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:	Morella House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	12 October 2021
Centre ID:	OSV-0008046
Fieldwork ID:	MON-0033391

About the designated centre

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

This designated centre provides full-time residential support to up to three male and female adults with a diagnosis or intellectual disability and autism, as well as specific needs including diabetes, epilepsy and responsive behaviours. The service is managed by a person in charge and a team of social care and support workers. Support is provided in a bungalow in a rural setting, with an internal apartment providing single-occupancy accommodation. Resident have access to services of the service provider's multidisciplinary team including occupational therapy, speech and language therapy, psychiatry and psychology.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 12 October 2021	11:20hrs to 19:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the residents during this visit. The residents appeared content in their home and living space and the inspector observed them engaging in fun and stimulating activities, watching shows and listening to music, and receiving appropriate levels of support from the staff members of the house.

The designated centre opened in summer of 2021 and all three residents had recently transitioned from other residential services. The inspector was shown evidence of the admission process in which the provider facilitated visits and reviews of the service by the incoming residents to ensure that the service and its staff were suitable to deliver on the residents' assessed needs and preferred routines. Residents were provided information on their new home, with discussions and social stories supporting them to get to know the team, the people with whom they would be living, and how they could personalise and decorate their bedrooms.

The house was suitable in size and design for the number and needs of the residents. Three residents live in the house, with one person living in their own apartment with a separate living and kitchen area, as well as a small yard with a sandbox and trampoline. Each of the residents were supported to decorate their space how they wished, with bedrooms highly personalised with their artwork, photos, posters and soft furnishings. Residents had their furniture positioned how they preferred and one resident had been supported to buy shelves online to display their action figures, DVDs and Lego creations. All residents had private en-suite toilet and shower facilities. There was a large garden space to the rear of the premises as well as a large recreational area for residents to hang out and work on art projects. Features had been added to the house to provide a safe environment for residents and prevent injury.

After opening, the provider had identified that the living room space was not of a sufficient size for the two residents in the main section of the house, and on the day of the inspection were constructing an extension to provide larger communal space. It had been explained to the residents how long the work would take and asked for suggestions on furnishings and décor for the new space. Work was also being done to repair and replace features and furnishings in the single apartment. The resident was supported to stay busy with community activities while the work was done on their living space. While this work would be ongoing for a few weeks, the apartment was cleared of working materials so they could use their space comfortably when they came home in the evening. Social stories were also used to support residents to understand and consent to supports, upcoming events and changes in the service. The staff also used these to support residents with social development skills including comfort with public settings, managing money, and maintaining a healthy diet and exercise routine.

The residents were supported to stay busy with interesting activities in the house

and community. The inspector observed the residents working on their art, watching television and streaming services, meeting with their families, and going on walks and drives with the staff. Residents were involved in adult education courses in computers, cooking and graphic design. The residents' preferred routines were supported by each resident having at least one staff available at all times and there being two centre vehicles, to go out as and when the residents preferred. The inspector observed interactions between staff and residents and found good examples of staff providing friendly, patient and encouraging support to the residents. The staff evidenced a good knowledge of residents' support needs, personalities and interests. Reminder boards were in place to advise staff on residents' agreed-upon routines, activities and meal choices for the week, and things they wished to buy online or in their favourite shops.

The next two sections of the report 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

The inspector found this centre to be staffed to provide a meaningful, consistent and person-centred level of support. There were appropriate arrangements to ensure oversight and governance of this new designated centre by the service provider as well as day-to-day operation of the service by the local leadership. Some improvement was required to ensure that events occurring in the service were submitted to the chief inspector based on the requirements of the regulations.

This recently-opened service was managed by a person in charge, team lead and deputy team lead who had experience in their respective roles from other designated centres. This allowed for the staff team, the majority of whom were yet to finish their probation, to be supported by experienced local leadership. The inspector reviewed a sample of minutes from team meetings and one-to-one supervision, in which the topics discussed were meaningful in supporting the team to work well together and with the new service users. All staff had completed an induction programme and had completed the majority of their mandatory training, with the remaining sessions booked for the coming weeks.

The inspector reviewed rosters and discussed with the management regarding the staffing complement of the designated centre. At the time of the inspection, there were vacancies equating to 3.5 full-time posts in the staffing complement, and these were at interview stage. Rosters indicated that the provider had multiple backup arrangements to ensure that staffing numbers were retained for day and night shifts as required to meet the needs of all three residents. These plans included staff working additional shifts, the supernumerary person in charge and team lead working shifts if required, relief staff allocated to the house, additional staff outside

of this relief panel who could be deployed to the centre, and staff from other designated centres. While these measures were utilised regularly in the sample of weeks reviewed, the impact on support continuity was mitigated as the relief shifts were mostly covered by the same few people.

