Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Stranbeg
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	05 October 2021
Centre ID:	OSV-0004909
Fieldwork ID:	MON-0034370

About the designated centre

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

Stranbeg is a centre run by the Health Service Executive. It provides residential care for up to seven male and female residents, who are over the age of 18 years and have a moderate to severe intellectual disability. The centre comprises of one bungalow dwelling and three apartments, which are located within a few kilometres of each other near a town in Co. Sligo. Residents have access to their own bedroom, bathrooms, living areas and garden spaces. Transport arrangements are also in place to ensure residents have opportunities to access the community and local amenities. Staff are on duty both day and night to support the residents who live here.

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 5 October 2021	10:15 am to 3:30 pm	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

Residents in this centre were comfortable in their home and received a good quality service. They were supported to be active participants in the running of the centre and to meet their goals.

The centre consisted of two buildings located a number of kilometres apart in two different towns; a dormer bungalow and three self-contained apartments. The inspector visited the bungalow in the morning and the apartments in the afternoon. At all times, the inspector adhered to public health guidance on the prevention of infection of COVID-19. The dormer bungalow had four bedrooms, one of which was en-suite. Each bedroom was decorated in a different style in line with the residents' needs and wishes. Safety concerns required that one bedroom had additional cushioning. It was noted that efforts had been made to make this room homely with the addition of family photographs. The main living area of the house consisted of a kitchen-dining room with seating area and a sunroom. There was also a separate sitting room. The seating areas of the house had new comfortable furniture. The kitchen required refurbishment and the inspector noted damage to a kitchen cabinet door. The laundry facilities were located in a small utility room next to the kitchen. Pipework in this room had recently been repaired and there was discolouration on the walls where this had been completed. The person in charge reported that this had been highlighted to the provider's maintenance department and that there were plans to put in a new kitchen and refurbish the utility room. The main bathroom and en-suite had wetroom style showers. The company that own the house had committed to widening the doorway into the en-suite to facilitate easier access and refurbish the main bathroom. Upstairs, there were two offices used by staff. Outside, the house had been newly repainted and the grounds were well maintained. There was a polytunnel in the garden for residents' use. There was also a garden chalet with two rooms; one used by a resident as a relaxation room and there were plans to convert the other into a sensory room. The apartments were in good structural and decorative repair. Each apartment had one bedroom, a wetroom and kitchen-living room. The apartments were decorated to the residents' tastes. Additional padding was also in place in one apartment as a safety measure to facilitate a resident's independent movement. During the inspection, an issue with fire doors was identified and this resulted in an urgent action plan being issued to the provider to address them within three days of the inspection. This will be discussed further in the report.

The inspector met with six residents on the day of inspection. One resident chatted with the inspector about their favourite interest and their preferred activity. When asked what they liked most about their home, they replied "the staff". Other residents were busy going about their daily routines. This included relaxing with magazines, watching television, and two residents were just leaving on the bus as the inspector arrived. One resident was out for the day with their family and staff reported that residents were supported to maintain contact with family and friends. There were particular days during the week when residents left to visit relations or

when visitors called to the centre. All residents appeared very comfortable in their home and with staff. Staff were warm and respectful in their interactions with residents. Resident questionnaires indicated that residents were happy in their home.

Residents were supported to engage in activities of their choosing. These included home-based activities; for example, residents helped with meal preparation if they so wished. Residents were also supported to pursue hobbies in the wider community; for example, horse-riding, swimming, attending the local gym. Staff had commenced a structured programme with one resident to introduce them to new experiences and identify activities that they find enjoyable. It was planned that these would be added to the resident's regular schedule of activities.

Residents' rights were upheld. Residents were offered choices regarding their clothing, food and activities. The inspector noted that one resident had a schedule displayed where they could identify and choose their preferred activities for the day.

Overall, residents appeared happy in their home and had a good quality of life. Staff interacted with residents in a friendly manner and supported the residents to engage in activities that they enjoyed.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

There was good oversight in this centre with clear lines of accountability and reporting relationships. Staffing arrangements and training were in-line with the assessed needs of the resident. The provider had systems in place to ensure a good service was delivered to the residents.

The inspection was facilitated by the person in charge who had good knowledge of the needs of the residents and the services required to meet those needs. Both houses had sufficient staff to meet the assessed health and social needs of the residents. Nursing cover was available and the person in charge had submitted a request that additional nursing support be made available during business hours. This had recently been granted with a plan to add another nurse to the daytime staff rota in the near future. Additional staff had recently been added to the rota to support residents who had one-to-one staff. As the additional staff member could take over some of the routine actions that had to be completed in the centre, staff had more time to dedicate to supporting residents in their personal and social activities. The person in charge had measures in place to ensure that staff were

familiar to residents. When agency staff were required, the same staff members were employed in the centre. Also, new staff had an induction process and shadowed another staff member for a period of time to ensure that residents were comfortable with the staff member. Staff reported that they had good support from management and that they could voice any concerns that might arise. Staff supervision occurred routinely in line with the provider's guidelines.

