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:	DC5
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	11 April 2024 and 12 April 2024
Centre ID:	OSV-0003642
Fieldwork ID:	MON-0034774

About the designated centre

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

St John of God, Designated Centre 5 is a designated centre located within a campus setting in County Kildare. The centre provides residential services to 13 adults with an intellectual disability. The centre is a purpose built building which consists of three kitchens, four dining rooms, four sitting rooms, staff office, two sensory rooms and 13 individual resident bedrooms. The centre is located close to a town with access to local shops and transport links. The centre is staffed by a person in charge, clinical nurse manager, staff nurses, social care workers and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 11 April 2024	10:25hrs to 17:00hrs	Erin Clarke	Lead
Friday 12 April 2024	08:30hrs to 12:30hrs	Erin Clarke	Lead
Thursday 11 April 2024	10:15hrs to 17:00hrs	Karen Leen	Support
Friday 12 April 2024	09:00hrs to 12:30hrs	Karen Leen	Support

What residents told us and what inspectors observed

DC5 designated centre is comprised of an institutional-type single-storey premises located on a campus operated by St. John of Gods Community Services Limited in County Kildare. The building was partly de-congregated, resulting in a large number of unused and unoccupied rooms. Due to the nature of the setting, building, and number of residents, this centre is classified as a congregated setting. (Congregated settings are where 10 or more people with a disability live together in a single living unit or are placed in accommodation that is campus-based).

On the first day of inspection, inspectors had an introductory meeting with the newly appointed management team of the centre. The person in charge was a clinical nurse specialist grade two (CNM2), and their reporting manager was a clinical nurse manager grade three (CNM3) who was also the nominated person participating in the management (PPIM) of the centre. Following the introductory meeting, the inspectors walked around the centre and took the opportunity to meet with residents and staff to gain an insight into what it was like living in the centre. Inspectors also spent time observing the environment and interactions between residents and staff.

Twenty-two residents previously resided in this designated centre before the provider implemented a decongregation plan in 2017 and 2018, and residents moved to smaller homes in the community. Each resident had their own bedroom that provided adequate space and storage. The living and communal areas were very spacious and staff had decorated the centre to make it more homely. However the centre's overall appearance was institutional in aesthetic.

The centre is divided into four houses, each set out across one floor. They are referred to as House 1, House 2, House 3 and House 4. All houses are managed as one unit in the day-to-day running of the centre, sharing the same staff and management team. The designated centre consists of three kitchens, four dining rooms, four sitting rooms, two sensory rooms and 13 individual resident bedrooms. Photographs on the walls showed some activities that residents took part in, including a fundraiser for Daffodil Day, bingo, and making crafts for St. Bridget's Day,

On arrival to the centre on the first day of the inspection, inspectors met one resident who was being supported by staff to attend their day service. Inspectors observed that the staff member assisting the resident was familiar with their communication support needs and was assisting them with additional time to transition to their day service.

During the inspection, the PPIM discussed the progress in moving away from centralised meal preparation on campus, resulting in meals being transported to the centre. The inspectors were informed that this process also required engagement with staffing unions for agreement. At the time of the inspection, the designated

centre was waiting for construction work on two new purpose-built kitchens to begin, which would allow for the preparation of home-cooked meals within the centre. While the centre had two functioning kitchens, these were used to store food, snacks, and light meal preparations and were not routinely used to prepare lunches and dinners. Minutes from a staff meeting detailed management's disappointment that a planned cooked Christmas Day dinner did not occur in the centre, and instead, meals were ordered from the centralised kitchen.

Inspectors met with three residents who were in the one of the designated centre's dining areas. The residents had just finished their breakfast and were being supported by staff to get ready for planned activities. The inspectors noted that while residents were waiting, one staff member completed a medicine round. For the most part, residents attended day services on the provider's campus, which they had historically attended.

One inspector spoke to a member of staff who was assisting a resident in one of the designated centres sensory rooms. The staff member informed the inspector that the sensory room was an area in the house that the residents immensely enjoyed, particularly the resident who was currently availing of the sensory area. The staff member discussed that the resident had a visual impairment and particularly enjoyed the textures and panels in place within the sensory room. The inspector observed the resident moving freely throughout the sensory room and moving between activities within the room with the assistance of staff. Other residents at this time were having their personal care and morning routines attended to in their bedrooms.

One inspector observed one resident standing in the dining room alone while they waited for breakfast. They peered through the window on the kitchen door a few times, where the inspector observed a staff member making the resident breakfast. It was unclear how the resident was supported in making choices regarding food and drink options. A staff member exited the kitchen with a bowl of cereal and was observed to engage in friendly communication with the resident. They explained that since the resident had started living in the centre within the previous year, their independent eating skills had decreased, and they now required support from staff in feeding. The inspector also observed a staff member spending one-on-one time with a resident in a living room, sitting down at their level and using sensory items to engage with them, which the resident appeared to enjoy.

