



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

Issued by the Chief Inspector

Name of designated centre:	Hempfield
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	08 February 2022
Centre ID:	OSV-0003379
Fieldwork ID:	MON-0033999

About the designated centre

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

In this centre a 24 hour residential service is provided to adults of a younger profile, but all over the age of 18 years. The primary purpose of the service is to provide support for persons with a diagnosis of autism and intellectual disability and the maximum number of residents that can be accommodated is four. The premises is a detached dormer type bungalow with services for residents provided on both floors; a self-contained apartment for one resident is provided at ground-floor level. The centre is located on the outskirts of a large town and ample provision is made for transport suited to the needs of the residents so they have daily access to services in the local community and beyond. The model of care is social and the staff team is comprised of social care workers and support workers. Daily management and oversight is assigned to the person in charge supported by deputy team leaders. Access to clinicians and multi-disciplinary support is largely available from within the provider organisation. Staffing levels and arrangements are based on the assessed needs of the residents; there are two staff members on duty each night with day time staffing levels reflecting 1 to 1 or 2 to 1 staff to resident ratios as needed.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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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
Tuesday 8 February 2022	10:15hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

Based on what the inspector observed, read and discussed this was an effectively managed and overseen service. Resident well-being, welfare and quality of life was maintained by a good standard of care and support. However, further exploration by the provider and a plan to progress as appropriate a resident's articulated wish to live elsewhere was needed.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. However, the inspector had opportunity to meet with all four residents, with the staff on duty, to observe practice and the routines of the service.

On arrival, the inspector saw that controls were in place to reduce the risk of the accidental introduction of infection to the centre. Staff ascertained inspector well-being as part of these controls. All staff on duty were seen to wear the recommended higher specification face mask and confirmed they had access to an adequate supply of these. The house was visibly clean and staff were noted to clean frequently touched items. The somewhat generalised wearing of disposable gloves observed by the inspector was addressed and corrected during the inspection.

The person in charge was on planned leave and the provider had put suitable arrangements in place for the management and oversight of the centre during this planned absence. The inspection was facilitated with ease by the deputy team leader who was deputising for the week.

While the house was busy there was an easy atmosphere. The inspector noted the different routines of the residents and staffing arrangements that reflected these routines. For example, two staff came on duty at 10:00hrs as residents were preparing to start their day. The support and care provided was individualised to the needs, choices and abilities of each resident and was maximised by the available resources. Three residents spent much of the day out in the community with staff. The inspector saw that residents had daily planners and what residents did each day was linked to their personal goals and objectives so that they had purposeful and meaningful routines. Goals included facilitating and maintaining contact with home, family and peers. In the house each resident had their own bedroom with access to a range of media and sensory items. Staff had sourced a projector for the main communal room to ease the impact of restrictions as one resident enjoyed trips to the cinema.

Staff had good knowledge of each resident's circumstances and any risks that presented to their safety or quality of life. Good oversight was maintained of resident health and well-being and residents had access as needed to their multi-disciplinary team (MDT) many of whom were available from within the providers own resources. Community based services such as the local general practitioners (GP's) were responsive to the needs of the service. For example, staff spoke of how

COVID-19 vaccination on site had been facilitated for two residents.

The assessed needs of residents included communication differences. Residents choose if they wished to meet the inspector and if they wished to engage. All four residents greeted the inspector perhaps through gesture or facial expression but were more content to continue with the activity at hand or their planned routines for the day. Residents presented as comfortable in their home and with the staff on duty. The support observed was respectful. In addition, to verbal communications staff used a variety of tools to consult with residents such as visual schedules and manual signing. Staff spoke with residents about their routines, the risk of infection, how to stay safe and advised residents of matters such as any staff changes.

A high level of compliance with the regulations reviewed was evidenced. Some minor improvement in the review and updating of risks and their management was needed. As stated at the start of this report one resident had articulated a desire to leave the centre. This was acknowledged and had been escalated within the organisation. However, further action was needed of the provider to explore what it was that the resident wanted and to progress as appropriate the resident's wish to relocate.

The next two sections of this report will present 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 service being delivered.

Capacity and capability

This was an effectively managed and overseen centre. The centre presented as adequately resourced, for example the centre was appropriately staffed and ample provision was made for transport suited to residents' needs. A high level of compliance with the regulations reviewed was evidenced. Some minor improvement was needed in the oversight and updating of the risk register and further review was needed of one resident's placement.