Staff training was largely up to date. Where staff needed refresher training, the person in charge had identified those staff members and had listed them for training sessions. On the day of inspection, an occupational therapist with a special interest in sensory processing was in the centre to conduct an assessment and they also provided staff training on-site.

The provider had good oversight of the centre. The annual review and six-monthly unannounced audits of the centre had been conducted in line with the regulations. In addition, there was a range of audits conducted routinely and a schedule in place that outlined when these were to take place. A review of documentation found that these audits were completed in line with the provider's own guidelines. Findings from the audits were converted into action plans to address any issues identified. These were also fed into a quality improvement plan that was reviewed and updated on a monthly basis. Complaints were audited on a monthly basis. There was a complaints procedure in the centre and information to contact the complaints officer was displayed. A review of these audits found that a recent complaint had been processed in line with the complaints procedure with a satisfactory outcome.

Overall, there was evidence that there was good governance and management in this centre. The provider had systems to monitor the quality of the service. The number of staff and their skill mix were suited to meet the assessed needs of the residents and to support them with their personal and social goals.

Regulation 15: Staffing

The number and skill mix of the staff was sufficient to meet the assessed needs of the residents. Nursing support was available as required during business hours and on-call. The rota showed that a consistent team of staff worked in the centre that were familiar to residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training in 10 mandatory areas, as outline by the provider, was up to date. Where staff required refresher training, this had been identified by the person in charge and the relevant staff were listed for training. Additional training specific to

the needs of the resident had been sourced and was delivered on-site on the day of inspection.

Judgment: Compliant

Regulation 23: Governance and management

The provider had completed the annual reviews and six-monthly audits as outlined by the regulations. Staff were comfortable raising any concerns that they may have about the service. There were clear reporting relationships and lines of accountability. The provider had a schedule of audits in place to monitor the quality of the service delivered to residents.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in the centre. Contact details for the complaints officer was displayed. There was evidence that a complaint had been managed in line with the complaints procedure to a satisfactory outcome.

Judgment: Compliant

Quality and safety

Residents' welfare and their quality of life was maintained by a good standard of care. Residents were supported to engage in activities that were meaningful and enjoyable to them. Measures had been taken to protect the safety of the residents. However, significant improvements were required in the area of fire protection. There were also improvements required to the upkeep and refurbishment of the premises.

The inspector reviewed the fire precautions in the centre and found that the provider had taken steps to maintain the systems used in the detection, containment and fighting of fire. Smoke and heat detectors, fire alarms, and emergency lighting were routinely checked and maintained by an external fire company. Staff had recently completed fire training. Fire drills were carried out routinely and under varying simulated circumstances. The person in charge reported that there were plans to get an external company to inspect the older fire doors that were in one building. However, the inspector noted that two fire doors in the other

building did not close properly into their frames and would not be adequate in the event of a fire. In addition, fire doors were not routinely inspected in the centre. This was brought to the attention of the person in charge on the day of inspection. An urgent action plan was issued to the provider and a response was received to report that the faulty doors had been repaired, all other doors had been inspected by the maintenance department, and that fire door inspection would be completed routinely going forward.

The centre itself was adequate to meet the assessed needs of the residents. Each resident had their own bedroom that was suited to their needs. There was sufficient space to spend time together or alone. There was space to receive visitors and meet with them in private. The buildings were accessible to residents. The person in charge reported that there were a number of plans to refurbish the buildings to improve accessibility, for example, widening doorways, making the garden wheelchair accessible so residents can access the polytunnel easily. There were also plans to put in a new kitchen, refurbish the utility room and bathrooms, install a safe soft area for residents, and fix a lock on a cabinet. Some of these works were due to be completed by the provider and some by the house owner. The refurbishments had been added to the centre's quality improvement plan a number of months previously. A review of this document found that works were due to commence in early September 2021 but this had not occurred and there was no further update on this plan.

The person in charge had a comprehensive risk register for the centre. Risks were identified and assessed. Control measures to reduce the risk were identified and the assessments were regularly reviewed and updated. Each resident also had risk assessments that were specific to their needs and were regularly reviewed. These risk assessments formed part of the residents' personal plans. Residents' health needs were assessed and a care plan was put in place for any healthcare need that was identified. The care plans were regularly updated and reviewed. The residents had a named general practitioner locally and there was evidence of the involvement of a variety of healthcare professionals as required. Each resident had a review meeting on an annual basis that was attended by the healthcare professionals involved in their care and by a representative of the resident's family. Personal and social goals for the year ahead were also set at this meeting. These goals were reviewed throughout the year and additional goals added as they arose. These goals reflected the residents' interests and encouraged them to remain connected to the wider community.

Multidisciplinary involvement was also noted in residents' behaviour support plans. There was input from a variety of professionals including psychiatry, psychology, occupational therapy and speech and language therapy. Staff in the centre had been proactive in accessing services for residents to identify any causes for behaviours and to support them to manage those behaviours. On the day of inspection, an occupational therapist was in attendance to support a resident with sensory processing and this service had been sourced by staff. Staff were knowledgeable of the steps to be taken to support residents manage their behaviours. A number of restrictive practices were in place as part of these plans. These were identified by the provider and a log of their use had been kept. They were discussed at a

restrictive practice committee. One practice was due for review with the psychologist as it had not been implemented in a number of months.