The inspectors met with one resident who had a sitting room that they could access through a room from their bedroom. The resident's bedroom and sitting room were decorated in line with their sporting interests. They were sitting beside a window and watching television and appeared happy in their environment.

During the inspection, all staff interactions with residents were found to be supportive and positive in nature. However, one inspector did observe a staff member physically redirecting a resident into a seating position. While the staff member intended to assist the resident, they did not provide sufficient time or communication for the resident to complete the movement themselves.

According to the centre's statement of purpose, residents living in the centre required a high level of support due to the nature of their disability. Although the inspectors found that the service did fit this description overall, they had concerns about how new admissions were being admitted to the centre, considering the statement of purpose. The statement of purpose is an important governance document that sets out information about the centre, including the types of service and facilities provided and the resident profile and is aligned with the centre's registration. For instance, compared to the statement of purpose submitted in 2021 for registration renewal, the inspectors noted that the 2024 document included dementia under the profile of residents for which the centre could cater. However, on the day of the inspection, the inspectors identified that no additional support had been implemented in the centre to support residents with dementia. On review of admissions to the centre, one resident with dementia had been admitted in June 2023; however, staff had not received any dementia training, and no environmental changes had been made to indicate that the centre was a dementia-friendly environment.

The inspectors found no documentary evidence that admission practices took into account residents living in the centre. There was no evidence that residents were consulted with and informed of new admissions. The inspectors were not presented with evidence that those responsible for the management of the centre were involved in the decision-making process for referrals to the centre. Therefore, the inspectors were not satisfied that the centre had an effective admission system in place to raise concerns about the compatibility of residents, suitability of the centre, flag regulatory findings and promote the rights of the current residents.

This inspection concluded that the provider was failing to effectively address the underlying issues of institutional practices and adhere to previous commitments regarding the centre's decongregation. As a result, some residents were experiencing poor quality service. The inspection revealed that residents' rights, safety and well-being were negatively affected due to living in a congregated setting and staff-driven policies and procedures instead of being based on residents' preferences.

In response to concerning findings, the inspectors issued an urgent action to the provider in relation to risk management. This required the provider to review the use of bedrails in the centre and provide assurances to the Chief Inspector within seven days. The provider had not ensured that staff responsible for the prescription, provision, installation, and maintenance of bedrails were appropriately trained in the competent use of these devices. Furthermore, the provider had no guidance or policy on bed rail management to guide staff in conducting proper risk assessments and understanding the potential risks associated with this equipment.

The inspectors also observed that the fire safety systems required enhancement, which is discussed further in the report. The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection found that institutionalised practices, lack of provider oversight of restrictive practices, and inappropriate admissions processes that did not consider previous regulatory enforcement action were affecting the provider's ability to offer a quality service to all residents. This inspection was planned as a one-day inspection, but due to the level of concerns presented on the day, the inspectors returned the following day to finish the inspection.

The inspectors found both the person in charge and PPIM competent to hold their roles and cognisant of the issues identified during the inspection. The centre had undergone several changes in governance during the previous year. The PPIM began their role in September 2023 after joining the campus in June 2023 as a CNM3, while the person in charge had only started their role the month before the inspection. Both had extensive experience working within the disability sector and demonstrated that they voiced concerns regarding the quality of care being provided in the centre. The CNM3 was able to evidence these concerns through meetings with staff and trade unions and enacting the Trust in Care process. (A process for upholding the dignity and welfare of residents). An assistant director of nursing (ADON) was also appointed in late 2023, and there was evidence of meetings between the PPIM, ADON and regional director regarding concerns in the centre.

The governance structure of the centre, campus, and wider region also included a programme manager who reported directly to the regional director. This role was found to be vacant for prolonged periods in 2023 and 2022, resulting in a provider-owned red risk-rated assessment of the risk of poor service provision to 90 residents within Kildare residential services due to having no programme manager in place.

In the opening meeting with the person in charge and PPIM, they were transparent and aware of the issues in the centre and brought these to the inspectors' attention. The PPIM, upon commencing their role, requested the support of senior managers external to the region in conducting baseline audits of the centre due to the number of outstanding actions arising from audits, inspection reports and their own observations of practices. The inspectors were assured by local management that they were motivated and were striving to implement person-centred practices during their short time working in the centre.

The inspectors were informed that the quality and safety team, responsible for conducting legally mandated visits to the centre on behalf of the provider, expressed significant concerns regarding the level of non-compliance found during the latest visit in March 2024. Due to the severity of the concerns, the team followed their own escalation pathway to the provider. The reason for the escalation was the institutionalised nature of the observed practices and the aggregate effect of all regulatory non-compliance identified during the visit. As a result, the provider was made aware of ongoing regulatory non-compliance, and some actions had been implemented, such as engaging with the workforce and unions, but these were still

in their infancy at the time of the inspection.

