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:	Steadfast House Residential Service - Group Home
Name of provider:	Steadfast House Company Limited By Guarantee
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	24 January 2022
Centre ID:	OSV-0001631
Fieldwork ID:	MON-0035200

About the designated centre

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

Steadfast house residential service provides person centred care to five female residents on a full time basis. Residents are supported on a individual basis in line with their assessed needs, wishes and preferences. The centre has a clear and professional management and staffing team in place to oversee the operation of the service. The centre is located within walking distance of a town, and residents can access a range of amenities and activities in the local community. Residents are supported by two staff during the day and one staff overnight. One resident attends day services in a local centre in the community, and day services are provided to three residents in the designated centre, as was their preference. One resident is supported by staff to undertake meaningful day activities. The centre is laid out to meet the individual and collective needs of residents in a homely environment.

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 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 24 January 2022	08:40hrs to 16:35hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

This centre was last inspected in November 2021, and significant concerns were identified during the inspection. As a result the provider was invited to attend a warning meeting with the Health Information and Quality Authority (HIQA). The provider was issued with a warning letter outlining the concerns HIQA had in relation to this designated centre, and the provider was subsequently requested to respond to the warning letter. This inspection was carried out as a follow up to the warning letter response and to the compliance plan received from the provider following the last inspection.

From meeting with residents, speaking with staff and from observing staff interacting with residents it was clear that significant progress had been made to ensure residents' rights were being upheld and that risks were being appropriately managed. This meant that residents were safe in the centre, their dignity and privacy was maintained, their decisions were respected, and residents were being provided with the necessary supports to ensure their needs were being comprehensively met.

The inspector met four of the residents on the morning of the inspection. Residents told the inspector of their plans for the day with some residents going to day services and others attending an appointment beforehand. One resident was at home at the time of inspection. Residents told the inspector they had enjoyed the Christmas break and had spent time with their families. One resident had recently purchased an electronic tablet and liked listening to country music on this. From reviewing documents, the inspector found staff were planning on supporting the resident to use this device to make video calls to their family.

Since the last inspection, an outside building had been completed, which the residents referred to as the 'cabin' One of the residents said she liked to go out to the cabin to relax and another resident said they liked to do their knitting there. Staff also told the inspector, that as part of safeguarding plans, there were daily activity planners and residents used the cabin to partake in some of these activities. Later in the afternoon the inspector joined two residents and a staff member in the cabin, and residents appeared very happy using this space, doing jigsaws, knitting and chatting with staff. The inspector found this cabin was warm, comfortable, suitably furnished, and provided residents with additional communal space to take part in those activities which they preferred, for example, listening to music and crafts.

Staff had a very positive approach with residents, and residents appeared to really enjoy the company of staff. There was a relaxed atmosphere with residents chatting and laughing together with staff about previous holidays and day trips. A staff member was also observed to sensitively provide support to two residents to engage in a relaxation session in the afternoon.

The inspector spoke with two staff members during the day. Staff outlined there had been significant improvements in the centre, and as a result their role and remit in relation to risks in the centre had been clearly set out. Staff also said the person in charge was very supportive, and they could raise concerns about any aspect of the service provided to residents, at any time with the person in charge and the person participating in management. In response to risks identified on the previous inspection, the provider had put in place a confidential email and phone line which staff could use if they felt the local reporting mechanisms were not effective in response to concerns.

The inspector also met with the chief executive officer and the person in charge during the course of the inspection, and information was provided on the changes to practices in the centre, planned improvements, updated management arrangements, and the proposed long-term governance arrangements for the centre.

Overall the inspector found the provider had taken positive actions to ensure the residents were receiving a good quality of service and to ensure most of risks which had been identified on the previous inspection were mitigated. However, auditing systems to ensure effective oversight were not fully commenced at the time of the inspection. In addition, the provider had yet to develop a system which dealt with the previously identified risk relating to verification of assurances provided to the board of management via reporting mechanisms.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

The inspector found the provider had made significant improvements since the last inspection, and had put systems in place to provide residents with an effective and safe service. This meant that the residents' needs were appropriately assessed and care and support was being provided in line with these needs. The provider had implemented a number of key policy changes in the centre, to ensure the rights of residents were protected, and to ensure risk and safeguarding concerns were escalated to management. In addition, the provider had provided additional support and training to staff to ensure they had the knowledge and skills to meet the needs of residents and to keep them safe. Some improvement was required in the system for monitoring the services provided to residents in the centre.