The person in charge managed this service and one other, and allocated protected time to be based on site in this designated centre. They had suitable cover arrangements in place for the days on which they were off-duty. On-call arrangements and access to provider-level management was available when required by the local team. The provider had conducted audits since opening in summer 2021 in aspects of the service including correct medication practices, the safeguarding of residents, progression of personal plans and goals, and infection control and hygiene. Where these audits identified areas in need of improvement, a time bound action plan was set out to address same.

In a sample of incidents reports reviewed and discussed with staff, the inspector found that the provider had not notified the chief inspector of all events required through the regulations. This included a period of time in which the provider implemented their isolation and control procedures with the premises and staff in response to risks related to COVID-19.

Regulation 15: Staffing

The provider had utilised multiple backup arrangements to ensure that the number and continuity of support staff was retained while recruitment was progressing to fill the remaining staff vacancies.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supported to undergo induction, probation, supervisions and training to ensure they had the required skills to deliver on residents' assessed needs.

Judgment: Compliant

Regulation 23: Governance and management

A clearly defined management structure was in place in the designated centre, with oversight and reporting arrangements in place to identify and address areas in need

of development in the service.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The provider had supported the residents in their admission and transition process, and all residents had a contract outlining the terms and conditions of their residency.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had not notified adverse events to the chief inspector in line with the requirements of the regulations.

Judgment: Not compliant

Quality and safety

The inspector found that there was suitable arrangements in place to provide person-centred, evidence-based support for residents and ensure that they were facilitated to pursue their preferred interests and routines, as well as working on personal development goals. Supports to keep residents and others safe in the service were in effect. Improvement was required in providing assurance that staff consistently follow correct practice during evacuation and fire safety procedures.

The building was of a suitable size and layout for the residents. Bedrooms were personalised based on the interests and hobbies of the residents, and they had been supported to furnish and decorate their new bedrooms how they liked. There was a large kitchen and dining area for the residents in the main house. At the time of inspection, the provider was extending the house to provide a larger sitting room in which residents could hang out, watch television, do artwork, and build Lego. The house included a separate apartment which was designed to support the needs of its occupant with appropriate safety features. This area was also undergoing renovations at the time of inspection to add and remove features based on the experiences of the resident since admission.

As the house was undergoing construction and renovation work, residents were

supported to understand how long it would last, and supported to spend time away from the house while the work was being done. Residents went for forest walks, met with their families, ran errands, went shopping, and engaged in other community activities. This was facilitated by access to two cars belonging to the service. The inspector observed residents coming and going during the day, as well as engaging in hobbies and relaxing in the house. Residents were attending college in a mainstream setting with an appropriate level of staff support, in courses including cookery, computers and graphic design. Residents were also involved in sports including cycling, swimming and bowling.

In response to suspected or actual events in which the safety of the resident was affected, the provider had put safeguarding and risk control measures in effect in the house and in the community. Where relevant, the provider had engaged with An Garda Síochána and the Health Service Executive safeguarding team to notify and consult regarding these plans. Residents were supported to discuss their feelings and encouraged to tell staff if they felt upset, anxious or unsafe. Residents were supported to protect themselves from harm and abuse, and were educated on maintaining their personal dignity, intimate support and sexual health in line with their assessed needs. The team lead described how upcoming goals would focus on residents being supported to budget and manage the money, and stay safe and secure in public settings.

Where residents expressed their frustration or distress in a manner which created a risk to themselves or others, staff were provided detailed, person-centred guidance on maintaining a low-stress environment and supporting the resident to express their feelings using their words over actions. For each potential behavioural expression, proactive and reactive strategies were in effect to support staff to predict and event and respond to it in a way in which the resident and the staff were kept safe from harm. Staff were provided with equipment to use for protection, and there was an appropriate level of environmental safety features and restrictive practices to control the relevant risk. Where de-escalation techniques were not successful, physical intervention techniques were authorised as a last resort measure, and support plans were detailed in differentiating how these would be done based on what was happening and where. These plans were kept under regular review, updated as required and done with input from the behavioural specialist.

