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:	Radharc Nua
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	23 July 2024
Centre ID:	OSV-0002633
Fieldwork ID:	MON-0043952

About the designated centre

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

Radharc Nua is a designated centre located in a rural area in Co.Wexford. The centre provides long-term residential care to five adult residents, with intellectual disability, dual diagnosis and significant high support physical and behavioural support needs. Residents living in the centre require full-time nursing care. The staff team consists of nursing staff and support workers. The residents attend day-services attached to the organisation and also have in-house individualised activities. The centre comprises of a large two-story house located in rural location. It has five single bedrooms with two living rooms, a kitchen, dining room, sensory room, five bedrooms, adapted bathrooms and a large accessible garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 23 July 2024	10:10hrs to 17:15hrs	Sarah Mockler	Lead
Wednesday 24 July 2024	09:30hrs to 12:30hrs	Sarah Mockler	Lead
Tuesday 23 July 2024	10:10hrs to 17:15hrs	Conor Brady	Support
Wednesday 24 July 2024	09:30hrs to 12:30hrs	Conor Brady	Support

What residents told us and what inspectors observed

An inspection in April 2024 identified significant failures relating to residents' rights, risk management and safeguarding in this centre. Immediate and urgent actions were issued at this time. In addition, a follow up inspection occurred in May 2024 to ensure that adequate safety measures were put in place to safeguard residents. The Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of this centre due to the provider's failure to ensure residents' safety at all times.

The purpose of this inspection was to inspect the safety of the service for the residents living there and ascertain the levels of progress made by the provider in terms of regulatory compliance.

The inspection was unannounced and took place over a two day period. Two inspectors were present across both days of inspection.

Overall, the findings indicated that the provider had made significant progress in achieving better levels of compliance and were delivering safe levels of care to residents. Residents were observed to be safe and well cared for in their home. However, some core concerns around the incompatibility of the resident group/mix in this centre remained.

As per previous inspection findings, residents living in this centre were assessed as not being compatible to live together. For example, residents with autism and other mental health presentations were frequently triggering each others behaviours resulting in incidents and/or outbursts in the centre. This was managed by a number of restrictive practices and constant supervision by the staff team. Although peer to peer incidents were low, staff were intervening, and at times receiving injuries themselves to prevent incidents occurring/escalating.

Across the two day of inspections the inspectors met all five residents that lived in the designated centre. All residents in this home used non-verbal means to communicate their immediate needs. Residents would lead staff members by the hand to bring them to the area where they wanted an item. For example, across the two days of inspection residents were observed to lead staff to the kitchen area to indicate when they were thirsty or hungry, or they would lead them to their bedroom if they wanted their television switched on.

Residents were seen to congregate in the main hall area of the home when all doors in the house were deactivated from the keypad locks, some residents spent time outside and residents were seen pacing and walking quickly from the hall up and down the corridors to the kitchen and bedroom areas.

One area that had improved was residents access to activities outside of the designated centre. On both days all residents left the centre for varying periods of

time. Residents went out shopping, for drives, and walks in the country side. There were two vehicles available to the residents. All residents could use both vehicles. Some residents were assessed to need specific safety harnesses when travelling. A new harness had recently been purchased which could easily be transferred from one vehicle to another allowing more flexibility in allowing this resident travel in different cars.

As part of the inspection process the inspectors completed a walk around of the premises. A number of restrictive practices were in place which included key pad locks, both on internal doors and external doors, a locked bedroom door, restrictions on access to water in bathrooms, and door alarms. As residents were not compatible to live in the same environment parts of the house were locked at different times of the day to try and promote a low stimulus environment. For example, meal times were staggered which meant the interconnecting door between the dining area and hall was locked. This kept residents separate at these times which was assessed as required for safety reasons. On the second morning, in the main hall, inspectors observed residents' behaviours escalate due to the presence of other residents level of noise. At this time a staff member intervened and de-escalated the situation. Of note was the degree and short time frame it took for the behaviors of concern to escalate quiet rapidly.

A number of premises works had been completed to make the centre less clinical in presentation, this included redecoration of the dining area, hall, and conservatory. Although there was a shutter in place between the kitchen and dining area the provider assured the inspectors that this was due for replacement in the coming weeks.

