Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Villa Rossa
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	14 June 2023
Centre ID:	OSV-0008362
Fieldwork ID:	MON-0040123

About the designated centre

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

Villa Rossa is a full-time residential service that can cater to the needs of up to five Children. It is a two-story
community house, which is located in Co Meath and is close to a number of towns and villages. The location of the house means that residents have access to a wide range of facilities and activities. The residents are supported twenty-four hours by a team comprising team leads and direct support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 14 June 2023	09:30hrs to 14:00hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

This was the first inspection of this service following its registration in December 2022. Two residents were living in the centre at the time of the inspection, one in a self-contained apartment and the other in the larger part of the house. The residents lived independently of one another and the configuration of the centre facilitated this to include separate gardens.

The two residents presented with complex needs and required high levels of support. Both residents were assigned two-to-one staffing support 12 hours each day and were also supported by three waking staff each night.

The inspector only had the opportunity to meet with one of the residents while visiting their apartment. The resident showed the inspector their garden and how they used their swing. The interaction with the resident was brief, but the inspector saw the resident enjoying the swing activity.

The second resident had only recently transitioned into the service and was finding the transition very challenging, they were expressing this challenge by engaging in episodes of behaviours of concern. In order to minimise the possible impact of the inspector's presence, the inspector did not engage in any interactions with the resident and removed themselves from the resident's home to support the resident's de-escalation.

Before leaving the centre, the inspector had identified areas that required improvement across areas, including behaviour support, risk management, staffing, communication with residents and ensuring that residents were engaging in meaningful activities regularly. The inspector found an extensive audit schedule; however, improvements were required to ensure that the audits were identifying areas that needed enhancement.

The following two sections of the report present the findings of this inspection concerning the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This inspection found that, several improvements were required to the service being provided to the residents. Modifications were needed to ensure that the systems and processes in place ensured that the service provided was safe for all residents and

that the oversight of the service provision was appropriate.

The inspector issued an urgent action plan to the provider requesting specific assurances regarding how the provider would manage behaviours of concern, to ensure that they could meet residents needs and maintain their safety. The following day, the provided submitted a detailed and comprehensive response, providing assurances that they were in the process of responding to the concerns and supporting the residents.

The inspection found that the provider had a defined management structure in place which was led by the person in charge. The person in charge was supported in their duties by two team leads and a team comprising, social care workers and direct support workers. There was also evidence of the person in charge being supported by members of the provider's senior management team.

The provider had developed an extensive suite of audits that were to be completed on a monthly basis. The inspector reviewed the report generated from the audits and found that areas of improvement had been identified. An action plan had been developed, and there was evidence of the person in charge responding to the actions. However, the inspector found that the audits and the report had not identified all areas that required improvement. For example, the audit had failed to recognise modifications were needed to behaviour supports, how residents were communicated with and ensuring that residents were supported to engage in meaningful activities regularly.

In addition to the auditing system, the provider had also carried out an unannounced visit to the centre and complied a written report on the safety and quality of care and support provided to the residents.

The inspector reviewed the staffing arrangements and checked the current staff roster and a roster from March 2023. The inspector did note that while there were adequate numbers of staff on duty there had been a number of changes to the staff team in the short period reviewed. The residents, as a result, were not receiving continuity of care with staff who would be familiar to them. This was an area that required improvement.

The inspector reviewed the training records of a sample of the staff team. There were systems in place to ensure that staff members received appropriate training and that their training was updated when required. The person in charge showed the inspector correspondence with staff informing them that they had upcoming training and the dates that the training needed to be completed.

The inspector also found that the residents or their representatives had been supported to visit the service before admission. Contracts of care had also been signed by residents or their representatives as per the regulations.

In summary, there was a need to review the existing management and oversight practices. Systems were in place, but these weren't identifying all areas that required improvement. Furthermore, on the inspection day, concerns were raised regarding the provider's ability to maintain the safety and meet the needs of all

residents.