This inspection was unannounced and the person in charge was on planned leave. Ordinarily the person in charge was based in the centre and was supported in the management and oversight of the centre by two deputy team leaders. The inspector found the provider had put in place effective arrangements for the management of the centre during the planned absence. The deputy team leader was deputising for the person in charge and confirmed they had suitable working arrangements for the week. The deputy team leader had the knowledge and information they needed to ensure consistent and effective oversight of the centre. The inspector saw the deputy team leader had ready access as needed to more senior management.

The provider had multiple systems of quality assurance that were focused on assuring the quality and safety of the service that residents received. For example,

management described and the inspector reviewed records of the processes for reviewing accidents and incidents. This included any incident where there was a requirement for staff to use a physical intervention. There was good access to and good input from the multi-disciplinary team. Members of the MDT and the management team visited the centre on a regular basis. There was evidence of regular communication between the person in charge and the staff team.

The provider was also completing the six-monthly service reviews required by the regulations. The inspector reviewed the report of the most recent review completed in November 2021. The review was detailed, there were no findings of concern and a limited number of actions for improvement issued. Many of the failings related to gaps in documentation. It was evident from speaking with the deputy team leader that the findings of reviews were shared with the staff team as were the actions needed for improvement.

Records seen by the inspector confirmed that as part of its quality assurance systems the provider monitored and promoted vaccination uptake amongst staff and residents.

Based on the sample of staff rotas reviewed the provider maintained staffing levels that were appropriate to the assessed needs of the residents and any associated risks. The rota also demonstrated good consistency of staffing. The staffing reflected in the rota was as described and as observed by the inspector. Staff start and finish times reflected the routines of the residents. For example, two staff came on duty at 10:00hrs as residents liked a slow start to their day and evening staffing levels supported community access for residents if this was what they wanted.

The staff training matrix matched the staff rota. The training matrix indicated that all staff had completed mandatory and required training such as safeguarding, preventing and responding to behaviour of concern and risk, first aid, medicines management and training in infection prevention and control. Newly recruited staff had to complete a prescribed suite of training prior to commencing work. Attendance at staff training was monitored in the centre and any training needed was requested from the training department.

Regulation 15: Staffing

The provider had staffing levels and arrangements that were appropriate to the number and the assessed needs of the residents living in the centre. Nursing advice was available from the wider organisational resources and community based resources. A planned and actual staff rota was maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff attendance at baseline and refresher training was monitored.

Judgment: Compliant

Regulation 21: Records

Any records requested by the inspector were made available. Records were kept as specified by the regulations. For example, records of referrals and follow-up appointments in respect of each resident.

Judgment: Compliant

Regulation 23: Governance and management

Based on what the inspector observed, read and discussed this was an effectively managed and overseen centre. The centre presented as adequately resourced. The provider had multiple systems of quality assurance that were focused on assuring the quality and safety of the service that residents received.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on these inspection findings there were arrangements that ensured HIQA was notified as required of certain events and incidents that occurred. For example, any occasion where a restrictive procedure was used.

Judgment: Compliant

Quality and safety

Resident well-being, welfare and quality of life was maintained by a good standard of care and support. However, further exploration and a plan to progress as

appropriate a resident's articulated wish to live elsewhere was needed.

The support and care each resident required was set out in their personal plan. The personal plan reviewed by the inspector was based on an up-to-date assessment of needs. The plan was kept under review and the overall effectiveness of the plan had been recently assessed by the person in charge. Staff said and there was documentary evidence of regular consultation with and input from the MDT. Staff discussed the personal plan with residents during regular key-working meetings. The plan included the goals and objectives that residents wished to pursue. There was a social and developmental theme to these goals such as developing the skills needed for independence and for building and maintaining relationships.

Staff spoken with had a sound understanding of each resident's needs, routines, choices and challenges. Staff described how they sought to respect and promote resident choice and decision-making while supporting residents to make good decisions, for example in relation to their dietary choices, sleeping patterns and personal care routines.

However, the inspector saw that one resident had and was clearly articulating a wish to leave the centre, to return home or to their place of origin. Staff recorded how the resident communicated this and the matter had been escalated by the person in charge to the provider's admission, discharge and transfer committee. Staff reported that the resident was content on many levels and was doing well in response to the support provided in the centre. The inspector was assured that regular access to home and to locations of significance to the resident was part of the resident's daily routines. However, a record seen highlighted a potential link between this desire to relocate, the residents overall well-being and periods of anxiety that at times manifested in behaviour of concern and risk to self and others. The resident was reported to struggle with the idea that the centre may be their "forever home". Therefore, while the matter was acknowledged and had been escalated, further action was needed by the provider to explore what it was that the resident wanted and progress as appropriate the residents wish to relocate.

