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:	Realta Services
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	17 May 2022
Centre ID:	OSV-0002616
Fieldwork ID:	MON-0032340

About the designated centre

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

Realta Services is a centre run by the Health Service Executive. The centre is located in a town in Co. Sligo. It provides both residential and shared care for up to six male and female residents over the age of 18 years, who have an intellectual disability. The centre comprises of one two-storey dwelling. Residents living here have own bedroom, some with en-suite facilities, sitting rooms, kitchen and dining area, utility and enclosed garden. Staff are on duty both day and night to support residents who avail of this service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 17 May 2022	09:30hrs to 16:30hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

Realta Service was found to be a very pleasant place, where residents were comfortable in their surroundings, enjoyed a good quality of life and were supported to be involved in their local community.

On arrival at the centre, the inspector was greeted by a staff member who said that there was a staff shortage that day. On entry, the inspector found that the staff on duty were actively completing the morning time tasks and although the environment was calm, the inspector could see that the staff were very busy and there was a sense of pressure.

There were two healthcare assistants on duty, along with a student nurse who was on placement in the designated centre. Another, healthcare assistant had come from an adjoining property to provide support. The person in charge had attended the centre earlier but had left due to other commitments. They returned a little later.

The inspector met with four residents who were living at the designated centre. A fifth resident who availed of a shared care placement had left to attend their day service. The inspector could see that the residents had high support needs which included support with mobility, support with medical care and positive behaviour support. One resident was having a cup of tea while looking out the window. The staff on duty told the inspector that they would usually attend a day service that day. However, due to the staff shortage described, there was no staff available to provide support, so they could not go. This resident used some words to communicate with the inspector such as 'football', 'tea' and 'toast'. Another resident was observed coming from their room and sitting in the dining room. The staff were observed encouraging this resident to rise from their armchair and to sit at the table. The inspector observed this interaction to be well intended however, felt that additional communication methods could be used to ensure that the resident was aware of what was expected of them. For example, to use the resident's name and to request that they sit at the table for breakfast. The inspector spoke with the person in charge about this observation and it was addressed promptly. A third resident was observed coming to the kitchen and later moving from the kitchen to the garden in accordance with their personal wishes. The person in charge explained that they enjoyed the outdoors and the inspector could see that a safe space was provided for this purpose. The fourth resident was enjoying a sleep in and was observed to be comfortable and cosy in their bed.

This designated centre was bright, spacious and it was evident that it was designed to suit the needs of the residents living there. Residents had their own bedrooms which were cheerful, cosy and personally decorated. There was a choice of sitting areas so that residents could sit together or apart if they preferred. There was a large kitchen and a separate dining room. To the rear of the house there was a utility room which opened out towards a shared garden. This area was spacious, with raised beds and fruit trees. In addition to this, there was a level access

courtyard to the side of the property where a seating area was provided and flowers were planted. This centre was clean, tidy and well maintained. However, during the walk-around of the centre, the inspector observed an issue with a fire door which will be outlined later in this report.

Links and interactions with the local community were found to be supported and encouraged, although as previously mentioned this was affected by the staff shortage on the day of inspection. Transport was available and one resident went for a drive in the afternoon. The person in charge told the inspector that the residents had regular contact with their family members, which was supported through visits, telephone calls and trips to meet for coffee. Access to the designated officer, the confidential recipient and an advocacy service was promoted through visual notices displayed on the notice board. There was no active contact with these services required at the time of inspection.

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

Capacity and capability

The provider had management arrangements in place to ensure that a good quality service was provided for people who lived in this centre, and that residents' quality of life was well supported. However, staff shortages on the day of inspection affected the quality of the service provided. Also, improvements were required with the governance and oversight of the staffing arrangements, the risk management arrangements, fire safety arrangements and the infection prevention and control procedures used.

The person in charge had recently commenced employment at this designated centre and this meant that the service was experiencing a time of change. The inspector found that the person appointed was an experienced employee, who worked full-time and had the qualifications and skills necessary to manage this service. They had responsibility for one other centre which was adjacent to this property and told the inspector that they had the capacity to ensure effective oversight of both services.