Regulation 15: Staffing

The review of a sample of staffing rotas demonstrated that there had been a number of changes to the staff team within a short timeframe. This meant that the residents were not receiving continuity of care, which was identified as particularly necessary for one resident.

The inspector does note that despite the changes, the provider had ensured that safe staffing levels were maintained with a significant staff presence each day.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had a system in place that ensured staff members received appropriate training. Staff members were also receiving supervision as per the provider's guidelines.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured that there were management and oversight systems in place. As discussed earlier, some improvements were required to ensure that these systems identified all areas that required improvement.

In addition, the risk control measures in place were not effective in maintaining the safety of the residents living in the centre.The provider was required to provide assurances on how they would meet the residents' needs and maintain their safety these assurances were submitted the day following the inspection.

Assurances provided included: an increase in the behavioural support provided and enhanced the staff team's guidance through on-site training. The provider also increased the management presence in the service and reviewed the staff team to ensure that the skill mix was appropriate to meet residents needs.

While the response was prompt, there was a period when residents needs were not being met by those employed to support them.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

A review of transition plans showed that the residents had been prepared for their transition. One of the residents had visited the service whereas the parents of the other had visited and prepared the resident for the transition. There was also evidence of outreach work being completed with the most recent transition. Staff members had visited them before as part of the transition process.

The provider had also ensued that contracts of care had been signed by appropriate persons and that the contracts contained the relevant information per the regulations.

Judgment: Compliant

Quality and safety

The inspection found that improvements were required regarding the service provided to both residents.

Following their transition of a recent admission, the resident's behaviour escalated in intensity; the resident had engaged in property damage that placed themselves and others at risk of injury. As mentioned earlier, both residents were receiving two-to-one staffing support, but this proved to be an ineffective risk control measure as the resident continued to engage in the behaviours.

During the inspection, the inspector found that the provider needed to ensure that there were systems in place to meet the needs of both residents. For one resident, the provider had not demonstrated that they could effectively meet the resident's needs or keep them safe. Due to these concerns, the provider was issued an urgent action plan and was instructed to provide assurances on how they would meet the resident's needs and maintain their safety. As mentioned above, the provider submitted a comprehensive response.

In regards to the most recent referral, the provider and the person in charge were in the process of developing the resident's personal plan and identifying routines and achievements for the resident to work towards. A personal plan and care plans were created for the second resident, who had transitioned into the service in December 2022.

The inspector was directed to a behaviour support plan devised in 2021 before the resident transitioned into the service. Following further requests, the inspector was

provided with a document called a transition plan that captured some guidance on supporting the resident. However, this document was developed when the resident attended a respite service and did not reflect their current living arrangements or changes to their presentation since their admission into the service. This is despite the resident transitioning into the service in December 2022.

The inspector was provided with recording sheets that had been introduced to track the resident's presentation. There was an information sheet called initial assessment that members of the staff team had recently completed regarding the resident's presentation. While some steps had recently been taken regarding developing a behaviour support plan for the resident, there had been significant delays.
The inspector found that enhancements regarding communication between residents and staff members were required. Through the review of daily notes, the inspector identified that a resident was asking staff questions relating to their family and returning home. The inspector asked if the staff had been given guidance on supporting and responding to the resident's questions. The inspector was informed that the staff had not received such advice. The inspector also sought clarity on whether the resident had been told why they were living in the service. The inspector was informed that this had not been addressed with the resident despite them living in the service since December of last year. Therefore, significant improvements were required to ensure that residents were communicated to and with in a manner that met the resident's needs and wishes.

The inspector, as mentioned above, reviewed the daily notes. The appraisal found limited recordings demonstrating that the second resident were engaging in regular, meaningful activities outside their home. An activity planner had been devised for the resident that listed that the resident would engage in an activity each day outside of their home. The records did not demonstrate that this was occurring. Therefore, improvements were required to ensure that the resident engaged in meaningful activities outside their home regularly.