There was a full time person in charge in the centre, who had been appointed in November 2021, and was responsible for this, and one other designated centre under the remit of this provider. The person in charge was a registered nurse and had a number of years management experience. The person in charge was in attendance in the centre on a daily basis, and staff told the inspector the person in

charge provided good support and was available by phone at any time should they require assistance. The inspector found the person in charge provided good leadership, and had lead the staff team in the key changes required to ensure improved standards of care and support for residents. For example, changes in practice relating to personal care, ensured that residents' privacy and dignity was maintained. In addition, the introduction of a structured activities, meant that residents were actively engaged in activities of their interest, and risks relating to safeguarding concerns were mitigated.

The quality of the service provided had improved and the provider had responded to ensure most of the risks identified during the previous inspection were mitigated. This included risks relating to safeguarding, positive behavioural support, medicines management and residents' rights. The inspector spoke to two staff members, one of whom outlined there had been a lot of changes for the better in the centre, and the other of whom told the inspector they had very good support from the management team. Staff confirmed that a confidential email and phone number was provided to staff, to report risks or concerns, if they felt they were not been dealt with appropriately at a local level. The provider had also initiated improved oversight arrangements. The person in charge and person participating in management were meeting on a monthly basis, and also meeting the staff team monthly. From a review of the last staff meeting it was evident that the expected standards of care and support had been clearly set out to staff, and staff were supported to understand new procedures such as raising concerns, the management of risk, and safeguarding residents.

A more robust reporting structure from the person in charge to the board of management was also in development. The provider had developed a quality and risk subcommittee at board of management level, and this committee was scheduled to meet a minimum of four times a year. The purpose of this committee was to provide assurances to the board of management that risks were being managed appropriately and that incidents were reported appropriately. As part of this process the person in charge was required to submit a monthly report on areas such as safeguarding, staffing matters, risks, positive behavioural support, restrictive practices, and person centred planning.

The person in charge had developed a schedule of proposed audits for the upcoming year including for example, monthly audits of medication and key performance indicators, and quarterly audits of fire, risks and incidents, individual support plans, training, restrictive practices and health and safety. The person in charge had also discussed with the person participating in management the need to appoint a team leader in this and another centre under the remit of the person in charge, with a view to team leaders being able to carry out cross audits between the two centres.

The inspector acknowledges that significant progress had been made in developing improved reporting systems to and from the board of management, however, these systems were very much in their infancy. It was not evident however, that there was a system in place to verify the outcomes of reports and audits independent of the management team. The inspector discussed this with the person participating in

management, and given the risk which had been identified on the previous inspection relating to the poor reporting mechanisms, the inspector was not assured that the new reporting mechanisms would mitigate the risk of relying solely on reports from the person in charge and person participating in management. Therefore improvement was required in the monitoring system at the level of the board of management to ensure the service provided was safe, effective and comprehensively met the needs of the residents.

Since the last inspection, there had been improvement in the maintenance of staff files and from a review of a sample of two files, the inspector found all the required documents as per Schedule 2 of the regulations were in place. The inspector reviewed a sample of staff rosters, and found staffing levels were in line with the assessed need of residents. There were two staff on duty during the day, and one waking night staff. At times, when there residents were attending day services, the staffing levels reduced to one staff during the day.

As part of the provider's compliance plan following the last inspection, staff had been provided with training in medicines management, safeguarding, positive behavioural support and human rights. Direct instruction had been provided by the person participating in management on the provider's new risk management policy and on the new incident management framework.

The provider had developed a number of key policies in response to the concerns identified on the last inspection, and to the warning letter issued to the provider. As mentioned a new risk management policy and incident management framework were in place, and a staff member told the inspector these procedures were now much clearer. In addition, an open disclosure policy, a protected disclosure policy and a supporting autonomy policy had been developed.

Notifications had been made to HIQA relating to incidents and practices in the centre.

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and had the knowledge, experience, and qualifications necessary to carry out this role. The person in charge was a registered nurse. The person in charge had responsibility for two designated centres, and was in attendance in the centre on a daily basis while on duty. The person in charge was knowledgeable on the regulations and their responsibilities.

Judgment: Compliant

Regulation 15: Staffing

All of the required documents as per Schedule 2 of the regulations were available on file for staff members. There were sufficient staff with the right skills and qualifications to meet the needs of the residents and to keep them safe. Nursing care was provided as required by the person in charge. Staffing rosters were appropriately maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had been provided with additional training in response to risks identified on the last inspection. This included refresher training in safeguarding and medicines management, and training in human rights. Staff competencies in medicine management had been assessed were planned to be re-assessed on a regular basis.

