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

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|---|---|
| Name of designated centre: | Radharc Na Cé |
| Name of provider: | Health Service Executive |
| Address of centre: | Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 18 February 2025 |
| Centre ID: | OSV-0002506 |
| Fieldwork ID: | MON-0046127 |

## About the designated centre

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

This designated centre provides both full-time residential and shared-care for adult residents with intellectual disability. It is located in a scenic location close to a busy rural town. The centre comprises a newly refurbished spacious bungalow which was designed to suit the accessed needs of the people living there. Care and support is provided by a team of nursing staff and healthcare assistants with waking night support available.

**The following information outlines some additional data on this centre.**

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|---|---|
| Number of residents on the date of inspection: | 4 |

## 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 February 2025 | 14:00hrs to 18:00hrs | Úna McDermott | Lead |
| Wednesday 19 February 2025 | 09:30hrs to 13:30hrs | Úna McDermott | Lead |

## What residents told us and what inspectors observed

Residents living in Radharc na Cé had a range of complex health and social care needs and the inspector found that they were provided with a good quality service by a competent staff team. The premises was accessible throughout and this met with mobility needs. Residents were supported to engage in planned day services, home-based activities and to participate in community events in line with their interests. However, improved oversight of the complaints system and the submission of statutory notifications was required in order to strengthen the quality of the service provided.

This inspection was unannounced and took place over two days in February 2025.The purpose of this inspection was to monitor and review the arrangements that the provider had in place in order to ensure compliance with the Care and Support Regulations (2013). It followed the receipt of information of concern which was submitted for the attention of the Chief Inspector of Social Services.

On arrival at the centre, the inspector met with a staff nurse who facilitated the first day of the inspection as the person in charge was on leave. The inspector found that they were skilled and knowledgeable. This meant that when the person in charge was absent from the service, good governance was maintained. The inspector requested that the staff on duty contact resident's representatives and inform them of the presence of the inspector should they wish to speak with them. Feedback from conversations held will be outlined below.

The inspector met with two residents on the first afternoon. One was spending time with staff in the kitchen. There was a scenic view from the kitchen window and an aroma of home cooked food. The resident did not hold conversations with the inspector, however, they presented as relaxed and content. The second resident was reported to prefer quieter spaces. They were seated nearby observing the daily routine. The staff on duty were observed interacting with both residents in a kind and caring manner and laughing with each other from time to time. The third resident arrived home later that afternoon. They were observed settling into their home for the evening, moving around their home and singing songs. The inspector found that the routine on the second day of inspection was similar. The atmosphere was organised and calm, staff knew what to do and resident appeared happy and content participating in the daily activities of a typical household.

A member of the senior management team attended the centre on the second day of inspection. Over the course of the two days, the inspector met with four staff members. They spoke about the residents respectfully and were knowledgeable on the likes and dislikes of each person. They spoke about the promotion of human rights and said that they had completed training which they enjoyed. They said that the space in the new house was fantastic and it impacted positively on the day to day life in the centre. They were happy with the resources provided at the centre and spoke about doing their best each to provide a good standard of care and

support to the residents living there. A staff member told the inspector that although the clinical care was required, this was provided to high standard. While clinical tasks were important, this did not impact on the holistic social care focus of the service.

The inspector spoke with three resident representatives by telephone. In the main, the feedback was very positive. Representatives said that their family members were happy, that they participated in lots of activities and that they are well looked after by fantastic staff. If a concern arose, they said that they were informed and it would be dealt with promptly. They said that they had no concerns regarding their family member's safety. Some feedback indicated that communication with the senior management team could be improved, that they had safeguarding concerns and that complaints were not well managed. Compliance levels with these regulations under the Health Act (2007) will be reviewed later in this report.

Overall, from observations made, conversations held and review of the documentation, the inspector found that the residents in this centre received a good quality, person-centred service where their rights were respected.

The next two sections of this 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 to each resident living in the centre.

## Capacity and capability

There were strong leadership and management arrangements in the centre which were consistently applied. This meant that a good quality and safe service was provided for the residents. However, improvements in the submission of statutory notifications to the Chief Inspector of Social Services and oversight of the complaints system would further strengthen the service provided.

Staffing numbers and skill-mix were suited to the needs of residents. Access to suitable mandatory and bespoke training was provided which met with the assessed needs of residents.