There was evidence of the person in charge seeking an educational placement for the resident. This had yet to be achieved, but the provider had sourced a tutor to work with the resident two days per week, this was proving to be successful. The staff team also supported the resident to re-engage with their family as there had been limited contact for a period. The resident and their family now met weekly, which was essential to the resident.

In conclusion, the inspection found that the provider needed to improve the service provided to both residents.

Regulation 10: Communication

Through the review of information and discussions with the management team, the inspector found that improvements were required to ensure that residents were communicated to in a manner that met their needs.

As discussed above for one resident they were seeking answers from staff members but were not receiving appropriate responses from the staff team. The resident had also not been supported to understand why they were living in the centre.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The review of records and daily notes identified that for one of the residents, there was limited evidence of the staff team supporting them to engage in meaningful activities outside of their home. A daily activation schedule had been developed and was on display. However, the scheduled activities were not completed each day. There was evidence of the resident, with the support of their staff, meeting their family in a nearby park and another example of the resident visiting a trampoline park. However, the evidence was minimal and did not demonstrate that the resident had adequate opportunities to participate in activities per their interests.

The staff team supported the resident reconnecting with their family and facilitated weekly family visits. The provider had also sourced a tutor for the resident, and there was evidence of the person in charge trying to source a school placement for them as well.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found that a risk register had been developed by the provider. The inspector also found that for one resident individual risk assessments had been designed to support staff in maintaining the resident's safety.

During the inspection day and as mentioned above, one resident engaged in property damage and escalated behaviours that placed them at risk. The resident was supported on a two-to-one staffing ratio during the incident. However, this control measure was not effective. There was a need to review the resident's behaviours and ensure that the control measures and approach were appropriate to the resident's needs.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

During the inspection, it became apparent that the supports in place to meet one resident's needs were inappropriate. As discussed earlier, the residents escalating behaviours placed them and others at risk. The staff team had been unable to meet the resident's needs during these episodes, and there was a need for a prompt review of the resident's needs and for appropriate support to be implemented.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A resident transferred into the service in December 2022. The resident presented with complex needs, including behaviours of concern. Despite this, the provider failed to ensure that an appropriate behaviour support plan was developed for the resident to ensure staff could best support the resident, keep them safe and meet their needs..

On inspection day, the staff team only had access to support plans that did not reflect the resident's current living arrangements, nor did the plans reflect the resident's needs, as the plans had been developed in 2021 and mid-2022 before the resident was admitted into the service. Therefore the provider needed to ensure that an appropriate behaviour support plan was developed promptly.

There was also a need for a prompt review of behaviour support interventions to respond to the escalating behaviours of the other resident who had recently transitioned into the service.

Judgment: Not 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Villa Rossa OSV-0008362

Inspection ID: MON-0040123

Date of inspection: 14/06/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Where there is a turn over of staff, all incoming staff are required to complete a four day onsite induction program. The aim of this induction programe is to ensure that all staff are fmailiar with the working arrnagements and support needs of residents within the centre and promotes contiuity of care. Please note a residnet was admitted to the centre on the 8th of June 2023, this necesitated the induction of new staff. All outgoing staff are offered the opertunity to compelte exit interviews with our HR department. The purpose of these exit interviews is to identify trends that may be impacting on staff retention. The rosters are being maintained by the Person in Charge with a consistent staff team. Rosters are planned in advance and any deficits are backfilled from within the team or with a panel of relief staff that are familiar with residents support needs. The Assistant Director of Services will review the rosters at each monthly governance meeting to ensure consistent staffing is being maintained in the centre for the residents support. In addition the Provider has recently appointed a person with organsiational responsibility for roster oversight. This will further support the Person in Charge with roster planning.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of all the audits conducted within the centre has been completed. The purpose of this review was to identify learning and to support the self-identification of issues going forward. As part of this process, the new Assistant Director of Service assigned to the service will complete shadow audits with the Director of Service, to enhance the assurance mechanisms available to the Provider. All staff have received on-site Professional Management of complex behaviour training	

specifically tailored to the support needs of the residents in this centre, completed 16.06.23.