Historically, inspections carried out in this centre had revealed poor compliance with the regulations, which resulted in adverse outcomes for residents. However, there was a noticeable improvement in compliance when the centre underwent decongregation in 2018. Originally, the centre accommodated 22 residents, but this number was reduced to 13 as part of the provider's representation to the Chief Inspector in response to the proposal to refuse the centre's registration. This decision to refuse registration was made following a series of inspections where significant concerns regarding the safety and wellbeing of residents were found. The representation received in 2016 outlined the decongregation plans for all residents living in the centre. Based on this representation, registration was granted in 2018 for a period of three years for a maximum of 13 residents (the number of residents remaining in the centre at that time).

However, due to funding issues, changes in needs, and improvements made in the centre, the further decongregation process after registration slowed down. As a result, ten residents remained at the time when the provider applied to renew registration in 2021 for a further three-year period. The provider reapplied for a maximum of 13 residents and was asked to provide further information and progress on their decongregation plans, as well as resident numbers. In response, the provider provided additional details regarding the need for the additional resident numbers. They explained that these numbers were required to manage the complex support needs of residents who were living in the community.

Upon subsequent inspections, it was discovered that the number of residents in the centre had not exceeded ten. However, during the current inspection, 12 residents were found to be residing in the centre. Due to the increase in residents and the provider reapplying for 13 residents and therefore not demonstrating progress to previously submitted compliance plans, the inspectors requested an update on the status of admissions into the centre.

Previous inspections had raised concerns that residents were not appropriately placed in the centre, resulting in regulatory action. On the first day of the inspection, the inspectors requested the admission documentation for two new resident admissions in the centre as these were not contained within the residents' files. They also requested an update on the status of new admissions to the centre, considering the centre's history, previous commitment by the provider to fully transition residents living in the centre to houses in the community, and national policy on decongregation settings.

A member of the provider's admission, discharge, and transition team met with the inspectors on the first day to discuss recent admissions to the centre. They confirmed that the centre was open to new admissions. When asked about the rationale and decision-making process for admitting residents into a congregated setting, they referenced an Ombudsman report regarding the appropriateness of placing people under 65 in nursing homes for older people. When further asked about the support requirements for recent admissions, the inspectors were not satisfied that these met the criteria for 'high support' as laid out in the centre's

statement of purpose. When asked for admissions meeting minutes and documentation relating to each resident, the staff member confirmed they maintained these records, and these were not available to staff in the centre or, more importantly, the person in charge who had the regulatory responsibility for ensuring the centre was suitable for meeting the needs of any potential resident. This was a repeated failure to adhere to the requirements of the regulations as identified by the inspector during an inspection in February 2023 within another designated centre operated by the provider.

The inspectors were informed these records would be made available on the second day of inspection due to the level of redaction involved as the records maintained contained several service users' information. These records were not presented at the time of the close-out meeting on day two.

In response to the previously mentioned urgent action issued, the provider committed to a multidisciplinary review of the use of bedrails, the sourcing of suitable bed bumpers from a reputable equipment provider, and referring all restrictive practices to the Restrictive Practices Committee and the Human Rights Committee. While this was an appropriate action taken by the provider, the action was taken in response to a directive from the regulator.

This, in turn, raised concerns about the provider's capacity and capability to effectively manage the quality and safety of care provided in this centre. Concerns regarding the practices of bedrails had been raised previously by the local management team. These practices did not comply with national guidelines or best practices and were not observed in community-based designated centres operated by the provider. The inspectors raised concerns regarding the lack of oversight of the restrictive practices on the first day of the inspection. An email response from a committee member on the first day of the inspection was considered inadequate, prompting the urgent action.

Trade unions representing different grades of campus staff were involved in various work practice negotiations. The inspectors were informed that changes to work practices that could positively impact residents had to be agreed upon by the relevant trade union. This was even the case for practices common in other areas of the provider's service and within the disability services industry in general. In July 2023, the Chief Inspector received unsolicited information about this centre. The information referred to residents being unable to go on outings unless with an attending staff nurse, which negatively impacted their preferred activities and general welfare. The provider was issued with a Provider Assurance Report (PAR) to respond to these allegations and give their assurances that residents could participate in activities of their choosing without restriction due to the skill mix of staff. The provider identified that there was a need for non-nursing staff to complete medicines training as per the organisational policy. The provider confirmed that nine staff had attended rescue medicine training, and social care staff had been scheduled to attend full medicine training by August 2023. However, issues regarding this concern were still present during this inspection, as discussed in the next section of the report.

The inspectors requested to review team meetings from 2023 and 2024 in the centre. These meetings allowed staff to raise any concerns about the quality of care in the centre, be kept up to date on service developments, demonstrate shared learning, and review residents. The inspectors were only presented with the minutes of one team meeting from 2023 held in September with nursing staff only, and it concerned a resident who lived in a different part of the campus.

There was an improved frequency of meetings held in 2024, and inspectors reviewed the minutes of five meetings. Two of those meetings were held for staff nurses only. Overall, the inspectors noted poor attendance at these meetings. The centre had a whole-time equivalent (WTE) of 30 plus staff working in the centre; however, only six to eight staff attended any one meeting. It was not documented that staff read or signed the minutes of such meetings.