As outlined previously, residents' rights were upheld. Residents were offered choices in their daily lives and these choices were respected. There were weekly meetings between staff and residents. This supported residents to make plans for the week, and make choices around daily activities and the weekly menu. A review of menus found that residents had a varied diet. There was ample fresh food in the fridge. Residents' with difficulties with eating and drinking had been assessed and staff were knowledgeable on the suitable food and fluid consistencies for residents. Residents' communication was supported to enable them to express their needs and wishes. Residents had a communication profile that was devised by a speech and language therapist. Picture-based communication systems to facilitate choice was being introduced with one resident. Staff were knowledgeable on the residents' communication styles and could interpret their behaviours.

There were good safeguarding measures in the centre. Safeguarding concerns were processed in line with the provider's own policy. Staff were up to date on their safeguarding training and knowledgeable on the steps that should be taken if there was any cause for concern. Residents had personal and intimate care plans in place. The provider had also taken steps to keep residents safe from the risk of infection. In addition to the routine cleaning schedule, an enhanced cleaning schedule was used to reduce the risk of the spread of infection. Temperature checks were carried out routinely. There was a contingency plan that supported residents to self-isolate in cases of suspected or confirmed COVID-19 infection. The person in charge had completed the Health Information and Quality Authority's infection prevention and control self-assessment and had reviewed it recently.

Overall, residents in this centre received a good quality service. Supports were available to meet the assessed needs of the residents, multidisciplinary services were accessed as required, and resident were supported to engage in activities of their choosing.

Regulation 10: Communication

Residents' communication needs were identified and supports were put in place to facilitate them to express their needs and wishes. Residents had access to appropriate media, for example, television, internet and tablet computers.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the assessed needs of the resident. There was adequate communal and private space. Residents had their own bedrooms and access to kitchen and laundry facilities. The provider had identified areas of the centre that required refurbishment and repair. However, the planned start date for this work had not been met and there was no plan that outlined when these works would commence.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents had access to ample fresh food and received varied meal options throughout the week. Residents with specific difficulties with eating and swallowing had been assessed and meals were prepared in line with these guidelines.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk register for the centre and individualised risk assessments for residents. There were control measures to reduce the risk and all risks were routinely reviewed.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had taken adequate measures to protect residents from the risk of infection. The centre was cleaned in line with the providers' guidelines and plans were in place to support residents to self-isolate in cases of suspected or confirmed COVID-19. The provider conducted regular audits of the infection prevention and control practices.

Judgment: Compliant

Regulation 28: Fire precautions

An external fire company routinely checked the fire detection, containment and fire fighting systems. The staff in the centre conducted regular fire drills with the residents. The drills were simulated under different conditions. However, two fire doors were found to be faulty on the day of inspection. These had not been identified by the provider and fire doors were not routinely checked. An urgent action plan was issued to the provider as a result of this finding.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were assessed and reviewed. An annual multidisciplinary team meeting was held with representatives from the residents' families to set goals for the year. There was evidence that residents were supported to meet these goals.

Judgment: Compliant

Regulation 6: Health care

The health needs of the residents were well managed. Health assessments were conducted. Care plans were devised for any health need identified on the assessment. There was evidence of input from a variety of health professionals as required by residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had input from a variety of health professionals to support them manage their behaviour. Staff were knowledgeable on the residents' behavioural support plans. Staff training was up to date in the management of behaviour that is challenging.

Judgment: Compliant

Regulation 8: Protection

The provider had measures in place to protect residents from abuse. All staff were trained in safeguarding. Safeguarding was included in the provider's audit schedule. Staff were knowledgeable on the steps that should be taken in cases of suspected abuse. The residents' personal plans included intimate care plans.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld. Residents were offered choices and these choices were respected by staff.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	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 Stranbeg OSV-0004909

Inspection ID: MON-0034370

Date of inspection: 05/10/2021

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: To ensure compliance with Regulation 17 the following plan has been implemented The Utility room upgrade which will include painting and the replacement of the utility work surfaces will be completed by 15/11/21. The kitchen area will be refurbished and this will include new cabinets, flooring and work surfaces .This will be completed by 15/12/21. The widening of the ensuite bathroom doorway will be completed by 20/01/22 The refurbishment of the main bathroom including new tiling , flooring and fixing will be completed by 20/01/22	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: To ensure compliance with Regulation 28 the following actions have been implemented -The maintenance team have inspected all fire doors within the two building within the centre -Two doors were identified and these have been repaired and are closing fully now. -Doors with free swings are completely latching and closing completely. -A log is now in place to ensure all fire doors are checked weekly to ensure they are closing correctly .If faults are identified this will be escalated to the maintenance manager immediately. These actions were completed by 8/10/21	

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 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	20/01/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	08/10/2021