Judgment: Compliant

Regulation 23: Governance and management

Overall there had been significant improvement in the governance and management arrangements in the centre. The provider had responded appropriately to the risks identified during the last inspection including safeguarding, positive behavioural support, residents' rights and medicines management.

Additional reporting mechanisms had been put in place to allow staff to raise concerns about the quality and safety of care and support provided to residents and to report concerns and risks if required, if they were not being appropriately managed locally. The management team were also meeting the staff on a monthly basis, and there was evidence that staff were being kept up-to-date on key changes within the centre, and on expected standards of care and support.

The oversight of the centre had improved since the last inspection. The person in charge was available to provide guidance and support to staff, and had put in place a number of improvements to ensure residents were receiving a good quality of care and support. For example, a new personal planning process had been rolled out, which gave residents a more enhanced input into planning for their goals and aspirations. There were more robust reporting mechanisms put in place including monthly management meetings, a monthly report to the board of management, and the establishment of a quality and risk committee.

The person in charge had developed an annual schedule of audits, and was proposing some of these would be carried out by a team leader from another centre, under the remit of the provider. However, the provider had not put

measures in place to verify the outcomes of reports and audits independent of the local management team, and therefore assurances that the centre was being monitored appropriately were not in place on the day of inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that HIQA had been notified of any incidents and practices occurring in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had reviewed and updated the risk management policy and introduced an incident management framework, reflecting a change of practice within the centre. The provider had also developed three new policies within the service, in response to risks identified on the last inspection. These included an open disclosure policy, a protected disclosure policy and a supporting autonomy policy.

Judgment: Compliant

Quality and safety

Since the last inspection there had been improvement in the quality and safety of care and support provided to residents. Residents were provided with the appropriate support to meet their behavioural and emotional needs, and there were systems put in place to ensure the risks relating to previous safeguarding concerns were mitigated. The rights of residents to be involved in decisions about their care and support had improved, and practices had been reviewed to ensure residents' privacy and dignity was maintained. Medicines management had improved and staff had been provided with training and information to ensure safe practice.

The inspector reviewed documentation pertaining to residents assessed needs and personal plans. Residents had been reviewed as required by the relevant professional, and plans were in place to guide staff in supporting residents with their needs. On the day of inspection, a number of residents attended an annual medical review, which also would inform personal plans. The person in charge had identified the need to make the planning process more engaging and person centred for

residents, giving them the opportunity to talk about and develop their life aspirations and goals. The inspector reviewed a sample of monthly resident key worker meeting and found comprehensive records were maintained and goals were developed based on these discussions. This meant that residents were involved in decisions about how they wished to live their life. Staff also recorded monthly key worker reports, and the progress of personal plans and goals were maintained. The inspector found plans were implemented in practice, for example, healthcare monitoring interventions were completed, and a goal for a resident to use an electronic device for video calls, photos and music were in progress. Residents also told the inspector they continued to enjoy one to one days with staff and they chose how they would like to spend these days.

The provider had engaged the services of a behaviour specialist. Residents had been assessed and behaviour support plans had been developed as required for residents. The inspector reviewed two of these plans and found they guided staff in proactively supporting residents to manage their emotions. In addition, records were maintained of behavioural incidents so as to inform reviews of behaviour support plans and reviews with the mental health team. The behaviour specialist had also provided staff with refresher training in positive behavioural support. In addition, a restrictive practice had been reviewed since the last inspection. The person in charge and person participating in management had identified the need for a rights committee to be established within the organisation, and proposed that going forward restrictive practices would also be reviewed by this committee.

Since the last inspection safeguarding issues had been reviewed and measures were put in place to ensure residents were protected. There had been no further safeguarding incidents since the last inspection, and all previous safeguarding concerns had been reported to, and subsequently closed by the safeguarding team. As mentioned staff had been provided with refresher training in safeguarding, and additional safeguarding reporting mechanisms had been put in place.

As mentioned the rights of residents to participate in decisions about their life had improved, and proposals to transfer a resident out of the centre had been discontinued. In the meantime, the provider had ensured the needs of the resident were assessed so as to inform the support the resident required to remain living in their home. In addition, intimate care plans were reviewed and informed staff of the care required to ensure residents' privacy and dignity was maintained. A staff member described these measures to the inspector. This meant that staff had the necessary knowledge to ensure the risk of residents' dignity being compromised was minimised. The inspector observed that care and attention had been provided by staff to those residents requiring additional support with personal care, both in the morning time and during a relaxation session in the afternoon.

There were regular residents' meetings and the inspector reviewed minutes of the last meeting. The person in charge was in attendance at this meeting, and it was evident that residents were given the opportunity to express their views and preferences, and were provided with information relating to the centre and their care. For example, information on healthy eating, the contact details of the local advocacy service, and how to make a complaint was shared with residents.