As part of the walk around the inspectors went to the outside area. The majority of the garden was surrounded by a large metal fence. Areas of the garden were sectioned off into different parts with gates with padlocks. One area of the garden was used to separate/isolate a resident from their peers and the home during periods of engagement in behaviours of concern and self-injurious behaviours. In this part of the garden was a large sheltered area with padding surrounding it to ensure the residents' safety. In addition, padding had been placed on metal poles on the fence and it was surrounded by plants to make to less accessible.

The measures taken by the provider had resulted in safer services being provided to the residents. Aspects of quality of care were also improving due to increased access to vehicles and activities out of the centre. However, the group of residents that lived in the home posed a risk to each other due to their specific assessed needs. Continuous monitoring of the service, lived experience of residents and consideration of alternative accommodation options were required to ensure that residents were afforded the best quality of life.

The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care.

Capacity and capability

Previous inspection findings had highlighted the issues with the compatibility of residents within the centre. The immediate safety concerns identified on the most recent two inspections in April and May 2024 had been addressed by the provider.

Residents were now found to be kept safe in their home with many improvements noted.

As part of the written response the provider had committed to providing more robust systems of oversight in place. This included regular oversight and governance meetings from senior level management within the organisation, quarterly reviews of audits by the person participating in management and enhanced supervision of the staff team. Inspectors found that this approach had improved the centre in terms of quality and safety of care and moved the centre into regulatory compliance.

Regulation 14: Persons in charge

A new person in charge was appointed in May 2024. The person in charge had been in this position in other designated centre's operated by the provider prior to their appointment to the current post. They met the requirements of Regulation 14 in terms of their qualifications and previous management experience.

The person in charge facilitated the inspection. They demonstrated that they were familiar with the provider's systems and processes. Although recently appointed to the centre, they had a history of working with these residents in previous roles so was familiar with a number of their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

There was an appropriate staff number and skill mix on duty in this centre. Staff were observed to be respectful, responsive and caring. Inspectors found that there were seven staff on duty during the day and two waking staff on duty at night. The staff team was made up of experienced nursing and care staff who provided good care and support to the five residents in the centre.

From a review of rosters, it was noted that agency staff were utilised on a frequent basis but a regular of cohort of staff were also present. This centre was at times a

very demanding environment for staff in terms of both being a busy, loud and sometimes volatile environment. Staff were observed to be managing this very well over the course of this inspection however ongoing management initiatives of staff support should be continually reviewed by the provider in this centre.

Inspectors reviewed seven staff personnel files and found each staff member had appropriate qualifications, evidence of training, professional references and Garda Vetting Disclosures in place.

Staff were observed over the course of inspection supporting residents, cooking homemade meals, baking cakes, bringing residents on outings, walking with residents and supporting residents with personal care

Judgment: Compliant

Regulation 23: Governance and management

The inspection found that the majority of required provider actions had been completed or were in the process of being completed. This had resulted in safer services being provided to residents.

As part of the governance actions completed, the provider had committed to forming a governance and oversight team which was chaired by the Head of Service. The inspector reviewed the notes from the meetings that had taken place to date. Eight meetings had taken place to date. In the notes, the actions identified from compliance plan responses were discussed in detail with specific actions delegated to a specific person. The subsequent meeting had notes evidenced how actions were progressed and what was outstanding. Overall, the meeting notes demonstrated that a comprehensive approach to oversight of actions was taken and closely monitored.

In addition, the person participating in management (PPIM) visited the centre on eight occasions from 20th of May 2024 to 10th of July 2024. The inspector reviewed the notes kept from these visits. During these visits it was noted that the PPIM completed walks around of the premises, met with staff, reviewed risk assessments and completed other relevant oversight duties.

Overall, it was found that a more robust approach to oversight was occurring with the introduction of enhanced processes. This was essential in a service whereby residents presented with complex and changing needs. The changes and improvements to oversight had been effective in ensuring actions were completed and bring a better level of compliance in the service.

