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:	Sligo Semi Independent Accommodation
Name of provider:	The Rehab Group
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	23 November 2021
Centre ID:	OSV-0004442
Fieldwork ID:	MON-0034828

About the designated centre

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

Sligo Semi-Independent Accommodation provides residential support to male and female adults with an intellectual disability. The centre provides support to residents based on the social care model, and identifies themselves as a low support service for residents to assist them to maintain and develop their independence in all aspects of daily living. The centre is located in a residential area on the outskirts of Sligo town, but close to local amenities such as shops and leisure facilities. The centre is also a short walk or accessible by public transport to further facilities and amenities in the town centre. The centre comprises of two houses in close proximity to each other. Residents have varied levels of independence and support needs and staff are available to support the individual needs of each resident. One house provides accommodation for three residents. Residents have access to a communal sitting room and kitchen/dining room as well as two bathrooms with shower facilities in each. The house also contains a staff office which caters for the administrative needs of both houses within the centre. The second house provides accommodation for four residents. Residents have access to a communal sitting room and kitchen/dining room along with a bathroom with a shower facility and an additional downstairs toilet. Both houses have rear gardens, which are accessible to residents at the centre. Residents are assisted by a staff team comprising of a person in charge, team leader and two community support workers. Staffing arrangements are provided in line with the assessed needs of the residents during the day, and there is no staff support at night, however, residents have access to staff contact details if they require staff support

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 23 November 2021	8:45 am to 4:00 pm	Úna McDermott	Lead

What residents told us and what inspectors observed

From what residents told us and from what the inspector observed, it was clear that residents were content living at this designated centre and were supported to be active participants in their communities, however, improvements were required which would improve the lived experience for the residents.

This designed centre consisted of two houses located in a busy residential area and within walking distance of each other. On the day of inspection there were six residents in residence. The person in charge told the inspector that one other resident was currently staying in hospital. The inspector had the opportunity to speak with three residents during the inspection and with two staff members while adhering to public health measures of mask wearing and social distancing. Residents' said that they were happy living at the centre and enjoyed their lives there. They told the inspector that they completed daily household chores and took turns to prepare meals. They said that they were involved in their local communities and spoke about the activities that they enjoyed, both individually, and together. These activities included shopping, going for coffee, going to the pub, meeting with friends and going to concerts. The inspector observed residents' and staff interacting with each other and saw that interactions were relaxed and effortless which showed that the residents' were at ease with the staff members on duty.

Sligo Semi Independent Accommodation was located close to shops, restaurants and community facilities.The living space in each house was a sufficient size to meet the number of residents' living there however, there was evidence of deterioration in the internal upkeep of both houses. For example, the inspector noted mould at the patio door in one of the houses and the door did not open and close correctly. Mould was also present in a resident's bedroom and there was damage to paintwork in some internal areas. In addition to this, the toilet seat in the second house was broken from the hinges and the cistern lever was not working correctly. This was repaired prior to the departure of the inspector. The inspector found that the front gardens were nicely presented, however an entrance door showed signs of wear and tear. The back garden was found to be cluttered with items due to go to the dump, was generally untidy and the bins were not closed correctly as they were too full.

Residents' told the inspector that they "got on well" with staff and this was evident during the time the inspector spent in the centre. They said that if they had any complaints or concerns, they would tell staff and it would be addressed. Furthermore, the residents' told the inspector that they had friendly relationships with each other. Although disagreements happened from time to time, they did not happen often.

From observations in the centre, conversations with residents and staff, and information reviewed during the inspection, it was evident that residents had a good quality of life, had choices in their daily lives, and were busy with activities that they enjoyed. However, due to the changing support needs of the residents it was

evident that improvements were required in the management of the staffing arrangements provided in the centre. The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impacted on the quality and safety of the residents' lives.

Capacity and capability

The inspector found that there had been a number of changes in the governance and management of the designated centre since the last inspection. These included a change in the person in charge and the person participating in management. The day-to-day staffing structure consisted of a team leader and social care workers. The inspector found that the staff were familiar with the residents' needs and also the systems and processes used in the centre. However, improvements were required in the staffing arrangements and overall governance and management of the centre, which would improve the quality and safety of the supports provided to residents.

The inspector found that the care and support needs of the residents in this designated centre were changing and this was acknowledged by the person in charge. Examples included; the aging profile of the residents and the deterioration in their physical and mental health. In addition, due to a change in family circumstances, one resident no longer went home as often as previously. The number of staff required in the centre needed to change in order to reflect this identified need. A second resident was due to be discharged from hospital after a period of illness. The person in charge told the inspector that they were concerned about this, and although the provider had recently increased the number of staff on duty during daytime hours, there was not enough staff on duty at night-time to provide oversight for both houses. This had a significant impact on the supervision and support provided to residents.

