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:	Cullen House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	18 April 2023
Centre ID:	OSV-0005046
Fieldwork ID:	MON-0039877

About the designated centre

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

This centre provides residential care and support for a maximum of three adults over the age of 18 years. The centre is a bungalow (inclusive of a one bedroom self-contained apartment) situated in a rural area in County Kildare and within driving distance to a number of towns and villages. It consists of three en-suite bedrooms, two kitchen-dining areas, a utility room, sun room and sitting room. Each of the residents had their own bedroom which had been personalised to their individual style and preference. There were spacious well-maintained grounds surrounding the centre. The service is staffed day and night by a full time person in charge, two deputy team leaders and a team of social care staff. Systems are in place to meet the assessed healthcare needs of the residents and access to general practitioner (GP) services, and other allied healthcare support form part of the service provided.

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 (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 18 April 2023	10:20hrs to 17:00hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During this unannounced inspection, the inspector had the opportunity to meet with the residents living in this designated centre, observe supports and interactions between residents and their support staff, and review documentation regarding their care and support.

In recent months, there had been a substantial increase in the frequency of incidents related to interactions between the three residents in this centre. There had been a trend of instances in which resident presentations during times of distress or anxiety had unintentionally had an impact on fellow residents, primarily related to the house being loud and over-stimulating and disturbing sleep through the night. A further impact of this was an increase in incidents of residents upsetting and becoming verbally abusive towards each other. The residents had repeatedly complained verbally and in writing to the provider that the current living situation was "not fair" and wanted things to change in their home.

Following efforts by the staff team to mitigate incidents in the centre, the provider had concluded that this designated centre was no longer suitable to meet the needs and wellbeing of all residents, and a more appropriate accommodation solution had been identified for one person. The inspector was provided evidence to indicate that this resident and their representatives had been informed of the planned changes and were consulted for their feedback prior to decisions being made. While a date for these changes had not been confirmed as of the time of inspection, the provider committed to undertaking assessments of the alternative accommodation to provide assurance that the location was safe and suitable to meet the resident's needs and that the impact on existing residents there was considered.

The inspector spoke with one of the residents and their front-line support staff about their experiences living in the designated centre. They commented that residents did not always get along, and they did not like when negative comments were exchanged between them. They told the inspector they did not like living in this house as there was not much going on in their day and in the local area. They commented that they felt unsupported to pursue activities and go places if they had not been set out in advance through an activity planner, and that it could often be boring living here. The resident spoke positively about their main support team members, including naming staff with whom they enjoyed playing games and who told the best jokes. They noted that they did not like days on which they were supported by unfamiliar staff who did not know them as well. The resident commented that they would feel comfortable raising complaints to the team, however commented that doing so did not always result in anything changing as a result.

The inspector met with a resident who did not communicate using conversation, and observed staff communicating with them in a kind and patient manner which was suitable for their communication profile. The inspector observed the resident being

relaxed and comfortable with their staff member, and they went for a long drive in the afternoon and got ice cream. Another resident was out on a drive in the community. The provider had enough vehicles to facilitate each resident to pursue their own preferred routine without impacting on others. Each resident was assessed as requiring individual assigned staffing, with 2:1 support for one person for eight hours in the day to facilitate safe community access. However, in reviewing records of shifts worked, the inspector observed that this staffing requirement was not always met.

The inspector reviewed plans and discussed with staff regarding resident goals such as travel, work experience, education opportunities and new social outlets, which were found to be rarely progressed with limited information on how residents would be supported and encouraged to achieve these objectives.

The residents lived in a countryside bungalow which was pleasant and homely. At the time of the inspection, members of the provider's facilities team were onsite, carrying out work such as repairs, painting and replacing old or damaged furniture.

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 provider had suitable governance arrangements in place to effectively manage this designated centre and oversee the quality of resident support. The provider was aware of the current risk in the service and was in the process of effecting a solution.

The provider had notified incidents in the service to the Chief Inspector of Social Services and had internally identified a pattern in incidents being reported in this centre from local management. The provider demonstrated evidence of action being taken to manage this, and how a planned transition was occurring in a manner which followed the provider's policy and included consultation with relevant stakeholders.

Improvement was required in the management of complaints raised in and about the service. Following a sample review of house meetings, daily notes, incident reports and resident commentary, the inspector found a number of complaints which had not been recorded in line with provider policy or accounted for in the records for the centre. For written complaints submitted by residents, the inspector was not assured that all complaints were being managed consistently in line with the provider's policy.

The inspector met a team of direct support staff who were knowledgeable on the

residents' support needs and had an overall good rapport with residents. The person in charge had recently left the centre, and the role was being covered by an interim manager, with two staff deputising, to ensure short term leadership arrangement until the person in charge position was filled. Staff members had recently been recruited to fill vacancies, and the centre had access to a regular panel of relief staff, however rosters indicated that these contingency measures had not always been sufficient to ensure staffing needs were delivered in line with the assessment of residents' needs.

Regulation 15: Staffing

At the time of the inspection the provider had a full complement of staff, as well as contingency measures to cover absences and annual leave, such as relief personnel and the management occasionally working front-line hours. However, this had not been sufficient to meet the assessed needs of residents. In a sample of records reviewed, a number of days had shifts which were not filled, as well as days on which the number of staff and the hours worked were not in line with the 1:1 and 2:1 hours of staffing for residents as identified in their assessments of need.

Judgment: Not compliant

Regulation 23: Governance and management

Reporting systems and oversight measures ensured that the provider was advised of serious or ongoing risks related to the designated centre. The provider demonstrated how they were responding to identified unsuitable living conditions, and measures to address this were in progress.