Judgment: Compliant

Quality and safety

Concerns in relation to the safety and quality of care being delivered to residents were identified on inspection in April 2024 and May 2024. The findings of the current inspection indicated that improvements were noted in the provider's systems in relation to safeguarding and risk, and residents were now safe.

As per previous reports it was identified that ongoing compatibility issues between residents was impacting the lived experience and quality of life outcomes for residents. All residents within the home were assessed as requiring a quiet/low arousal environment. At times, due to residents congregating in the main hall and the noise levels within the home this was directly impacting on other residents and triggering incidents of behaviours of concern. This was directly observed by inspectors on the second day of inspection.

The provider had made significant efforts to improve the service which included having sufficient staffing, re-arranging the layout for sleeping arrangements, the provision of more activities for residents and environmental changes to ensure the designated centre was safe. However further improvements were required in this area to ensure residents had a right to live in a home that met all their specific assessed needs.

Regulation 17: Premises

A number of improvements and changes had been made to the premises. This resulted in the centre presenting as more homely and less clinical in presentation. Improvements internally included, new flooring, storage cabinets, painting, and furniture being sourced for the dining, conservatory and hall area. The hall was awaiting some new storage to be installed and the kitchen area required the removal of a metal hatch. The provider outlined the plans that were occurring in relation to this in the coming weeks.

In addition, residents bedroom location had been reviewed with one resident relocating to a bedroom upstairs. This meant that an additional room downstairs was now allocated as a sensory/quiet space for the residents. Furniture was being sourced for this room on the day of inspection.

All parts of the centre presented as clean and well maintained on the day of inspection. Each residents' bedroom was nicely presented and decorated.

Externally, planting of hedges and addition of padding to structures that posed a risk to residents had been completed. A structure outside, which had been built for one resident to relax in was getting new furniture on the day of inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk was found to be overall, appropriately managed in this service and a number of additional risk controls had been implemented by the provider since the previous inspection. Some improvements were required in terms of risk reporting, review and learning from incidents.

Inspectors found that this centre had a large number of significant risk areas due to the nature of the service provided, the profile and behavioural presentation of the residents and the large environment of the centre itself.

A risk register was in place with a series of risks recorded such as resource/staffing risks, risk of assault or injury to residents and staff, risk of absconding, risk of self harm, risk of peer to peer incidents, risk of seizure activity, risk of slips, trips and falls, safeguarding risks and the risk of inappropriate sexualised behaviours.

Staff demonstrated a good knowledge of risks and were able to discuss how risks were being managed and responded to in this centre. Staff highlighted various control measures and practical management techniques utilised in managing risk. For example, keeping certain residents apart, providing a safe environment, ensuring appropriate staffing levels, travelling on activities at certain times/with certain residents, supporting residents through difficult/negative episodes of challenging behaviour.

Incidents and accidents were being logged and reported through the National Incident Management System (NIMS). There were some improvements required in the efficiency of reporting, responding and learning from incidents. For example, recent incidents of head butting had not been appropriately reported and/or assessed based on a review of NIM's incidents. Additional control measures had not been considered post incident. Inspectors observed staff being head butted on this inspection. Inspectors were concerned that given the high volume and various types of negative and challenging behaviours prevalent in this centre, that there was a risk of the normalisation and acceptance of some risks and incidents. This will need to be reviewed and monitored closely by management from a health and safety perspective to ensure both staff and residents are being kept safe at all times.

In addition, a psychologist had recommended specific risk assessments in relation to sexualised behaviours that were occurring. At the time of inspection this action remained outstanding and these risk assessments were not in place. Although the provider had outlined a plan on who was going to take over this piece of work there was no clear time line to when this would occur. While this risk was being managed appropriately, in practice, the supporting documentation needs to be in place to offer the appropriate guidance to staff.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found the safeguarding issues highlighted on the previous inspection had been appropriately addressed.

Updated safeguarding plans had been completed for each resident. All staff had undergone updated safeguarding training and refresher training. Garda vetting was in place for all staff. Clear organisational policies and procedures were in place regarding the prevention, detection and reporting of safeguarding concerns. Intimate care plans were in place to protect residents and staff demonstrated awareness of these care plans. Staff knew the types of abuse and how to report and record any concerns through the appropriate channels. There were seven staff on duty during the day and two staff on duty at night so there was no lone working in this centre. Visitors to the centre were announced and maintenance workers were observed coming and going in a respectful manner.