Staff spoken with told the inspector that they were happy working in this designated centre and that there were good communications systems in place. A staff training programme was in place and refresher options were offered. A review of the documentation showed that staff training was up to date. The person in charge had ensured that regular supervision meetings with staff were taking place and staff spoken with had knowledge of the HIQA regulations and standards.

Records viewed during inspection, such as staff training records, healthcare assessments and personal plans were informative and up to date. The provider ensured that an annual review of the service occurred each year, which provided for consultation with residents and their families.Provider-led audits were taking place every six months. There were systems in place for regular internal audits to occur in the areas of health and safety, infection prevention and control, and fire safety. However, from what the inspector read and from what she was told, their was

insufficient oversight provided and a significant risk remained at night-time as there were no staff support arrangements in one of the houses. Furthermore, the fire safety checks were not always effective, for example, the daily check was not up-to-date and the gate at the side of the house was difficult to open. Therefore, the provider was not effective in ensuring that a good quality and safe service was provided.

Regulation 15: Staffing

The provider did not ensure that there was sufficient staff on duty to meet the assessed needs of the residents and this impacted on the quality and safety of the service provided. Examples included; the aging profile of the residents, the deterioration in their physical and mental health and changes in family circumstances which meant that residents were present at the centre more frequently than before.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to a training programme as part of a continuous professional development plan. Refresher was provided and was up to date.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that an annual review was taking place and the twice per year audits were up to date. However, improvements were required to staffing arrangements and fire safety checks in order to ensure the effective oversight of the service and safe delivery of care and support to residents.

Judgment: Substantially compliant

Quality and safety

Residents at the centre had up-to-date individual assessments and person centred-

plans were in place. The inspector found that residents were involved in setting goals, which were recorded and there was evidence of follow up. Residents were found to be engaged with their communities. Activities included, part-time work or volunteering in the retail sector, attendance at a daytime art group and going to a 'night riders' horse riding club. Residents told the inspector that they met with their friends and family members regularly. In addition to this, residents told the inspector that they had planned a trip to a concert and that they went as a group the previous weekend. This showed that individual choices were respected and the voices of the residents were listened to.

The inspector found that the residents in this centre were aging and there was a deterioration in their health. This meant that increased support was required. There was evidence that arrangements were put in place for medical and multidisciplinary review. In some cases this included being placed on a waiting list due to the impact of COVID-19. A review of the documentation showed that residents had access to national screening services in accordance with their age profile. There was evidence that staff had noticed subtle changes in hearing and eye sight and eye test and hearing test appointments were arranged and attended. Residents had access to a physiotherapist and an occupational therapist. The inspector noted a recent referral for mobility assessments for residents that required increased support. This showed that there was a consistent approach to the heathcare needs of the residents which were prioritised and supported.

Appropriate practices were in place in relation to the safe prescribing of medicines and there was evidence of regular review. Residents that took their medicines independently were supported to do so and this was monitored appropriately and changes were made if required. For example, one resident had a trial period during which an electronic reminder device was used. This showed that maintaining independence was valued while also acknowledging the requirement for safety. In addition, there was a collaborative approach to medication management in this centre. which included consultation with the residents, their mental health team and input from the practice development team.

The provider ensured that there were procedures in place for the prevention and control of infection and staff training courses were provided. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19; including outbreak management plans and the HIQA self-assessment tool was up to date. However, the inspector found that the hand-washing facilities provided required attention as there was insufficient soap provided and no hand drying paper or towels provided. In addition to this, mops used for cleaning were not returned to the appropriate storage facility after use.

The provider had procedures in place for the identification, assessment and management of risk. Site-specific risk assessments were completed and were reviewed and updated if required. Internal audits were taking place, however not all risks identified were addressed. For example, the inspector noted that the seal of an external door was damaged which impacted on the insulation. A review of documents showed that this was recorded three months previously and remained outstanding. This was repaired by the end of the day of inspection. As previously

outlined above, there was evidence of deterioration in the internal and external upkeep of both houses. Some of the matters highlighted by the inspector were addressed by the end of the inspection.