The person in charge had ensured that there was a planned and actual staff roster in place. This was viewed by the inspector but due to the unexpected absences on the day of inspection; it did not provide an accurate reflection of the staff on duty. Nursing care was provided at this service in accordance with the statement of purpose and the assessed needs of the residents. A plan was in place to provide relief staff nurses if required. However, as previously referred to there were unplanned staff absences on the day of inspection. The person in charge told the

inspector about the efforts made to source replacement staff using the plan in place. However, the plan was not effective and this required review.

Staff in the centre had access to training, including refresher training as part of a programme of continuous professional development. The service had identified bespoke training modules which showed attention to the needs of the residents, for example, dementia training. However, not all refresher training modules were completed, for example, moving and handling refresher training, safe administration of medicines and cardio-pulmonary resuscitation (CPR) for healthcare assistants. This was identified on the annual review and the inspector found that the person in charge had a plan in place to ensure that staff had access to these refresher options in the near future.

A review of the documentation provided evidence that an annual review had taken place recently and the twice per year provider-led audit was up to date. The provider had management systems in place which supported the delivery of a safe and appropriate service for the residents. This included a range of policies and procedures, risk assessments and internal audits. The management structure was clearly defined and staff were aware of who to report to for assistance, or to raise a concern if required. However, as previously referred to there were staff shortages on the day of inspection which impacted on resources in place and on the typical lines of authority in use.

The provider had a system in place to ensure that incidents and accidents occurring were reported and addressed. A review of this system showed that incidents notifiable to the chief inspector were completed in line with the requirements of the regulation. Furthermore, the inspector found that the provider had an effective complaints procedure in place and this was available in accessible format. Access to advocacy service was provided if required and any complaints received were addressed promptly and in line with the provider's complaints policy.

The next section of the report will describe the care and support people receive in Realta Service and if it was of good quality and ensured that people were safe.

Regulation 14: Persons in charge

The person in charge recently appointed was an experienced employee, was working full-time and had the knowledge and skills required to fulfil the role.

Judgment: Compliant

Regulation 15: Staffing

The provider had systems in place to ensure that the number, qualifications and skill mix of staff was appropriate to the needs of the centre and its statement of purpose. Staff shortage due to extenuating circumstances on the day of inspection meant that this required review.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff in the centre had access to training, including refresher training as part of a programme of continuous professional development. Not all refresher training modules were completed. However, the person in charge had a plan in place to ensure that staff had access to these refresher options in the near future.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that an annual review and a twice per year provider-led audit was up to date. Management systems and structures were in place however, these required increased oversight to ensure that they were effective.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents were notified to the chief inspector in a timely manager and in line with the requirements of the regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider effective complaints procedure in place and this was available in accessible format. Access to advocacy service was provided if required and any complaints received were addressed promptly and in line with the provider's

complaints policy.

Judgment: Compliant

Quality and safety

Resident's wellbeing and welfare was maintained by a good standard of evidence-based care and support. However, improvements were required in the area of staff replacement, risk management, fire safety and infection prevention and control.

The provider had ensured that residents had an appropriate healthcare plan and where medical treatment was recommended, this was facilitated by the staff team. Residents were supported to understand information about their healthcare needs through the use of posters, social stories and easy-to-read documents for example, regarding COVID-19 testing. Support from the multidisciplinary team was provided and there was evidence that residents met with their general practitioner, clinical nurse specialist, behaviour therapist, occupational therapist, speech and language therapists and physiotherapist in accordance with their needs. Furthermore, the inspector found that residents received holistic support at times of illness for example, through linkage with the community palliative care team if required.

The person in charge had ensured that staff employed had knowledge and skills required to support residents with behaviours of concern. Staff had training in positive behaviour support and were aware of how to respond, support and de-escalate situations that arose. Positive behaviour support plans were used in this centre and there were restrictive practices in place. There was evidence of multidisciplinary involvement and there was a restrictive practice committee in place. Restrictive protocols were used which ensured that the least restrictive procedure was used for the shortest duration necessary. A sample reviewed showed that these were up-to-date and regularly reviewed.