Residents finances were reviewed and each resident had an account managed by the provider in the residents own name. Residents had access to their finances and were supported to make purchases in line with personal preferences. For example, a resident had been shopping in IKEA on the day of inspection and was supported to purchase a number of items for their bedroom. Another resident was being supported legally to regularise their financial affairs having been recently left an estate in a will. The provider was supporting the resident appropriately in this regard.

Inspectors did observe that given the resident profile and behavioural presentation of some residents that it was very challenging at times for the staff to keep themselves and the residents safe. Staff knowledge and experience, appropriate response/intervention, physical responses, separation of residents and restrictive practices were all used in this centre to keep residents and staff safe.

Judgment: Compliant

Regulation 9: Residents' rights

Resident compatibility in this centre remained a concern for the inspectors due the levels, complexity and frequency of the behaviours displayed and the vulnerabilities of the residents living in the centre. This also directly impacted choice available to residents as for example meal times and activities had to be staggered. This concern had also been identified by the provider.

The provider had completed compatibility assessments in the last couple of weeks.

The inspector reviewed all five assessments in place for each resident. The assessments were entitled 'Environmental Compatibility Assessments'. The function of the assessment was was to review the environment only and did not take into consideration other people that lived in the home and their specific assessed needs.

In addition, although some residents' assessments identified that the restrictions in place for them impacted other people in the home that did not require them. The corresponding environmental assessment for the relevant residents that did not require restrictions failed to identify this barrier. It was unclear on how this assessments were effectively addressing the compatibility of the residents considering they were inaccurate at times and did not fully account for all variables in their living situation.

Although the measures taken by the provider, such as residents leaving the centre on a more frequent basis, restructuring the layout, and enhanced oversight of risk and other aspects of care were resulting in less incidents. The long term suitability of the resident group required ongoing review to ensure all residents' specific needs were being met and that a rights based approach to care and support could be upheld at all times.

Judgment: Substantially 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	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Radharc Nua OSV-0002633

Inspection ID: MON-0043952

Date of inspection: 23/07/2024

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 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Person in Charge has developed a template to summarise incidents, identify learning, identify where review or changes are required to documentation e.g. risk assessments and to identify where additional control measures are required.

All residents' incidents are reviewed monthly at the senior manager's "Quality Patient Safety" meetings and all staff incidents are reviewed monthly at the senior manager's Health and Safety meeting. All staff meetings are reported to the Health and Safety Advisor and also to the Health and Safety Authority if a staff member is injured at work and absent for greater than three days.

All resident risk assessments are reviewed three monthly by the PIC and ANP in Behaviour Support. All Health and Safety Risk Assessments are reviewed at least annually and more frequent if required. The Health and Safety Advisor also completes annual Health and safety audits in the centre and provides feedback and recommendations which are actioned.

The Provider has liaised with Psychology to request a review of the previously suggested specific risk assessments in relation to their suitability for the residents in question. In the absence of these specific risk assessments for residents who may require them, they have the following in place; risk assessments and support plans for the management of sexualized behaviours of concern (which are reviewed every 3 months and more frequently if required), Positive behavior support plans and safeguarding support plans.

The Provider has sourced training for staff to support residents with the "Management of Sexualised Behaviours" specifically for residents who may lack capacity. Awaiting confirmation of training dates from the person providing the training on their return from leave 02/09/2024.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Person in Charge (PIC) is completing a review of Environmental Compatibility Risk Assessments completed and will make the required additions to each assessment. The service continues to review and enhance their own Compatibility Assessments in the absence of a Standard template. The Person Participating in Management (PPIM) for Radharc Nua currently sits on a National Expert Advisory Group who meet monthly with the purpose of developing a national standardised "Compatibility and Choice Assessment", and shares any learning and information from this group with the PIC.	

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 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.	Substantially Compliant	Yellow	30/09/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/09/2024