Due to ongoing concerns in the centre, the agenda for meetings was very staff-based and focused on human resources issues, expectations of roles, annual leave, breaks, training, and rosters. While these were important and necessary topics, the inspectors only found evidence of one resident being discussed in detail. Updates on residents' progress, goals, meaningful days, and needs were not included in team meetings. This was a missed opportunity for staff to discuss important developments and events for residents. This was evidenced by the quality and safety team's findings. One staff member outlined to them that they had supported a resident in joining a tidy town's community group the previous year, but this resident was not supported in continuing to engage with the community group when the staff member went on leave.

Team meetings also evidenced the efforts that the PPIM and person in charge were making to tackle institutional practices in the centre. Concerns about cancelled activities due to some staff's hesitancy about driving the centre vehicles were discussed and actioned.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and with professional experience of working and managing services for people with disabilities. They were found to be aware of their legal remit with regard to the regulations.

They were very responsive to the regulatory process and, having only worked in the centre for one month, had a good understanding of the residents' needs.

Judgment: Compliant

Regulation 23: Governance and management

During this announced inspection, the inspectors found that the local management team of the centre was striving to improve outcomes for residents. However the inspectors found an absence of provider-level-led strategy, quality improvement, and responsive action taken to address regulatory findings. For example, this inspection identified many areas that were previously actioned within this centre or other centres within the region and had not been addressed, shared, or actioned appropriately.

The inspectors discovered that the provider failed to ensure that the residents received high-quality and safe care. This was partly due to the combined impact of failing to address long-standing industrial relations issues within the centre and the wider campus, and the practice of admitting residents into a congregated setting with no transparent process.

The inspectors, having concerns about the practice of prescribing, maintaining, and overseeing bedrails in the centre, issued an urgent action plan to the provider to address these concerns. This action was taken following questions asked during the inspection as to the rationale for the exclusion of these practices from the Restrictive Practice Committee. The inspectors were concerned regarding the response received from the committee, saying that they only review restrictive practices in place due to behavioural needs or where there is a risk of serious harm. The inspectors identified a number of safety concerns in relation to the bed rails that posed entanglement and entrapment risks.

Furthermore, the response received did not assure the inspectors that the committee was being guided by best practices or had correctly interpreted the most up-to-date guidance. For example, the email referred to an obsolete Health Information and Quality Authority guidance document from 2016 on restrictive practices, which was no longer published as 2023 guidance had superseded this document. The inspector first brought this risk and gap in service provision to the attention of the provider in December 2023 during a thematic inspection of restrictive practices in another designated centre. However, the provider did not use this feedback or inspection report to reflect or improve practices across their services.

The inspectors were also concerned about the interpretation of the use of restraints and enablers to explain the reasons for exclusion from the committee. The inspectors viewed a draft restrictive practice policy that was two years overdue and awaiting board approval. The provider was required to ensure that the policy was reviewed in line with the findings of this inspection.

The provider had not ensured that the workforce was organised and managed to ensure that staff have the required skills, experience, competencies and confidence to meet the assessed needs of residents and to respond in a timely way to residents' changing needs. This was demonstrated by restrictions on non-nursing staff in administering medicines compared to their counterpart colleagues working in community-based designated centres operated by the provider.

This inspection concluded that the provider was not demonstrating that they had the capacity or capabilities necessary to offer a quality service to all residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

During the inspection, inspectors were unable to find evidence that recent admissions to the designated centre were carried out in accordance with the organisation's admission policy. Inspectors also found evidence that some residents admitted within the past two years had not had their needs assessed by senior management members, allied health professionals, and the multidisciplinary team or had a consultation with the person in charge before being admitted to the designated centre.

Although a member of the 'Application for Supports Committee informed inspectors that such meetings had taken place, minutes of transition meetings were not available to the inspectors during the two-day inspection. Despite the inspectors' request to review the documentation in advance and during the inspection, they were unable to identify the rationale for each resident's move to the centre or if their assessed needs at the time of admission were in line with the designated centre's statement of purpose.

Furthermore, inspectors found that only one recent admission had a transition plan that documented the resident's journey to the designated centre. However, the transition plan was not used to report the resident's transition adequately and was only used to monitor residents' daily progress notes. For example, notes referred to personal care.

An admission that arose from the internal transfer of a resident was not managed or organised by this committee and it was unclear what system was in place to oversee these admissions.

Judgment: Not compliant

Regulation 3: Statement of purpose

Although the provider had prepared a statement of purpose in line with regulations, it was discovered that the centre was not functioning in accordance with all the stated criteria. For example, the statement of purpose stated it was the policy of St John of God Kildare Services that the admission process is efficient and effective in identifying the appropriateness of referrals to the service and that it is in keeping with the stated model of service and the service's mission.

Several objectives and aims mentioned in the document that described the centre's purpose and function were not apparent during the inspection or were contradicted by evidence.

