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:	Woodbeg
Name of provider:	St Catherine's Association CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	25 May 2023
Centre ID:	OSV-0003409
Fieldwork ID:	MON-0037577

About the designated centre

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

Woodbeg is a designated centre operated by St. Catherine's Association in Co. Wicklow. Woodbeg provides full-time residential care for two young adults with a diagnosis of autism and intellectual disabilities. The centre is a four-bedroomed bungalow set on a large site with a garden to the front and rear. A full-time person in charge is appointed to the centre and they are supported in their role by a deputy manager and social care workers. The person in charge divides their time between this centre and one other designated centre. Transport resources are assigned to the centre.

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
Thursday 25 May 2023	10:15hrs to 16:15hrs	Sarah Cronin	Lead
Thursday 25 May 2023	10:20hrs to 16:15hrs	Michael Keating	Support

What residents told us and what inspectors observed

This was an unannounced risk-based inspection which took place following a notification of concern sent to the Office of the Chief Inspector. Inspectors found mixed levels of compliance with the regulations, with improvements required in governance and management, safeguarding, staffing, staff training and development and positive behaviour support. These are detailed in the body of the report.

The designated centre is a large 4-bedroomed bungalow in a rural setting outside a town in Co. Wicklow. The house is home to two young people who have intellectual disabilities and autism. The house comprises a large sitting room, a kitchen and utility space, a conservatory, two resident bedrooms, both of which are en suite, a staff office, a bathroom, a sleepover room and a relaxation room. Outside the house was surrounded by a garden which had equipment for the residents to use. Residents' bedrooms were personalised and decorated in line with their preferences. There were photographs of residents engaging in activities on the wall.

Residents in the centre have complex communication needs and communicated using verbal communication, which required staff to know the context of the words they were using. Residents also used body language, eye contact and behaviours at times to communicate. Staff were required to know residents and their communication support plans well in order to give clear and consistent responses to questions and interactions. Inspectors had the opportunity to meet with both residents over the course of the day. One resident invited inspectors to come and speak with them about their plan for the day. They spoke about places they liked to go and showed them their tablet device. The resident later showed inspectors their bedroom. They had a choice board on the wall and showed inspectors the various places they liked to go and what they liked to eat or drink when they went to each place. The second resident had been on a trip with staff to a local woodland and was sitting in the conservatory area relaxing. They were noted to wander freely around the house and were relaxing on a swing in the garden as inspectors left the centre.

Residents were supported to engage in activities of their choosing by staff. These included going for long walks, going out to eat, going for drives and going bowling. The house was equipped with activities and equipment for residents to use such as arts and crafts supplies, a trampoline and swing and a basketball net. There was a sensory room in the centre, but this was currently used as a staff sleepover room while repair work took place. Each resident had their own tablet device to use and were noted to be supported by staff to access the websites they wished to view. One resident was supported to have a video call with family using their device.

Inspectors noted that the staff on duty on the day of the inspection had a good rapport with the residents. It was evident they were familiar with how best to support their communication and behaviour support needs. Interactions were

respectful and residents appeared to be comfortable in the company of staff.

In summary, from what residents told us and what inspectors observed, it was evident that residents in the centre were supported to engage in activities of their choosing. Both residents were well presented and appeared comfortable in the company of staff. There was a relaxed atmosphere in the house. 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 care of residents living there.

Capacity and capability

As outlined at the beginning of the report, this inspection took place following a notification of concern submitted to the Office of the Chief Inspector. Inspectors sought immediate assurances from the provider following this notification. This inspection found that the provider was taking appropriate actions to investigate the incident and had put additional measures in place ensure the ongoing safety of residents living in the centre.

Inspectors found that the governance and management arrangements in place were not effective in monitoring and overseeing the quality and safety of care of residents in the centre. Six-monthly unannounced provider visits had taken place as required. However, the report viewed by inspectors had not identified significant gaps and concerns relating to complaints, the culture within the centre, staff supervision or consistent implementation of residents' care plans. Remote oversight had been in place for a number of months prior to the inspection by the previous person in charge, meaning that there had not been a consistent presence from management in the centre over a significant period of time.