Residents also spoke about changes they would like to see in the centre, and a decision was made to change a small sittingroom into a sensory room.

Risk assessments had been updated following a review of residents needs, and control measures were in place to mitigate potential risks. For example, these included the use of assistive equipment, measures to reduce the risk of burns, positive behavioural support and infection prevention and control precautions. As discussed the provider had implemented a new risk management policy and incident management framework. An adverse incident occurring in the centre had been followed up as required, and the resident had been reviewed by their general practitioner. Incidents were proposed to be reviewed on audit on a quarterly basis, and reported on a monthly basis to the quality and risk subcommittee.

Medicine management practices had also been reviewed, and staff had been provided with refresher training in medicines management. Staff competencies in relation to medicine management had been assessed, and were to be reviewed on a quarterly basis throughout the year. The inspector spoke to a staff member who was knowledgeable on the medicines and the reason they were prescribed for residents. Medicine management plans were in place for residents, and information was available on the types, form, effects and side effects of medicines in use in the centre. There was a system in place for staff to contact the person in charge in the event a resident required a PRN (as the need arises) medicines.

A medicine administration process was not observed during the inspection.

Regulation 26: Risk management procedures

Up-to-date risk assessments relating to residents' needs were in place, and control measures were implemented in practice. Incidents were appropriately managed, and a plan was in place to audit incidents on a quarterly basis. A new risk management policy had been developed, along with a new incident management framework.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Improvements in medicine management practices meant that staff were knowledgeable on the types of medicines in use in the centre. Staff competencies in medicines management had been assessed and were to be reviewed on a quarterly basis going forward. Staff had attended refresher training in medicines management and medicine management plans were in place for residents.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Up-to-date assessment of needs were completed for residents and personal plans were developed based on these needs, and on the outcome of reviews by the general practitioner and allied healthcare professionals. Residents were actively involved in the development of plans and goals, and in the ongoing review process. Plans clearly outlined the support residents required to met their needs and to achieve their goals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had been provided with the support in order to help them manage their emotions and behaviour. Where required, residents had been assessed by a behaviour specialist, and behaviour support plans outlined the proactive and reactive responses to support residents in managing their behaviour. Refresher training had been provided to staff in positive behavioural support.

A restrictive practice had been reviewed since the last inspection, and the provider had identified the need for a rights committee within the service, to review restrictive practices going forward.

Judgment: Compliant

Regulation 8: Protection

Appropriate measures were in place to ensure residents were protected, and the inspector observed these measures were implemented in practice. An additional safeguarding measures had been introduced in the centre and staff could report concerns thorough a confidential phone number or email, in the event that local procedures were not effective. All previous safeguarding concerns had been reported to the appropriate personnel and had since been closed. There were no current safeguarding concerns in the centre.

Since the last inspection, staff had attended refresher training in safeguarding.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were actively involved in decisions about their care, and the running of the centre. Residents regularly met with staff individually, and as a group with the person in charge during residents meetings. Plans, goals, and changes in the centre were agreed and acted upon based on these discussions. Practices in the centre relating to personal intimate care had improved, which meant that residents' privacy and dignity was maintained and respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Steadfast House Residential Service - Group Home OSV-0001631

Inspection ID: MON-0035200

Date of inspection: 24/01/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

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

The board of Directors of Steadfast House have nominated the Interim CEO to visit the service on a weekly basis, to review documentation, consult with staff and have weekly meeting with residents to ensure the highest standards of care and quality of service.

The interim CEO is reporting back to the Board of Directors on a regular basis.

Monthly staff meetings with the interim CEO and PIC have taken place and meeting minutes have been disseminated to the relevant parties. These meetings include discussions of any current safeguarding concerns and incidents reported.

The daily report book has been reviewed on a weekly basis by the PIC.

The PIC has revised and updated the annual audit schedule. All scheduled audits are due to be rolled out from February 2022.

The PIC is currently completing all monthly/ quarterly audits and associated action plans are either closed out or on going.

A clear line of reporting has been defined and this information has been shared with staff. Staff have reported they now feel empowered to raise concerns and that they feel reassured that any concerns raised will be dealt with appropriately and in a timely manner.

An External Audit Protocol is currently being developed in conjunction with the HSE. A meeting has been scheduled for Wednesday 16th March 2022 to finalise the terms of reference to include a Quarterly External Inspection to be carried out by the HSE who will in turn report back to the Board of Directors of Steadfast House.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2022