These included the following:

- A person-centred approach to service delivery that ensures that each individual is directing, guiding and included in all decisions and actions in relation to him/herself
- To support the individual in seeking housing or accommodation best suited to their needs.
- Provide appropriate support to individuals based on choice and needs.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors found that some restrictive practices that were in use in the designated centre were not being reported to the office of the Chief Inspector. For example, inspectors identified that a number of residents required a physical hold by staff in order to complete necessary blood tests. This hold for phlebotomy was not returned in the designated centre's quarterly notifications when implemented.

Judgment: Not compliant

Quality and safety

The inspectors found that the quality and safety of the service provided in the centre to residents were significantly compromised due to limitations of the workplace to undertake tasks that allowed residents to access their community without unnecessary limitations. This was in part due to the impact of long-standing industrial relations issues within the centre and the wider campus. For example, within the provider's community settings, it was common practice over the previous decade for non-nursing staff to receive training to support residents in taking their medicines and also administer rescue medicines in the event of a seizure. This practice facilitated and supported residents' access to activities in the community in the absence of nursing staff.

During the inspection, documentary evidence and notifications submitted on the use of restraints within the centre were reviewed. It was stated that nursing staff were responsible for prescribing such restraints. However, when the nursing staff were questioned, they said they did not have responsibility for such assessments and instead stated that they only made recommendations for review by the occupational

therapist and multi-disciplinary team (MDT). Inspectors found no documentary evidence of review by occupational therapy or MDT on the use of bed rails by six residents in the centre. In addition, the inspectors were informed via email that the restrictive committee were not responsible for the oversight of such restraints.

On reviewing risk assessments and documentation of incidents in the centre, the inspectors found that these were not recorded to a suitable standard. For example, for one incident of a resident found with their limbs over or within their bedrails, it was a one-line entry on the incident recording sheet. Both the person in charge and PPIM were aware of the poor standard of documentation for incidents in the centre. They expressed difficulties at times in retrieving information regarding incidents. In response to reviewing incidents in the centre, the PPIM submitted a number of notifications to the Chief Inspector since commencing in the post regarding allegations of staff neglect or derogation of duties.

Inspectors found that the arrangements in place for the management of linen and laundry and clinical and hazardous waste were not adequately monitored and could lead to the risk of infection in the designated centre. This was a similar finding to an infection, protection, and control (IPC) inspection in the centre from January 2022, where the arrangements for external collection of incontinence bins were found to be unsatisfactory. As a result of that inspection, the provider was issued with an urgent action plan to carry out a deep clean of the centre.

It was found that the registered provider had not made sufficient arrangements for the management of residents' linen. The inspectors requested a walkthrough of the system. Despite the installation of washing machines in the centre since the previous inspection, residents' laundry was still being taken off-site for cleaning. Laundry was placed in wash bags, which were then transferred to large laundry bins located outside the four exit points in the designated centre prior to being collected for laundry service. These bins were found not fit for purpose.

Regulation 26: Risk management procedures

The inspectors had significant concerns regarding the prescription, assessment and oversight of restrictive practices in the centre, namely bed rails and bed bumpers. The risk for entrapment, entanglement, and appropriate and correct usage had not been competently assessed, responded to or subject to the oversight mechanisms of the restrictive practice committee.

As a result of the discrepancy in roles and responsibilities, the inspectors found poor practice in relation to use of these restraints. The provider had not ensured that the individuals responsible for the prescription, assessment and review of bed rails were appropriately trained in the competent use of these devices.

Examples:

- The bedrails were in poor condition with no service records available, and

there is movement observed in the bedrails away from the mattress and bed edges posing an entrapment risk
- The risk assessments conducted failed to consider the compatibility of bed rails, bed bumpers, mattresses, and the residents' needs. Additionally, they did not explore less restrictive or alternative options.
- Where alternative options were recommended for one resident, such as low-low bed, crash mats and wedges, these had not been implemented for the individual.
- The measuring of entrapment zones on the bed and bedrails was not carried out to ensure minimum and maximum distances to reduce or identify the risk of entrapment.
- Some bed bumper systems in place consisted of duvets placed over bedrails, along with cushions. However, the risk of suffocation using non-air-permeating material had not been considered. Furthermore, the bed bumpers were in poor condition, ripped and frayed.

The provider was given an urgent compliance plan, which required them to take action on the bedrails to minimise the risk to residents. The provider had seven days to respond to their compliance plan, which was received and found to be satisfactory. In addition to the urgent findings under this regulation, additional evidence was also found.

Inspectors identified a number of poor practices in relation to risk management during the course of the two-day inspection. For example, an inspector observed medicines being crushed for one resident. Upon inquiry, the staff member explained that medicines required to be crushed were placed in small bags designed for this purpose, which were then placed in the crusher. The inspector noticed medicine residue around the point of crushing and was informed that sometimes the bag can burst, causing medicines to spill out. The inspector asked if this medicine was then discarded and documented. The inspector was informed that records were not kept to demonstrate this practice. When the inspector brought to the attention of the staff that the crusher had residue present during the medicine round, the staff member who was completing the medicine round cleaned the residue appropriately before completing the medicine round.