The provider had employed a new person in charge, who had commenced in the centre in three weeks prior to this inspection taking place. They were full-time in their role and had oversight of two designated centres in total. The person in charge spoke with inspectors about their supervision schedule for staff and their plans to enhance the monitoring and oversight of care of residents. The person in charge had regular meetings with their line manager.

Inspectors found that staffing levels had recently increased as a safety measure in the centre. There were defined staff ratios in place for each resident in the centre for both day and night. Actual and planned rosters were viewed and these indicated that while most shifts were filled in line with the ratios required, there were occasions where the full staff complement was not available which had a negative impact on residents. This is detailed under Regulation 15: Staffing.

Inspectors viewed a training needs analysis for the centre and the training matrix. For the most part, staff had completed training in mandatory areas such as safeguarding, fire, manual handling and safety interventions. There were some gaps

in refresher staff training in areas of resident care such as anaphylaxis and epilepsy. These had been identified by the provider. However, training had not been provided to staff on areas specific to residents' assessed needs. Staff supervision had not been carried out in a number of months in line with the provider's policy.

Regulation 15: Staffing

Inspectors viewed actual and planned rosters which indicated that while most shifts were filled with the appropriate ratio of staff, there were occasions when the full staff complement was not available. This had a negative outcome on residents. For example, there were two complaints which indicated that there had been occasions where a resident was unable to leave the centre during an incident of a peer engaging in behaviours of concern due to staff shortages.

Judgment: Not compliant

Regulation 16: Training and staff development

As outlined above, staff had completed training in mandatory areas such as fire, safeguarding and manual handling in addition to safety interventions for managing behaviours of concern. However, inspectors found that staff did not receive training to enable them develop skills to care for residents who had specialist care needs. For example, residents in the house had a diagnosis of autism. Inspectors found that only a small number of staff had received any training in supporting people with autism.

Staff supervision had not taken place for a number of months. This posed a risk in this centre due previous concerns raised by staff in relation to team dynamics, culture and work practices. The new person in charge had a clear supervision schedule in place and enhanced levels of supervision were planned for the remainder of the year.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the governance and management arrangements in place for the centre were not effective in monitoring and overseeing the quality and safety of care of residents in the centre. Six-monthly unannounced visits had not taken place in line with regulatory requirements. However, these visits had not identified a number of areas identified on this inspection. For example, issues relating to

conflict, culture and inconsistent work practices relating to residents had been voiced by staff in the centre since September 2021. This had been identified as an issue on an inspection of the centre in March of 2022. This was not identified in audits, nor was there clear evidence to indicate that the provider had responded in a timely manner to staff concerns on the quality and safety of care of residents.

At centre level, there had been remote oversight arrangements in place for a number of months prior to the inspection by the person in charge, meaning that there had not been a consistent presence from management in a significant length of time. This had a negative impact on both the staff team and on residents living in the centre.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that residents were supported to engage in activities of their choosing and that they were facilitated to make choices in relation to their daily routines. However, improvements were required in the area of safeguarding and positive behaviour support. Residents in the centre were supported to have best possible health. They received input from allied health and social care professionals including speech and language therapy, occupational therapy, psychology, behavioural support and physiotherapy.

Residents had positive behaviour support plans in place which outlined reactive and proactive strategies to best support each resident. Restrictive practices in use in the centre were notified to the Authority in line with regulations and reviewed by the provider every six months. However, guidance in relation to physical holds in the centre required improvement to ensure consistent and safe practices by all staff when these were used.

There had been a number of allegations of abuse in the centre in the year prior to inspection. Inspectors found that these had been appropriately documented, reported and investigated in line with National policy. Residents had detailed personal care plans in place to guide staff practices. However, inspectors viewed two complaints which had been screened by the provider. Both of these complaints related to safeguarding concerns and had not been recognised by the provider as safeguarding issues requiring notification to both the Authority and the HSE. This was discussed with the provider on the day of the inspection.