The provider had appropriate systems and processes in place which improved following the last inspection and this underpinned the safe delivery of the service. The provider maintained good oversight of the service through routine audits and unannounced visits. Actions to address gaps found were recorded on the centres quality improvement plan and actioned within a defined timeframe.

Further information on the findings under this domain are documented under the regulation section below.

## Regulation 15: Staffing

Staffing levels met with the assessed needs of the residents living at the centre.

The inspector reviewed a sample of rosters from 1 January 2025 to the date of inspection. It was well maintained and provided an accurate account of the staff on duty on the day of inspection. Nursing care was provided in line with the statement of purpose for the centre. There was a sufficient number of staff employed and where additional staff were required this was planned for. Staff were familiar with the residents which meant that consistency of care and support was provided.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspector found staff had received training in areas that were relevant to the care and support of the residents.

A sample of mandatory and refresher training modules were reviewed. These included training in fire safety, positive behaviour support and safeguarding. In addition, bespoke training in the promotion of human rights and wound management training was provided. All modules reviewed were up to date.

In addition, staff had access to a programme of performance management and supervision. Meeting were held in line with the structure provided.

This meant that staff were supported in their role and provided with guidance on how to improve the standard of care provided.

Judgment: Compliant

## Regulation 23: Governance and management

The registered provider had good governance and management arrangements in this centre. This had a positive impact on the quality and safety of the service provided to residents.

There were clear lines of accountability which meant that staff knew who to report to. Team meetings were taking place on a regular basis and staff said that they felt free to raise compliments or concerns if required.

Audits were completed in line with the provider's schedule and the requirements of

the regulation. The six monthly provider-led audit was completed on 18 February 2025. The annual review of care and support was not yet due. The provider had an enhanced unannounced audit plan in place at the time of this inspection and an unannounced provider-led audit had taken place on the morning of inspection.

The person in charge had a quality improvement plan for the centre. This was last reviewed on 18 February 2025 and was subject to weekly update at the time of inspection.

Clear and comprehensive documentation systems were in place which was an improvement on previous inspections. These included daily logs, monitoring documents, assessments, care plans and support plans.

As outlined, if the person in charge was not available in the centre, the inspector found that the day to day routine continued under the guidance of the most senior staff member on duty. This meant that the good governance arrangements were sustained and this had positive outcomes for the residents.

Judgment: Compliant

## Regulation 31: Notification of incidents

The inspector reviewed the incidents arising in the centre from 1 April 2024 to the date of inspection (18 February 2025). On review of the documentation, the provider identified a notifiable matter that was not reported to the Authority within the three day time frame. This related to an allegation or suspicion of abuse in May 2024. A retrospective notification was subsequently received.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The provider had an established complaints process which was designed to attain the most appropriate outcome for residents.

The complaints policy was up to date and staff were aware of what to do if a concern came to their attention. The policy was available in easy to read version and a copy was in each residents bedroom.

In the main, complaints were dealt with in line with this process, however, some improvements were required with the documentation process as follows:

Where complaints were made and investigated, they were not always documented as such. This included a concern that arose through a multi-disciplinary team review

in June 2024. This gap in the process was identified by the provided and amended retrospectively.

Judgment: Substantially compliant

## Quality and safety

The inspector found that this centre provided a good quality service. Residents' needs were assessed and appropriate supports put in place to meet those needs. Residents' safety was promoted and if concerns arose enhanced training, support and audits were put in place to improve the service.

Residents received a person-centred service in this centre. The residents' health, social and personal needs had been identified and assessed. The necessary supports to meet those needs had been put in place.

The safety of residents was promoted in this service. Staff were aware of the systems in place to ensure residents' safety. This included safeguarding procedures and the control measures in place to protect residents from risk. Risks to residents and the service as a whole had been identified and control measures put in place to reduce those risks.

Information management systems were reviewed by the inspector. Residents' information was streamlined and accessible and this provided clear guidance for staff.

Further information on the findings under this domain are documented under the regulation section below.

## Regulation 10: Communication

The provider had arrangements to support residents to communicate their preferences which were working well.

Resident had communication profiles which provided information on the supports provided to residents. Discussions with staff found that where communication recommendations were made by specialists, they were used as advised. For example, a staff member spoke about using objects of reference to assist with residents' decisions and these were observed in use on the days of inspection.

Judgment: Compliant

## Regulation 26: Risk management procedures

The provider had good risk management systems, including systems to respond to emergencies which promoted and supported the safety of residents.