On observing the breakfast time meal, the inspector observed two residents sitting alone around a table in a dining room while their breakfast was being prepared in the kitchen. Two tubs of prescribed thickening powder, used to treat residents with dysphagia (swallowing difficulties), were present on the table. Notwithstanding the requirement for prescribed medicinal products to be securely stored at all times, this product was subject to a safety alert due to the risk of harm and asphyxiation by accidental ingestion when not correctly stored out of reach.

The inspector brought this risk to the attention of a staff member who entered the room. When alerted, the staff member went to remove the products immediately. When asked if they were aware of the safety alert related to the product, the staff member replied that they were, adding that it was usually kept in a cupboard in the kitchen, out of reach of residents. However, the inspector noticed that the cupboard

was unlocked and, therefore, was not assured that no one could access it.

Judgment: Not compliant

Regulation 27: Protection against infection

Inspectors reviewed the external laundry bins and found them to contain rainwater, leaves, old items of dirty clothing, black dirt particles that emitted a foul smell. Residents' laundry bags were then placed in the laundry bins on top of the aforementioned waste. Inspectors found that each of the laundry bins were found with the same level of poor hygiene. Inspectors also found breaks in the bottom of one of the laundry bins, and the cover, which kept residents' laundry bags protected while awaiting collection, was ripped away from the corners of two of the laundry bins. The person in charge and the PPIM contacted the provider's maintenance team and had new bins provided by the end of the inspection.

Incontinence bins were in place at four exit points from the designated centre and were found to be in poor condition and overflowing; several had broken foot-operated mechanisms and were dirty from the ground. The inspectors found that bins were placed outside in unsheltered areas that contained mud and leaves, which was also an observation and action on the IPC inspection. When emptied, the bins would reenter the centre and be placed in the bathrooms. During the walk-around with inspectors, the PPIM requested the removal of a number of bins from the centre to maintenance on-site on campus. Bins were due to be emptied three times a week and should have been collected the day before inspection; however, due to the number of full bins, the inspectors were not assured this had been completed. Inspectors found that a number of bins were not in working order, for example the foot pedals were broken and not in use or when stood down on they did not open, this meant that staff would have to lift the lid of the bin in order to place contents of waste into the bin. Inspectors were informed that the provider was in the process of attempting to change bin providers due to concerns previously identified.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had established a schedule of fire safety works to be carried out in the designated centre, which were necessary to comply with the regulations. The provider had completed a significant amount of fire safety works in the centre, including installing fire doors and self-closing mechanisms; however, further works were required. The inspectors noted these were all highlighted in the pending upgrade work schedule.

During the inspection, it was observed that there were adequate escape routes in case of a fire, and they were kept clear. The management team were conducting fire drills regularly, and after-action reviews were completed when concerns were raised regarding the safe evacuation of residents. The designated centre was compartmentalised to contain the fire to specific zones in the house. However, the inspectors noted that the fire doors meant to provide compartmentalisation had large gaps in the centre line and a large keyhole, which compromised their effectiveness. The provider had already identified the issue and included the replacement of these doors in the schedule of works.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Inspectors found that a number of residents in the designated centre had positive behaviour support plans in place. However, on review of these plans, inspectors found a number of inconsistencies in the support plans, with key elements missing from the support plan required to guide staff practice and implementation. For instance, four residents' positive behaviour support plans required staff to implement reactive strategies to support a resident during identified behaviours of concern. However, these reactive plans were not available for review in the resident's support plan to guide staff practice and could not be made available to inspectors during the course of the two-day inspection.

The inspectors also identified a behaviour support plan in place for one resident, which detailed a resident's required support plan for day service but had not taken into consideration their recent admission to the centre. Inspectors were informed by the PPIM and the person in charge that the positive behaviour support plan had been discontinued. However, inspectors noted that the positive behaviour support plan was still in place in the centre as part of the resident's assessed needs and could find no evidence of review or discontinuation. Inspectors also found that one positive behaviour support plan in place as part of the resident's assessed need was missing several pages and guidance to support residents during identified behaviours of concern.

Inspectors found restrictive practices in place that the provider had not identified as restrictions that required review by the provider's restrictive practice committee. The inspectors found that some restrictive practices had not been reviewed appropriately to ensure that residents' safety was maintained at all times. For example, inspectors had been informed that residents who require the use of bed rails in order to maintain safety had been assessed and reviewed by members of the centre's nursing team. However, upon review of documentation in relation to the use of bed rails, inspectors found that bed rail assessments were incomplete and were not reviewed regularly. Where it was documented that a review by a member of a multidisciplinary team was required, this had not been implemented.

