plans to move residents within the centre to ensure compatibility and address the housing request that had been submitted by one resident. Individual risks regarding residents were documented in the personal plans and control measures identified. In addition, the person in charge had a risk register for the entire centre and had identified risks to residents and staff. These risk assessments were routinely reviewed and updated.

Overall, the quality of care to residents in this centre was of a good standard. Residents were supported to be active participants in the running of the centre and to be independent. The centre is adequate to meet the residents' needs but is in need of refurbishment. Residents' safety was promoted but further improvement regarding the safety of residents in relation to fire and infection control is needed.

Regulation 17: Premises

The premises were adequate to meet the assessed needs of residents. The premises had adequate private and communal space and was equipped with the necessary facilities for residents. However, refurbishment was required in the house to address damage and wear. This had been identified by the provider but there was no definitive date provided for when these works would commence.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was a comprehensive risk register for the centre and individual risk assessments for residents. Control measures to reduce risks had been identified and these were routinely reviewed and updated.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had implemented cleaning schedules and additional measures in light of COVID-19 to protect residents from the risk of infection. However, dust and coating was noted on a vent in a bathroom and damage to surfaces meant that they could not be fully wiped down creating an infection control risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had implemented routine fire drills and personal evacuation plans for residents. However, it was not possible to ascertain if internal doors were fire doors, the fire alarm system was not integrated within the entire centre, the magnetic locking mechanism on the interconnecting door was not integrated with the fire alarm system, and not all doors were fitted with self-closers. An urgent compliance plan was issued to the provider as a result of these findings. The provider's response provided assurances that the risk was adequately addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had individual assessments of their health, personal and social care needs. These were reviewed annually. The resident and their family member, if appropriate, were involved in the assessment and in setting goals for the year.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were identified. Each resident had a corresponding support plan for any identified health need. Residents had a named GP. There was evidence of input from a variety of health professionals as required by residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had plans in place to support them to manage their behaviour. These plans were devised by a behaviour support therapist. Staff had up-to-date training in supporting residents with their behaviour.

Judgment: Compliant

Regulation 8: Protection

All staff had up-to-date training in safeguarding. The provider had put measures in place to protect residents' safety with additional staffing. The residents had been made aware of ways to report any safeguarding concerns.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld in this centre. Residents privacy and dignity was respected. Residents' choices were respected. Residents were registered to vote. Information in relation to advocacy services were displayed in the centre.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	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-0027197

Date of inspection: 30/11/2021

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: • As of the 07.12.21 The rota now reflects all staff working in Lifford Accommodation including redeployed staff.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in Charge completes a formal monthly audit in which actions are reviewed for completion each month. The monthly audit tool also identifies when actions are to be completed.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Person in Charge is liaising with the Housing Association that residents hold tenancies with to arrange refurbishments and address wear and tear in both houses. This will be progressed by 31St March 2022, pending agreement and funding of the works required by the Housing Association and/or the funder of the service.	

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• On the 07.12.21 Person in Charge updated the daily and weekly enhanced cleaning schedules to ensure that vents in bathrooms are now fully cleaned and wiped down.
• The Team Leader will review the enhanced cleaning schedule on the weekly Team Leader – the Person in Charge will review that this is being completed on a monthly basis as part of the Person in Charge monthly audit.
The Team Leader/Person in Charge will complete a monthly Infection Prevention and Control Audit.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A Fire Safety Audit was completed by Pro Fire on the 06.12.21
• The Person in Charge updated and reviewed fire risk assessment on the 10.12.21. Fire drill was completed on the 10.12.21 in which residents in both houses evacuated as the alarm activated in both houses.
• Waking night staff were implemented on the 10.12.21-22.12.21 to mitigate the risk of a fire occurring in Lifford Accommodation.
• The inter-connecting Fire door was installed on the 21.12.21 and all doors were fitted with self- closures. The service returned to a sleep over staff from the 22.12.21 based on risk assessment.
• ABC fire consultants from the contracted fire safety company were on site on the 15.12.21 to reconfigure the alarm system across both houses to ensure that once the alarm is activated residents and staff in both houses are alerted to evacuate.
• The automotive release magnet on the partition door now fully releases to ensure effective operation upon alarm activation.
Remaining fire doors will be installed and completed by the 28.02.22

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	07/12/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2022
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'	Substantially Compliant	Yellow	07/12/2021

	needs, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	07/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	03/12/2021
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Red	03/12/2021