The inspector reviewed the centre's risk register. This was comprehensive and the risks identified were specific to the service. They were reviewed on 14 February 2025 by the person in charge.

The inspector also reviewed the risk assessments that had been developed for three residents. These gave clear guidance to staff on how to reduce risks to residents and were subject to regular review.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Residents personal plans contained assessments of their health, social and personal care needs and ensured their needs were supported in a consistent manner by staff at the centre.

A review of assessments for three residents found that their assessment of need was well presented, well maintained and in date. Each resident had a keyworker who had oversight of this information and this ensured regular review.

Residents had review meetings held annually and associated person-centred plans. These documented goals such as going to smaller local football games and building on this in order to progress to larger games. The resident's representative was involved in setting this goal which meant that a consultative and meaningful process was used. Another resident had plans to go on a holiday and each step of this plan was documented in their person-centred plan. A third was considering a swimming activity, however, this was approached with caution and the staff said that if the resident did not show an interest that they would not be required to go.

Overall, staff were provided with clear information through their support plans and activities of interest were arranged with the input of resident's representative and in line with their preferences.

Judgment: Compliant

## Regulation 6: Health care

Healthcare arrangements ensured that residents' needs were meet effectively and consistently by either their representatives or staff at the centre. Overall, healthcare needs were well provided for.

Residents had the support of a general practitioner (GP), nurse specialists and consultant-led care as required. In addition, allied health professionals visited the residents at their home or consulted with them in clinics. These included chiropody, dietitics, dentistry, occupational therapy, physiotherapy and speech and language therapy.

Evidence was provided that where family members were involved, the staff from the centre also attended appointments in order to ensure that consistency of care and support was provided for those with complex care needs.

Where recommendations were made, these were followed up on promptly. For example, a sleep specialists visited on the morning prior to commencement of the inspection. The staff member on duty was actively addressing the recommendations in order to provide clear guidance to staff when the inspector arrived.

Overall, residents at this centre had a range of complex care needs which were supported through a range of assessments, interventions and care plans. Access to professionals was provided and staff were trained in how to support each individual need.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The provider had effective positive behaviour support arrangements in place. This meant that there was a consistent and informed approach by staff in meeting residents' needs which was subject to regular review.

Information to guide staff was clearly documented on nursing interventions or positive behaviour support plans. Access to specialist in behaviour was provided if required.

Where proactive recommendations were made, these were followed. For example, residents were supported calmly with distraction, touch therapies and use of simple language. The reasons for behavioural episode were explored using pain assessment tools in order to understand the voice of the resident.

Where restrictive practices were used, they were found to be the least restrictive, monitored effectively and used for the shortest time possible.

Judgment: Compliant

## Regulation 8: Protection

The registered provider had clear systems in place to manage allegations of abuse, which were effective and kept residents safe.

All staff, including agency staff, were provided with safeguarding training. When asked, an agency staff member told the inspector the identity of the designated officer, provided an outline of the different forms of abuse and correctly identified what they should do in order to escalate a concern.

Resident had comprehensive intimate care plans which meant that personal care was completed in a respectful manner using a planned approach.

Safeguarding was a standing item on the agenda for staff meetings. This meant that it was a current topic of conversation that was given regular attention in order to enhance learning, promote discussion and keep residents safe.

Where concern arose, safeguarding plans were in place which included enhanced in person audits. These were completed by senior management in order to monitor the safety of the service provided.

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 23: Governance and management | Compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Radharc Na Cé OSV-0002506

## Inspection ID: MON-0046127

## Date of inspection: 19/02/2025

**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:<br>• An NF06 has been submitted retrospectively to the regulator on the 27/02/2025<br><br>• Going forward the Person in Charge will ensure that all notifications are submitted to the regulator within the required timeframe. Date Completed 27/02/2025 | |
| Regulation 34: Complaints procedure | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 34: Complaints procedure:<br>• The Person in Charge and the management team have completed a refresher of the Complaints training on HSEland. Date Completed 24/03/2025<br><br>• The Person in Charge will ensure that all complaints are managed effectively and in adherence to the HSE Policy on the Management of Feedback (Comments, Compliments, and Complaints). Date Completed 24/03/2025<br><br>• Complaints is a standing agenda on local governance meetings. Date Completed 10/03/2025 | |

## 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 31(1)(f) | 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: any allegation, suspected or confirmed, of abuse of any resident. | Not Compliant | Orange | 27/02/2025 |
| 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. | Substantially Compliant | Yellow | 24/03/2025 |