Furthermore, inspectors found that one resident was identified as not requiring the use of bed rails in 2022 and continued to have bed rails and side bumpers in place. Inspectors spoke to members of the nursing team about the prescribing of bed rails and the process involved. Inspectors were informed that nurses did not prescribe bed rails or make the assessment for bed rails. Inspectors were informed that the nursing team would identify safety concerns and would refer residents' assessed need for bed rails to the multidisciplinary team, including physiotherapy and occupational therapy. Inspectors could find no evidence of a review of bedrails by the multidisciplinary team and the nursing team in the designated centre. No evidence of meetings could be provided to inspectors during the course of the two-day inspection of the designated centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Significant improvements were required to ensure that residents received a quality service that was person-centred and respectful of individual residents' rights. The provider had not ensured that the centre was operated in a manner that ensured residents had freedom to exercise choice and control in their daily lives and participated in and consented to decisions about their care and support.

Inspectors also observed that a number of residents living in the designated centre were being subjected to hourly night-time checks. Inspectors could not be shown documentation supporting the requirement for hourly night-time checks of residents, nor could the inspectors find documentation supporting a medical reason for night-time checks for residents. Staff spoken to during the course of the inspection informed inspectors that hourly checks were completed on residents due to bed rails being in place on residents' beds. On reviewing the hourly night-time check documentation, inspectors found that it provided no further detail than the hour staff ticked and a final signature on completion of the staff members' duty.

Inspectors found that activities for residents were led by routine and resources of the centre rather than the residents and their support needs and wishes. For example, inspectors identified periods when residents would have to return to the centre when out on social activities for medicine to be administered. The inspectors acknowledged that the provider was working through industrial relations in order to provide the safe administration of medicine courses to all staff in the designated centre, as this was impacting the lived experience of residents in the centre. The inspectors were informed that the week before the announced inspection was the first week that trained non-nursing staff were able to take rescue medicine from the centre so residents could go on a social outing. While this was a positive development, residents living in this centre compared to residents living in a community-based designated centre in the same location operating under the same provider were found to be disadvantaged and subject to rights restrictions due to

the influence of staffing unions.
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 14: Persons in charge	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for DC5 OSV-0003642

Inspection ID: MON-0034774

Date of inspection: 11/04/2024 and 12/04/2024

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Registered Provider is completing a programme of education and staff support in this Designated Centre to ensure person centred practices are in place. • All required actions resulting from HIQA inspections and regulation 23 unannounced visits shall be addressed and where actions cannot be resolved locally, they shall be escalated in line with the SJOGCS Quality and Safety Governance processes. • The registered provider will ensure all actions identified during this inspection are addressed within the submitted dates. • All managers within Kildare residential will be in attendance. The information from this forum will then be presented at the monthly Regional Quality & Safety Meeting, with part of the existing agenda assigned to discuss previous recent HIQA and internal PQSD quality inspections. • All relevant departments have been reminded to escalate any shared learning to this monthly forum. Furthermore, HIQA inspection outcomes will be added to the monthly supervisor's forum agenda as applicable. • Kildare Residential Services will develop an overarching QEP for the residential services to ensure all actions are addressed within a timely manner. Each designated center's QEP will be robustly reviewed at the monthly coordinator's meeting with the Programme Manager. Commenced 28.03.2024 Monthly meetings will be held with all Kildare residential managers (PICS & Coordinators) to share learning and experiences and enhance the quality of service provided. These meetings commenced on 22.04.2024 and will run monthly going forward. Commenced: 22.04.2024 • Admission, Discharge and Transfer Committee (ADT) meetings take place monthly within the region. Notes of these meetings are issued to each Programme Manager. Each Programme Manager will ensure that as part of their monthly meetings with both coordinator and local residential managers that the relevant discussions and proposed plans relating to ADT are discussed in detail at those appropriate meetings. All minutes	

will be available for the regulator to review.
Commenced: 15.05.2024
• The Registered Provider is ensuring the required skills mix, training, and staff competence to meet the assessed needs of residents is in place, and safe administration of medication training by all grades of staff has commenced across Kildare residential campus-based services in order to reduce the restrictive practices in relation to administration of medication.
To be completed 20.09.2024
• For governance and management regarding the use of Bed rails, please see Regulation 26 for actions.
Due for completion: 20.09.2024
• A compatibility assessment will be completed by Residential Programme Managers and co-ordinators as required.
With immediate effect.
• The Regional Director will ensure that the respective Chairs of the Regional Restrictive Committees are guided by the most up-to-date HIQA guidance on restrictive practice.
Completed 16.05.2024
• The Registered Provider has ensured that the SJOGCS Restriction Free Practice Policy has included all up-to-date HIQA Guidance information on promoting a care environment that is free from restrictive practice. To be completed 31 June 2024
• The Registered Provider will ensure all staff are fully inducted into the revised Restriction Free Practice Policy. This will be done through staff meetings in the DC's and discussion at supervisor's form – To be completed 31 July 2024
• The Registered Provider will ensure that staff receive the appropriate training to support residents with their changing needs. On-going as required.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• A review of the compatibility assessment template will be completed by Residential Programme Managers and co-ordinators as required. With immediate effect.
To be completed by 27.05.2024
• SJOG Liffey Services will ensure full implementation of the SJOGCS Supports Policy for Individuals with an Intellectual Disability (Admission/ Entry/Transition/ Transfer/Discharge/Exit)
• Each Programme Manager will ensure that arising from their monthly Admission, Discharge and Transfer Committee (ADT) meetings which takes place on a monthly basis within the region, follow on meetings will take place with both coordinator and local residential managers to discuss proposed plans relating to ADT are discussed in detail at those appropriate meetings. Notes of these meetings are issued to each Programme Manager. All minutes will be available for the regulator to review.
Commenced: 15.05.2024

• An ADT compliance checklist against the organisation's policy will form part of the transition plan for residential placement within the region. To be completed by 24.05.2024.

Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose and Residents Guide are currently being reviewed by the Residential Programme Manager and Co-ordinators within Kildare Residential Services to ensure that all information contained within accurately reflects the services and supports provided. To be completed 24.05.2024	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The person in charge shall ensure all restrictive practices within the designated centre are notified to the regulator in line national guidance. Due for completion: 31.08.2024	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The registered provider confirms that all current bed rails and sleep systems have been risk assessed for entrapment and entanglement. These risk assessments are currently being reviewed to ensure all risks identified at inspection are addressed. Completed.• Senior nursing staff, occupational therapists, and physiotherapists working collaboratively together and the residents themselves, where they choose to participate, will complete a full review of sleep system requirements in the DC. All systems in place will be checked to ensure they are not in poor condition, ripped, or frayed. Identified equipment will be	

considered to ensure it is the least restrictive practice while addressing any identified risks. This will be completed by 6th May 2024. Completed.• If a sleep systems are required, they will be sourced and purchased from a suitable, reputable equipment provider. A servicing schedule will be devised with the equipment provider, and a copy of service records will kept in the DC, available for review, with immediate effect. • All restrictive practices will be identified, tracked, notified and reviewed at scheduled intervals. The documentation will include the restrictive practice the resident's will and preference, a reduction plan, MDT input, the rationale for use of the restriction, and evidence of the consultation process with the resident and their circle of support. This will be reviewed annually at a minimum. This will commence in line with the review of beds in the designated centre as mentioned above. Date?• All restrictions identified through the above-mentioned review will be referred to the Restrictive Practices Committee and the Human Rights Committee. date?• All staff members will receive additional training on human rights, using restrictive practices, and identifying and reducing restrictive practices. This will also be a standing item on the agenda of monthly staff meetings to ensure continuous attention from all staff. It will commence at the next monthly staff meeting in DC.

All staff will be re-inducted at staff meetings on the need to maintain medication safety at all times and the risks associated with this.
Due for completion: 31.05.2024
The Person in charge shall implement a cleaning schedule for the use of the silent night medications crusher. This will include the cleaning of the crusher tool after every use. Review of medication guidelines will inform to only crush one medication at a time.
Due for completion: 17.05.2024- completed
The person in charge shall ensure that all thickening agents are stored correctly and safely.
Due for completion: 13.04.2024 - completed

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Person in charge has completed a review of waste management. A trial of the removal of incontinence bins has been completed and all incontinence bins at this designated centre have been removed.
Due to be completed: 17.05.2024 - completed
The person in charge will review the laundry process to ensure the safe and required compliance levels are in place to protect residents' personal clothing. This review will include the practice of managing residents' clothing in relation to laundry.
Due to be completed: 30.05.2024
All bins in use in this DC are foot pedal-operated bins and are in working order.
Completed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider has identified the fire related non compliances noted on the day of the inspection and a business case has been issued to the Service Funder for works to be completed. Awaiting approval of same.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Person in charge has arranged for full MDT reviews relating to all positive behaviour support plans. All updates following the reviews will be reflected in the behaviour support plans and made available. All required documents will be completed and available to guide staff practice.
Date for completion: 28.06.2024
The Person In Charge will ensure all out of date Positive Behaviour Support Plans will be removed from circulation.
Date for completion: 28.06.2024

For actions required relating to restrictive practices, please refer to reg. 26.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The person in charge has reviewed the requirement for hourly checks at night to ensure there is a clear rationale and detailed recording system for the same.
Date for completion: 01.05.2024 – completed.
Safe medication administration training for all grades of staff has commenced across Kildare residential campus-based services to reduce restrictive practice in relation to medication administration, this will support the provision of social and community inclusion.

To be completed 20.09.2024
The Provider will ensure residents exercise choice and control in their daily lives and ensure consultation in respect of areas of their lives.
Immediate effect.

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	20/09/2024
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	20/09/2024
Regulation	The registered	Not Compliant	Orange	20/09/2024

23(3)(b)	provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	24/05/2024
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	19/04/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures	Not Compliant	Orange	30/05/2024

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	29/11/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/11/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	24/05/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or	Not Compliant	Orange	31/08/2024

	environmental restraint was used.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	28/06/2024
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.	Not Compliant	Orange	28/07/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	28/07/2024
Regulation 09(2)(a)	The registered provider shall	Not Compliant	Orange	20/09/2024

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.			
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.	Not Compliant	Orange	20/09/2024
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	20/09/2024