As briefly referred to above there were times when residents expressed behaviours that posed a risk to themselves and others including their peers and the staff team. There was regular access as needed to the appropriate clinicians and in response to incidents that occurred. The support plan was seen to be regularly reviewed by the behaviour support team. The plan outlined preventative and responsive strategies and reactive strategies as a last resort where there was imminent risk to the resident or others. Staff had completed training in the management of actual and potential aggression. Staff confirmed sanctioned interventions were practiced regularly each week amongst the staff team so that they maintained their skills. There was clear guidance for staff on when to disengage. Incidents where staff had to physically intervene had to be reported by staff on the provider's incident reporting system. The inspector discussed and saw a post incident review; this review included assurance of adherence to the plan where physical intervention by staff was necessary.

The provider was aware of and fulfilled its responsibility to protect residents from

harm including possible harm from a peer. Staffing levels and transport arrangements promoted the individuality of the service and facilitated residents to have different routines, make different choices and engage in activities of their choosing. Staff said some residents were also content to spend time together. The provider took appropriate action to protect residents and fulfilled its reporting obligations to HIQA and to other stakeholders such as the local safeguarding office.

Overall, the inspector found the risks presenting in the centre were identified, assessed and controls were in place. There was evidence of corrective actions. For example, additional controls were put in place in response to incidents such as further clinical review, review of medicines and the allocation of additional staff for a prescribed period of time. The review of risk assessments largely corresponded with the findings of fire drills, fluctuating COVID-19 requirements and incidents that occurred. However, there was some minor inconsistency in the review and updating of risks and controls such as the risk for peer to peer incidents occurring.

The provider had procedures in place to ensure it had effective fire safety management systems. For example, there was a fire detection and alarm system, emergency lighting, fire-fighting equipment and fire-resistant doors with self-closing devices. There was documentary evidence that these systems were inspected and tested at the recommended intervals. Staff induction included familiarisation with escape routes and the evacuation procedure. Staff and residents participated in regular simulated evacuation drills. Challenges did arise at times but staff were able to successfully evacuate all residents. Challenges such as possible resident reluctance to evacuate were included in the personal emergency evacuation plan.

The provider had adopted infection prevention and control procedures that were consistent with HIQA's National Standards for infection prevention and control in community services (2018). Infection prevention and control was part of the daily management and routines of the centre. For example, the inspector saw there was a good standard of environmental hygiene. Provision was made for the storing of cleaning products and equipment. This area was clean and organised and equipment such as buckets and mops were appropriately stored. Staff understood the colour coded system of cleaning that was used. However, it was observed that better guidance could be provided for staff on the specific products to use when attending to the cleaning of frequent touch points. All staff on duty were seen to wear the higher specification FFP2 face mask. The deputy team leader confirmed adequate access to stocks and clearly described the contingency plans for responding to any suspected or confirmed COVID-19. There were daily procedures for staff to establish and declare they were free of symptoms indicative of infection prior to coming on duty. In addition to the core suite of infection prevention and control training staff had also completed the HIQA module on Regulation 27 and the National Standards for infection prevention and control in community services (2018).

Adequate provision was made for hand hygiene facilities for staff. For example, there were sanitary facilities for staff on the ground floor and a wash-hand sink was provided in the staff office. Hand sanitising products were available at ground and first floor level. However, the inspector noted that all staff on duty were wearing

disposable gloves in situations and for tasks where their use would not be required or recommended. For example, where there was no direct contact with blood or body fluids of potentially infectious material. Prolonged and generalised use of gloves should be avoided for a number of reasons. For example, it has been found to increase the risk of cross transmission. This was discussed and explored with staff and management who were receptive to the discussion and this practice was addressed and ceased with immediate effect.

Regulation 10: Communication

Residents assessed needs included communication differences. Residents used a variety of means to communicate with staff. There were tools to support and facilitate effective communication where verbal ability was limited. For example, staff described how one resident had engaged with and now used a basic 12 manual sign vocabulary. Staff understood the co-relation between communication and behaviour. The inspector saw the residents had access to and enjoyed a range of media.