The person in charge had left the role, and a new person in charge was due to commence in the coming weeks. The provider had interim arrangements in place to provide managerial cover on a short-term basis.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Resident admissions were conducted in line with the statement of purpose, and the admission process had considered the needs of new residents and the safety of other residents already living in the service. Residents had a written contract with the provider but these were not all signed by the resident or their representative.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notification of incidents had been provided to the Chief Inspector within the time frames required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The practice around the management of complaints was inconsistent. The complaints records for the designated centre did not account for all complaints which had been made by service users. Where records of some complaints made by service users were available, there was insufficient evidence to indicate what action had been taken on foot of same, how the provider was assured of whether or not the resident was satisfied with the outcome or actions taken, and whether the complainant was informed of the appeals process.

Judgment: Not compliant

Quality and safety

The provider and front-line staff were taking suitable measures to ensure that residents' choices were protected from instances of potential or actual abuse. While the provider had plans in place to source new accommodation more appropriate to meeting resident needs, until this was done the identified compatibility challenges had continued to have a negative impact on residents' wellbeing in the designated centre.

The provider had systems and reporting structures in place which had effectively identified and investigated instances in which residents had been subject to psychological or financial abuse, or had been supported or spoken to in an inappropriate manner. The provider had referred matters to the Health Service Executive safeguarding team and An Garda Síochána as required. Regarding peer-to-peer incidents, regular conversations took place on the topic of mutual respect in a shared living space, and the safeguarding officer was visiting the residents on a regular basis to ensure that they felt safe and secure in their home and could raise concerns they had.

Some improvement was required in ensuring the structures for planning out personal goals, exploring new hobbies and social outlets, and identifying educational and work opportunities were done in a manner which encouraged residents to participate. Development of these objectives was required to provide sufficient guidance to residents and to staff on their respective roles in how these objectives would be progressed in a measurable and achievable timeframe.

In the main, residents were supported to have their voice heard in the service and were encouraged and facilitated to utilise feedback, complaints and keyworking structures to make their choices and opinions known. The provider had a weekly survey platform for residents to communicate not only whether or not they were safe and happy, but to also make suggestions and commentary on the service and their care and support to the provider, and identify where the service could be enhanced for them.

Regulation 13: General welfare and development

Needs and wishes for residents to engage in meaningful and varied opportunities for work, education, social outlets and community activities were identified by residents, staff and management, however active engagements were limited at the time of inspection.

Social, occupation and recreational goals such as employment, travel and training were identified between residents and staff, but there was limited information on how these would be supported to progress in a specific, realistic and measurable manner.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

Planned discharges in the centre were discussed and agreed upon in consultation with resident representatives. Structures were in place to ensure that discharges took place in a planned and safe manner, which took account of the needs of the affected service users.

Judgment: Compliant

Regulation 8: Protection

The provider had initiated and put in place investigations in relation to alleged,

witnessed, or suspected abuse of residents and taken appropriate action where residents were harmed or suffered abuse. The provider had followed their safeguarding procedures in doing so, and had referred matters to the designated officer and An Garda Síochána as required.

Residents continued to be at risk of psychological distress and triggered anxiety without intent from incidents occurring in the designated centre. However, there was evidence that the provider was taking steps to arrange more appropriate living arrangements for service users to address this risk. Staff were following person-centred strategies in supporting low-stress environments and responding to incidents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector observed evidence to indicate that residents were facilitated to discuss their concerns with the team, provide feedback on the service, and to make choices in their plan of support. Residents were supported and communicated with in a manner which respected their privacy, dignity and autonomy.

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	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cullen House OSV-0005046

Inspection ID: MON-0039877

Date of inspection: 18/04/2023

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The management team shall continue to complete a review of planned and actual roster in the Centre in line with individuals assessed needs of the Service User.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: 1. The management team will conduct a review to ensure that the Contract for the Provision of Services will be signed by the individual or their representative where applicable. Note: This has been completed, however where an individual is a Ward of Court they are unable to sign documentation.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:	

1. A Senior Management led review of the Organisation's policy and procedure [PL-Ops-002] on Comments, Compliments & Complaints, will be completed to ensure a record is maintained by the Person in Charge (PIC) of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether the resident was satisfied.

Note: This review has been completed. Following a Senior Management led review of Organisations policy and procedure [PL-Ops-002] on Comments, Compliments & Complaints, the policy was updated to reflect that it is the individual's choice, will and preference if they wish to make a formal written complaint regarding a concern, they may have. Therefore, should an Individual decline to make a complaint, their concerns raised will be noted on the Individual Specific Comments Log.

2. Where a formal written complaint is received by the Individual, the management team will ensure that the complainant is informed promptly of the outcome of his or her complaint and details of appeals process.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. Each individual Personal Plan reflects their goals and aspirations, inclusive of community involvement. The management team will ensure these goals are Specific, Measurable, Achievable, Relevant and Time-bound (SMART).

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. A Service User has been identified to move to a respite setting within the service and for an alternative appropriate placement to be identified thereafter.

Note: The current bed in respite is occupied and it is due to become available in July (or sooner if possible) pending the registration of a new designated Centre.

2. The management team shall ensure arrangements remain in place to support a Service User to transition to an alternative environment and will endeavor to mitigate any risk of potential psychological distress, where required.

3. The management team will ensure any further instances of alleged abuse will be responded to as per policy and procedure [PL-C-001] on Safeguarding Vulnerable Persons at Risk.

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 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	09/06/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	25/05/2023
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of	Substantially Compliant	Yellow	25/05/2023

	giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	25/05/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	25/05/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/07/2023