Risk management systems were in place to ensure that risks in the centre were identified, assessed and managed. Risks were regularly reviewed at centre level and for resident-specific risks. Adverse incidents were appropriately managed and actions as required.

The provider had suitable fire safety precautions in place in the centre. There were

detection and containment systems, fire fighting equipment and emergency lighting in place. Regular fire drills took place and demonstrated reasonable evacuation times. Actions from the last inspection had been completed.

Regulation 26: Risk management procedures

The provider had suitable systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies. There was a risk register in place which was regularly reviewed. Residents had individual risk assessments in place. Adverse incidents were found to be documented and reported in a timely manner. These were trended on a monthly basis by management to ensure that any trends of concern were identified and actioned.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had suitable systems in place to detect and contain fire in the centre. Actions identified on the last inspection had been addressed and there were adequate means of escape, including emergency lighting. Staff whom inspectors spoke with were aware of fire evacuation procedures and all staff were trained in fire safety. Equipment within the centre were regularly checked and serviced as required. Fire drills occured on a monthly basis and a recent evacuation had taken place with the minimum staffing complement available. All drills viewed by inspectors demonstrated reasonable evacuation times. Each resident had a personal emergency evacuation plan in place which was regularly reviewed.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a GP and a range of health and social care professionals such as speech and language therapy, occupational therapy and behaviour therapy. There was evidence of input from a number of professionals on each residents' care plan. Residents were facilitated to attend health care appointments, and these were clearly documented on their files.

Judgment: Compliant

Regulation 7: Positive behavioural support

While residents had positive behaviour support plans in place, these were not suitably detailed to guide consistent staff practices in relation to the use of physical holds. For example, one resident's plan outlined that safety intervention holds could be used, but it did not specify which holds were appropriate for that resident to ensure the least restrictive measure was used.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that two allegations of abuse which were made in the form of complaints had not been appropriately identified by the provider. This meant that some safeguarding concerns, which were having a negative impact on residents had not been reported and documented in line with National Policy.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Woodbeg OSV-0003409

Inspection ID: MON-0037577

Date of inspection: 25/05/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The organisation is actively recruiting to meet any deficits in WTEs. In the interim, agency staff are being used to address deficits. When those deficits cannot be filled a risk assessment is carried out to put measures in place to mitigate the impact on residents. Local management are also working frontline to support residents as required. Complete. As an interim measure the WTE number has been increased to address this deficit and SCA will submit a business case to the funding agent to make this a permanent arrangement. 31st August 2023	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The centre's SOP has been updated to included autism training as required training. All staff have been mandated to complete the course. 31st August 2023.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The PPIM will ensure that staff issues raised within supervision is an agenda item on their regular meetings with the local management teams. 14th July 2023	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All staff are trained in Safety Intervention techniques, and directed by the training ensures the least restrictive measure is used at all times. The residents positive behaviour support plan will be updated, in consultation with the Positive Behaviour Support Specialist, to reflect that safety intervention holds are a last resort and staff are to utilise the least restrictive hold to ensure the safety of the individual and those around them. Local management meet with positive behaviour support specialist every 2 weeks to review any Behavioural incidents or more frequently if required, attends staff meetings as required, all restrictive practices used in SCA ie physical holds or restraints including frequency and duration are recorded in quarterly restrictive practice log books which receive a further indepth review by QCT department manager and location manager prior to submission to the regulator via the HIQA portal. Ongoing, complete.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: NFO6s have been submitted via the HIQA portal. All staff across the organisation will be reminded of the need to submit NF06s if a resident is negatively impacted by the behaviour or actions of a peer. All complaints are submitted to the DLP/DO at time of receipt for review and trending of data. 14th July 2023	

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/08/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/08/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2023

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.	Not Compliant	Orange	30/06/2023
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	14/07/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/06/2023
Regulation 08(3)	The person in	Not Compliant	Orange	14/07/2023

	charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			