Judgment: Compliant

Regulation 11: Visits

Reasonable controls were in place such as checking with visitors for possible signs of infection to ensure that visits to the centre and to home were safely facilitated.

Judgment: Compliant

Regulation 12: Personal possessions

Residents required support to manage their personal finances. The deputy team leader described the recently enhanced processes in place to safeguard residents monies such as the recording of access so that it could be traced, the recording of all debits and deposits, daily and weekly monitoring of transactions and balances. There were records in place confirming these processes were consistently implemented.

Judgment: Compliant

Regulation 13: General welfare and development

Residents received an integrated type service where opportunities for community access, community based programmes and activities were co-ordinated from the centre. Staffing levels and arrangements facilitated good choice for residents and promoted the individuality of the service provided. Programmes and activities availed of were linked to the residents personal plan and resident choice, ability and interests. Residents were of a younger profile and most enjoyed being out and about with staff for example going to the cinema, the library, the gym and to local beaches. Residents were supported to maintain contact with family and home.

Judgment: Compliant

Regulation 17: Premises

The provider monitored the suitability of the premises to meet the needs of the residents. For example, the inspector saw a recreational area developed at the rear of the house since the last inspection. Work had commenced on converting the existing sanitary facilities so they were more suited to residents preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector was assured there were systems in place for the identification, management and review of risks. However, there was some minor inconsistency in the review and updating of risks and controls such as the risk for peer to peer incidents occurring.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While the inspector did not complete an in-depth review of the providers policies there was sufficient evidence for the inspector to conclude the provider had adopted infection prevention and control procedures that were consistent with HIQA's National Standards for infection prevention and control in community services (2018). Infection prevention and control was part of the daily management and routines of the centre. The provider was receptive to matters raised by the inspector

in relation to the generalised use of gloves and this was addressed during the inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had effective fire safety management systems in place including procedures for the evacuation of the centre in the event of fire or other such emergency.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

One resident had and was clearly articulating a wish to leave the centre and to return home or to their place of origin. The resident was reported to struggle at times with the idea that the centre may be their "forever home". This had been escalated by the person in charge to the provider's admission, discharge and transfer committee. However, further action was needed by the provider to explore and establish what it was the resident wanted and to progress as far as was reasonably practicable the residents wish to relocate.

Judgment: Substantially compliant

Regulation 6: Health care

Records seen by the inspector confirmed staff monitored resident well-being and sought advice and care for residents when concerns arose or needs changed. Residents had access to the clinicians and services they needed.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff had completed training in the management of behaviour that posed a risk including training in de-escalation and intervention techniques. Staff practiced restrictive practices that were sanctioned so that they maintained their skills in their

safe use. Clinical oversight was maintained of the behaviour support plan and any use of restrictive interventions to ensure that they were used as a last resort.

Judgment: Compliant

Regulation 8: Protection

The provider had safeguarding policies and procedures that were implemented as needed in response to any concerns or risks that arose, for example if the behaviour of one resident impacted on another.

Judgment: Compliant

Regulation 9: Residents' rights

The support observed was respectful of the individuality, privacy and choices of residents. Staff spoke respectfully of residents and confirmed that if a resident did not wish to comply with a particular request or routine this was respected. While there was a need for restrictive practices the house did not present as a restrictive environment. Staffing arrangements facilitated the individuality of residents routines such as when they got up and when they went to bed. However, staff sought to support residents to make good decisions so that they enjoyed good health.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hempfield OSV-0003379

Inspection ID: MON-0033999

Date of inspection: 08/02/2022

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 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <ol style="list-style-type: none"> 1. A full review of Risk Management plans, risks and controls will be conducted by the 25 March 2022. 2. All Service Users Risk Management Plans to be discussed with the Staff Team at the next monthly Team Meeting held on the 25 March 2022 to ensure a consistent approach is provided by all Staff. 	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ol style="list-style-type: none"> 1. The Person in Charge (PIC) shall conduct a review of the Comprehensive Needs Assessment to review the placement of one Service Users who wishes to relocate closer to home. Review to be completed by 29 March 2022. 2. The Person in Charge (PIC) shall ensure the Comprehensive Needs Assessment is discussed at Admissions, Discharge and Transition meeting to review alternative placement locations in line with the Centre's Policy and Procedure on Admission, Discharge and Transitions [PL-ADT-001] and in line with one Service Users who wishes to relocate closer to home 29 March 2022. 	

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 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	25/03/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	29/03/2022