The provider had ensured that there was a risk management policy which was in accordance with the requirements of schedule five of the regulations. A centre based risk register was available and individual risk assessments were in place if required. These assessments identified hazards present, assessed the nature of these hazards and showed the measures and actions in place to reduce or remove the risk. However, the inspector found that the oversight of these assessments was not effective and that they required review. For example, some risks identified in relation to the COVID-19 pandemic were not in line with current public health guidelines and required updating. Furthermore, although risks in relation to the unexpected absence of a resident were in place they were not reviewed and were out of date.

Procedures were in place in this centre to prevent and control the spread of infection. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19. These included a staff and

visitor safety pause system, however on the day of inspection this was not used when the inspector entered the designated centre. However, the staff were notably busy on the morning of inspection as outlined previously. They were observed to be wearing FFP2 masks and practicing hand hygiene at appropriate intervals throughout the day. Furthermore, when spoken with they were aware of what to do in order to control and spread of infection if required. There was a site specific COVID-19 response plan available for review. The inspector found that this referred to another designated centre and the isolation zones therein. Therefore it was not effective. Residents had individual COVID-19 packs which included easy-to-read information on symptoms, swabbing and a checklist which was up to date and used for residents returning to the designated centre from their homes. However, it did not include person-centred isolation plans to be used if a resident became unwell. For example, the location of their isolation, the facilities that they could use and the access to and from the property if required. This was not in line with the requirements of the provider's contingency plan. This centre had experienced an outbreak of COVID-19 earlier this year and the inspector found that although outbreak meetings had taken place at that time, there was no evidence of a post outbreak review. This meant that there was no opportunity to learn from the experience of the outbreak and to put plans in place to make changes if required in the future.

The provider had fire safety management systems in place which included the detection, containing and extinguishing of fire. Staff had access to fire training and this was up to date. There was evidence that fire equipment was maintained and arrangements were in place for means of escape. However, the systems in place to contain fire were not effective. For example, although there was a fire door in place, part of this structure included a 'leaf' which could be opened or closed. On the day of inspection, the inspector found that this part of the door was open on arrival and remained open until the matter was highlighted to staff. This meant that in the event of fire, an effective seal could not be achieved and therefore the door was ineffective. Furthermore, a review of the personal evacuation plans provided were out of date and required review.

Regulation 26: Risk management procedures

The provider had ensured that there was a risk management policy which was in accordance with the requirements of schedule five of the regulations. However, the inspector found that the oversight of these assessments was not effective and that they required review.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures were in place in this centre to prevent and control the spread of infection. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19. However, the process used in the centre required review to ensure that they were fit-for-purpose and effective.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider failed to ensure that adequate arrangements were in place for the containment of fire. Furthermore, the evacuation plans in place required review to ensure they were up to date.

Judgment: Not compliant

Regulation 6: Health care

The provider had ensured that residents had an appropriate healthcare plan and where medical treatment was recommended, this was facilitated by the staff team. Residents were supported to understand information about their healthcare needs through the use of posters, social stories and easy-to-read documents for example, regarding COVID-19 testing. The inspector found that residents received holistic support at times of illness for example, through linkage with the community palliative care team if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff employed had knowledge and skills required to support residents with behaviours of concern. Positive behaviour support plans were used in this centre and there were restrictive practices in place. Restrictive protocols were used which ensured that the least restrictive procedure was used for the shortest duration necessary.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Realta Services OSV-0002616

Inspection ID: MON-0032340

Date of inspection: 17/05/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15 the following actions will be completed There is sufficient WTE employed within the designated centre to meet the needs of the residents in accordance with our statement of purpose. There is a planned and actual roster in place. The actual roster is a live document and is reviewed and updated every day. There is access to a number of agreed agencies and there is a number of inducted and familiar agency staff available who will be contacted in the event of unplanned leave Staff who are willing to work overtime will be contacted in the event of unplanned leave to fill any vacancy which may arise. Day service will be contacted in the event of unexpected leave, to make arrangements to support residents to attend day services as scheduled. A risk assessment on the impact of reduced staffing levels in the centre has been reviewed and updated on 03/06/2022.This risk assessment will now highlight the requirement to contact the Assistant Director of Nursing to secure additional staff for the center and to accommodate the schedule of planned activities and Day Services . This is a nurse led centre and there is nursing staff rostered on each rotation of duty.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
To ensure compliance with Regulation 23 the following actions will be completed ,