An emergency assessment of a residents behaviour support needs was completed on the 16.06.23. This assessment included reviewing what proactive and reactive strategies are required to support the escalation of behaviour for one resident and was immediately implemented as a support guide to the staff team. The outcome of the assessment and the effectiveness of these strategies were reviewed at the Childrens Services MDT on the 22.06.2023 and will continue to be reviewed at each MDT meeting in future months.

Senior management have increased visits to the centre, announced and unannounced, including at night and will continue to do so. Contingency arrangements remain in place to ensure that out of hours management supports are available in the event they are needed.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
In conjunction with residents nominated representative, a plan of communication was developed by the Person in Charge to best inform the resident as to why they were residing in the designated centre.
The Person in charge met with the resident on 26.06.23 and implemented this plan. All staff have been briefed on consistent responses to support the resident with their understanding of this. The communication strategy will also be incorporated into the residents postive behaviour support plan.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Training has been provided to the staff team on recording resident activities, opportunities, choices and schedules. The purpose of this training is to ensure residents engagment in activieies is planned, organised and recorded effectively.
The Person in Charge is monitoring the recordings daily and the Assistant Director is also monitoring the recordings at least weekly to ensure oversight of residents activities and choices are to ensure they are captured accuertly. Progress on this matter is reviewed at team meetings, with team at next team meeting 2 6.07.23.
The Person in Charge will continue to engage proactively with reprentaives of the board of education, to identify an appropriate school placement for all Children residing in the centre.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All staff have received on site Professional Management of Complex behaviour training specifically tailored to the support needs of the residents in this centre, completed 16.06.23.

A specific training session for senior management in the Management of Complex

Behaviour has been scheduled for the 01/08/2023.One resident was admitted on the 8th of June.

An emergency assessment of one resident's behaviour support needs was completed on the 16.06.23. This assessment included reviewing what proactive and reactive strategies are required to support the escalation of behaviour for one resident and was immediately implemented as a support guide to the staff team.

The effectiveness of these strategies are under continual review- these measures have proven effective to date. A protocol was also implemented to guide staff response to unsafe behaviours. The Director of Services and Assistant Directors of Services has reviewed all incidents since admission, to identify trends, triggers and patterns of behaviours.

The Assistant Director of Service will be present in the centre for all potentially high stress situations for this resident, including during planned family visits.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Additional supports put in place with immediate effect include specific on site Professional management of complex behaviours training for the staff team. Positive behaviour support specialist developed an interim Positive Behaviour Support Plan, providing staff with strategies to support the resident in the management of adverse incidents. 16.06.23.
The residents support requirements were reviewed with the Childrens MDT on 22.06.23 and will continue to be reviewed as required.
All incidents are reviewed by members of the senior operations management and learning disseminated.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A review of the providers systems has been completed to enhance the service's comprehensive assessment of need. Going forward all new admissions will be screened by a positive behaviour support specialist prior to admission, to assess what type of behavioral supports they may require. Where applicable interim behaviour support plans will be devised within 28 days of admission. With a full plan being devised as soon as practically possible and in line with each resident assessed needs. These behaviour support plans will be reviewed at least annually.

In relation to the residents in the centre. Data collection for the resident's behaviour support plan has been completed and the development of a comprehensive behaviour support plan is in progress. This is due to be finalized on 31.07.23.

Additionally the positive behaviour support specialist developed an interim Positive Behaviour Support Plan for another resident, this provides staff with strategies to support

the resident in the management of adverse incidents. 16.06.23. All staff have received on site Professional Management of Complex behaviour training specifically tailored to the support needs of the residents in this centre, completed 16.06.23.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/07/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/06/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support,	Substantially Compliant	Yellow	30/06/2023

	particularly in circumstances where staff are employed on a less than full-time basis.			
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	30/06/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Red	16/06/2023
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	16/06/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's	Not Compliant	Orange	31/07/2023

	behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			