The registered provider had ensured that there was an up-to-date site-specific fire safety policy and procedure in place. The inspector found that residents had personal emergency evacuation plans (PEEPS) in place and were aware of what to do if the alarm sounded. In addition to this, the residents were meeting as a group to discuss fire safety. However, the inspector found that improvements were required to ensure the safety of the residents was protected. These included ensuring the the daily fire safety check was up to date and that escape routes were regularly checked, kept free from clutter and in good repair. Although residents were involved in regular fire drills, the evacuation scenarios used had not assessed all possible circumstances for example, morning, evening and night-time evacuation drills.

Regulation 17: Premises

Improvements were required in the internal and external upkeep of the premises. For example, the paintwork had deteriorated and mould was present in some areas and the patio door was difficult to open and close.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Systems were in place to identify and record risks, however improvement were required in the follow-up risk management processes in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures were in place for the prevention and control of the spread of infection, however improvement were required with the hand-washing facilities provided and the storage of cleaning equipment.

Judgment: Substantially compliant

Regulation 28: Fire precautions

An up-to-date fire safety policy and procedure was in place and fire drills were taking place. Improvements were required in the evacuation scenarios used as they had not assessed all possible circumstances for example, morning, evening and night-time evacuation drills.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate practices in place in relation to the safe prescribing, storing and administration of medicines

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had up-to-date individual assessments in place which were subject to regular review.

Judgment: Compliant

Regulation 6: Health care

Residents had access to the support of a general practitioner (GP) and to healthcare supports provided by the multidisciplinary team.

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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant

Compliance Plan for Sligo Semi Independent Accommodation OSV-0004442

Inspection ID: MON-0034828

Date of inspection: 23/11/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• A meeting place took place with the funder on 22/12/21 to review the needs of individuals residing within Sligo semi Independent with the funder.
• A business case is currently being developed for the funder to meet the assessed current needs of the resident's within Sligo Semi Independent, this is based on reports received from members of the MDT. This will be completed by the 11/02/2022.
• The provider commits to ensuring the service is staffed to meet the assessed needs of all residents in the interim of the business case being developed and approved by the funder.
• An additional 39 hours of support has been introduced as an interim measure prior to the inspection.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
A meeting place took place with the funder on 22/12/21 to review the needs of individuals residing within Sligo semi Independent with the funder.
• A business case is currently being developed for the funder to meet the assessed current needs of the resident's within Sligo Semi Independent, this is based on reports received from members of the MDT. This will be completed by the 11/02/2022.
• The provider commits to ensuring the service is staffed to meet the assessed needs of all residents in the interim of the business case being developed and approved by the funder.
• An additional 39 hours of support has been introduced as an interim measure prior to</td></tr>
</table>

the inspection.
• The PIC will ensure all fire checks are completed and this will be reviewed during the monthly PIC audit.
• The Team Leader will ensure also that fire checks are completed during the weekly audit completed.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The housing agency who sustain the tenancies with the residents have completed a housing review on the 4th of November 2021. Actions identified including painting are for completion in quarter 1 of 2022.
• The PIC has since the inspection further contacted the housing agency that the service users have tenancy arrangements with and has escalated again the need for painting of both the interior and exterior of the premises.
• The PIC has made arrangements for a contractor to address the mould that is present in some areas within the service. This will be completed by the 30/01/2022.
• The patio door has since been repaired on the 25/11/2021.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The PIC will ensure all maintenance is completed in a timely fashion.
• All required maintenance will be notified to the PIC immediately by the staff team and Team Leaders. Actions will be taken locally to progress any maintenance issues in a timely manner and any larger issues will bed escalated to the housing agency for them to address accordingly.
• The PIC will review all required maintenance as part of the monthly PIC audit.
• The annual health and safety audit will be completed to review and highlight any other potential risks by the 28/02/2022.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The PIC and Team Leaders have ensured that adequate hand soap and paper towels are available with immediate effect.
• Ensuring adequate hand soap and paper towels are available at all times has been added to the daily cleaning schedule.
• All relevant cleaning equipment is now stored in a designated area within the garden shed. This will be checked by the Team Leader weekly whilst reviewing cleaning records.
• Education sessions will take place with service users in order to support their understanding on the importance of utilizing hand soap that is not watered down in ensuring maintaining IPC measures in the center. This will be done by the 16/1/22.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC will ensure that fire drills will be completed on a wide range of potential scenarios using the approach of simulated fire drills as well as part of quarterly fire drills. This will take effect from January 2022.
• The PIC will validate the completion of the above when completing monthly PIC audit's.

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	11/02/2022
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 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and	Substantially Compliant	Yellow	31/03/2022

	suitably decorated.			
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	11/02/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/03/2022
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	16/01/2022

Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/01/2022