The house was equipped with an addressable fire detection and alarm panel system. There was suitable firefighting equipment on site, and multiple exit routes to get outside. All rooms of the house were equipped with self-closing doors and seals to provide containment of flame and smoke in the event of a fire. While staff members had received training in fire safety protocols online and in their previous place of work, a review of the training dates indicated that staff had yet to attend a fire safety and evacuation session based on the procedures related to this premises and resident profile. This was scheduled for the coming weeks. Practice evacuation drills had taken place in the service, however the reports from these drills were not detailed on the procedure followed as per the emergency plan, and what actions were being taken to reduce the time taken to evacuate below five minutes. There had not been a practice evacuation simulating a night-time scenario to provide

assurance that a safe and efficient evacuation could take place when staffing levels were at their lowest. In reviewing the daily fire safety checks done by staff, the inspector found that these checklists were pre-filled, pre-signed and photocopied for each month, with safety checks noted as being completed for days after the inspection took place. This did not provide assurance that these routine checks were actually being carried out.

Overall the premises were clean and in a good state of maintenance, and renovation works were being carried out on the day of inspection in an area of the premises which had been damaged. The centre was sufficiently equipped with sanitising and personal protective equipment to carry out good infection control practices. Staff were observed following proper use of hand hygiene facilities and face coverings, as well as sanitising touch surfaces. The provider had a protocol in effect for how to respond to a suspected or actual case of COVID-19, including how to most effectively isolate and protect residents during a potential outbreak.

Regulation 11: Visits

Appropriate precautions were taken to ensure that safe visiting arrangements could take place in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported with a range of personal, educational, recreational and social objectives based on their assessed needs, interests and preferences.

Judgment: Compliant

Regulation 17: Premises

The premises was suitable in size and design, and maintenance works were taking place to ensure the house was kept in a good state of repair and cleanliness.

Judgment: Compliant

Regulation 27: Protection against infection

The designated centre was equipped to give effect to infection control procedures, and the staff had contingency plans in place on how to respond to a potential or actual outbreak of infection among staff or residents.

Judgment: Compliant

Regulation 28: Fire precautions

Some improvement was required in ensuring that a safe and efficient evacuation could be carried out in a night-time scenario. All staff in the centre were yet to be trained in centre-specific fire safety procedures. The inspector was not assured that routine fire safety checks were being carried out, as checklists were pre-filled and pre-signed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' support plans were person-centred, evidence-based, and were composed and revised with input from the relevant health and social care professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff were provided detailed proactive and reactive strategies to support residents and keep people safe during episodes of frustration or distress. Where restrictive were prescribed, their rationale was specified and reviewed to ensure their use was the least restrictive option to manage the relevant risk.

Judgment: Compliant

Regulation 8: Protection

Residents were supported to be safeguarded from harm or abuse. Safeguarding plans were set out to control specific risks, with input from the relevant external

bodies on same.
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 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Morella House OSV-0008046

Inspection ID: MON-0033391

Date of inspection: 12/10/2021

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 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: 1. The Person in Charge (PIC) will ensure a regulatory notification is submitted to the authority within 3 days of the occurrence of any incident set out in regulation 31(1) (a) to (h). 2. The Person in Charge (PIC) will ensure there are systems in place to monitor and report all adverse events resulting in non-serious injuries to Service Users and a quarterly report is submitted to the authority to notify of any incident set out in regulation 31(3) (a) to (f).	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. (a) The Person in Charge (PIC) will conduct a review of the Designated Centre's fire safety procedures to ensure that there is adequate means of escape which reflect the Service Users needs and evacuation methods likely to be employed. (b) Following the review, the PIC will ensure Service Users relevant Care Plans and Personal Emergency Evacuation Plans (PEEPS) are updated to adequately accounted for the mobility and cognitive understanding of Service Users in the evacuation procedure (c) The PIC will ensure all Service Users in the Designated Centre are fully informed of their updated PEEPS through key-working sessions with their Care Staff. 2. The Person in Charge (PIC) will ensure that all Care Staff in the Designated Centre receive appropriate training specific to the Centre and to the individual Service Users' emergency evacuation plans and procedures.	

3. The Person in Charge (PIC) will ensure a record is maintained on the Designated Centre's fire records including details of fire drills, fire alarm tests, fire-fighting equipment, regular checks of escape routes, exits and fire doors.

4. All the above points will be discussed with all Staff in the Designated Centre at the next monthly team meeting held on 30th November 2021.

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 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/11/2021
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	30/11/2021
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	30/11/2021

Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/11/2021
Regulation 31(1)(b)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.	Not Compliant	Orange	30/11/2021
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be	Not Compliant	Orange	30/11/2021

	notified under paragraph (1)(d).			