A full review of the provider annual and six monthly report has taken place and all actions are schedued to be closed out or fully closed out on by 13th June 2022.
Any actions outstanding from the six monthly and annual report i.e. training will be added to the centres QIP for governance and oversight with an agreed date for completion. The QIP is reviewed on an ongoing basis by the PIC and submitted to the DON monthly.
Management systems have been reviewed to ensure risk assessments are completed reviewed and updated as appropriate including the risk rating.

The skill mix and number of staff for the centre will be kept under constant review to ensure sufficient staffing levels are in place to meet the assessed needs of all residents.

All mandatory training will be completed by 07/06/22. Staff will submit attendance record/ certificate of training and update training records in the designated centre.

PIC will review training records on a monthly basis at a minimum to ensure compliance with service mandatory training schedule.

The PIC will be supported by CNM3 to monitor compliance in relation to Regulation 23: governance and management.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with Regulation 26 the following actions will be completed ,

A full review of the covid 19 individual risk asessment that are located in each individuals covid folder has been undertaken, and each resident now has fully updated individual isolation plans as outlined in the contingency plan. All isolation plans identify each individuals zoned areas in the event of a contracting Covid 19.
Each resident covid 19 care plan has been reviewed and reflects how they will isolate in the event of them becoming covid 19 suspected or confirmed.
The pic has reviewed the long term residential care facitiliies guidelines and the visitors policy has updated accordingly. The visitors sign in log has been updated to include a date of visit. Completed 03/06/2022.
A post covid outbreak review has been completed and documented and learning disseminated. Completed 03/06/2022
Any planned or unexpected absences from the centre will be documented in each resident directory . This has been communicated with all staff and will be further

discussed at the team meeting.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
To ensure compliance with regulation 27 the following actions will be completed.

There is full compliance with the mandatory hand hygiene and standard precautions HSEland modules- to be completed 7/06/2022
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All Covid 19 support plans have been reviewed and updated to include isolation procedures, the faciliites available and access to and from the property as per the centres contingency plan. All associated risks for each resident in relation to Covid 19 has been assessed as required and included in their covid care plan.
A full review of all alcohol gels within the centre has been undertaken and are now all in date.This is added to the cleaning schedule to ensure all alcohol gels remain in date .
The contingency plan has been reviewed following the inspection and updated to be site specific and meet the profile of the residents residing here.

A post covid outbreak review has been completed on 03/06/2022 in the centre to include

• A chronology of events e.g. onset of symptoms, PCR/antigen results etc.
• Communications with IPC/external parties
• NF02a/NIM's submission dates
• Implementation of the Covid contingency plan-Discuss learnings, what worked and what could be done differently
• Staff and residents de-brief
• Document findings in residents and staff meetings so that info is triangulated
• Update Covid contingency plan and individual isolation plans accordingly
• Document any further actions that are required e.g. schedule of deep clean
• Copy of post outbreak review to be filed with contingency plan and outbreak meeting minutes

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

There is 100% compliance with fire training in this designated centre.
All peep plans have been reviewed and updated. This was completed 22/05/2022
The fire risk assessment has been reviewed and updated to include the protocol on the leaf door and hydraulic closure.
A protocol around the leaf door has been put in place and displayed on the door as a visual reminder for all staff.A copy of this protocol has been signed by all staff .This will be placed in the Health and Safety Folder . Completed 22/5/22
Leaf door will be upgraded to provide a hydraulic door closure to ensure the leaf door automatically closes after use to ensure compliance with fire regulations. To be completed by 13/06/2022
Education sessions with staff have taken place to highlight the importance of compliance with the protocol. This has been added to the agenda at the next team meeting.
The daily, weekly and monthly procedures to ensure fire safety will continue in this designated centre.

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 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	16/06/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	13/06/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Substantially Compliant	Yellow	03/06/2022

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	15/06/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	13/06/2022