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:	No 4 Stonecrop
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	21 June 2023
Centre ID:	OSV-0005127
Fieldwork ID:	MON-0039572

About the designated centre

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

The designated centre provides residential supports for a maximum of eight male residents, aged over 18 years. The facility, laid out in four courtyard cottages, can support persons with intellectual disability including those with autism. The individuals may have multiple/complex support needs. Some residents may present with behaviours that challenge. The supports provided focus on understanding and meeting the individual needs of each person living here, by creating as homely an environment as possible. Individuals are encouraged to participate in household, social and leisure activities and to reach their fullest potential in these areas of their lives. Each person living in the designated centre requires some support in activities of daily living in terms of their personal care, housekeeping, food preparation, managing finances and participating and accessing local community facilities and events. Residents are supported 24/7 by social care staff and care assistants, with nursing support provided by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 21 June 2023	08:30hrs to 16:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

No. 4 Stonecrop is a residential centre located on the outskirts of a large town. It provides full-time support to seven residents. On arrival to the centre residents were being supported to start their day. From speaking with a number of staff it was unclear who the senior staff on duty was and whom staff would report to should a concern arise as the person in charge was not on duty. The inspector contacted the person participation in management to ascertain who could support the inspection. The person in charge arrived the centre a short time later.

The inspector observed a number of residents complete their daily routine. Residents being consulted in what time they wished to attend their day service and what they would like for breakfast. Residents in two houses were observed being supported to complete their laundry and other household chores. Interactions between staff and residents were observed to be respectful and jovial in nature.

One resident spoke with the inspector and staff about the activity of buying a "dinky" car at the weekend. The resident was supported by staff in this conversation with the use of a visual prompt and was assured by this. The resident smiled at staff and went about their daily routine. Staff spoken with were keenly aware of the support needs of residents. They discussed how a review of staffing levels in the centre had improved the quality of life of residents and had resulted in the decrease in the use of some night medicines.

In the afternoon, residents were observed returning to their houses. Staff spoke with residents about how their day was and what activities they had participated in. Residents spoke happily of their day and their plans for the evening. They greeted staff on their commencement of their work. One resident was supported to make their cup of tea and have a snack, with staff observed to promote the resident's skills.

The centre presented as a warm and homely environment. Some areas of the centre did display a large amount of information some of which was no longer relevant for example, out of date guidance relating to COVID-19. Also, two hand sanitiser units in a house were not working effectively and required review. At the time of the inspection, the provider was renovating an area linked to the centre to provide one resident with additional living space. An application to vary the centre's conditions of registration was to be submitted when this work was completed.

Since the previous inspection consultation with residents with respect to the operations of the centre had improved. This included discussion in resident meetings, keyworker meetings and one-to-one meetings. Evidence of this was within resident's personal plans.

In summary, this inspection did evidence measures being introduced by the provider since the previous inspection to drive service improvement and ensure the service

provided to residents was safe and effective. The next two sections of the report present the finding of the inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection was completed to monitor adherence to the compliance plan response submitted by the provider following an inspection by the Chief Inspector of Social Services in November 2022. It was evidenced on the day of the current inspection that improvements had occurred in such areas as consultation with residents and premises.

A suitably qualified and experienced person in charge oversaw the day-to-day operations of the centre. This individual possessed an awareness of the supports needs of the residents and of regulatory responsibilities of a person in charge. This included in areas such as appropriate staff supervision and notification of incidents. The person in charge did provide direct support to residents on a regular basis resulting in 0.4 whole-time equivalent (WTE) allocated to governance. The person in charge reported directly to the person participating in management, through regular phone contact.

The registered provider had appointed a governance structure to the centre, however, on the morning of the inspection as the person in charge was not present, staff were not aware of the senior person on duty. On the staff roster some days did reflect who was senior but this was not consistent. Also, staff were not aware of the on-call guidance available.

The provider had ensure the completion of the regulatory required monitoring systems including an unannounced visit to the centre in January 2023. This report incorporated consultation with 3 residents currently residing in the centre. A report was generated following the visit which included a review of the compliance plan submitted to HIQA and the outstanding actions from this. A review of incidents, complaints and restrictive practices were completed, but did not identify all practices within the centre which were restrictive in nature. A comprehensive action was in place to monitor areas requiring attention including the review of individuals' goals and ensuring all audits were competed within the allocated time line. The annual review of service provision was scheduled to be completed in July 2023.

A centre specific audit schedule was in place to monitor the day to day operations of the centre. This included in such areas as infection control and fire safety. However, the person in charge had self-identified that continued improvement was required to ensure all audits were completed within the provider's set time frames. This as stated previously was an action identified in the January 2023 unannounced visit to the centre. Staff members generated a weekly report of significant issues. This was reviewed by the person in charge with any areas of concern escalated to senior

management. Any actions required were noted and tracked by the management team. The person in charge also completed regular review of daily notes and handover books to ensure these were maintained to high standard with information pertaining to residents reported in a dignified and correct manner.

Following the last inspection by the Chief Inspector a full review of staffing arrangements were completed. Additional staff was allocated to the centre to ensure the staffing level and skill mix was appropriate the assessed needs of all residents. Staff reported the positive impact of this to all residents. The person in charge maintained an actual and planned roster to ensure continuity of care. Staff spoken with throughout the inspection were aware the assessed supports needs of residents.

The person in charge ensured staff were appropriately supervised in accordance with the organisational policy. This included formal supervisory meetings. The person in charge completed monthly staff meetings to ensure the staff team were aware of their roles and responsibilities and to raise any issues within the centre. The person in charge also worked alongside staff members. The person in charge had systems in place to ensure staff were supported and facilitated to complete mandatory training. Overall, there was a high compliance evidenced in the training matrix provided and a plan was in place to address any identified gaps.

Following the Chief Inspector's previous inspection the provider had completed a full review of service level agreements in place. These ensured that the service to be provided to residents was now clear and accurate, including the fees to be charged. Residents and their representatives were consulted in the development of these. There were no planned admissions to the centre.

Regulation 14: Persons in charge

The registered provider had ensured the appointment of a suitably qualified and experienced person in charge to the centre. They were employed in a full-time capacity.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the allocation of the appropriate staff numbers and skill mix to the meet the assessed needs of the residents currently residing in the centre. The person in charge maintained an actual and planned roster.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The staff team in the centre had up-to-date training in areas including infection prevention and control, fire safety, safeguarding and manual handling. Where refresher training was due, there was evidence that refresher training had been scheduled.

There was a supervision system in place and all staff engaged in formal supervision. From a review of the supervision schedule and a sample of records, it was evident that formal supervisions were taking place in line with the provider's policy.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The governance systems in place ensured that service delivery was safe and effective through the ongoing audit and monitoring of its performance resulting in a thorough and effective quality assurance system. For example, there was evidence of audits taking place to ensure the service provided was appropriate to the residents' needs. The audits included the annual review 2022 and six-monthly provider visits. These audits identified areas for improvement and developed action plans in response.

Improvements were required to ensure adherence to the centre specific auditing schedule.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had agreed in writing the terms that each resident shall reside in the centre. There were no planned admissions to the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development of the statement of purpose. This document required review to ensure that all information required under Schedule 1 was present and accurate. This included the WTE of staff allocated to the centre

Judgment: Substantially compliant

Quality and safety

No.4 Stonecrop was operated in a manner which respected the rights of the residents. Measures were undertaken to ensure residents were aware of their rights and how to communicate their supports needs to staff. These included regular weekly house meetings to discuss the day-to-day operations of the centre such as meal planning and activities. Topics discussed were now evidenced to be relevant to the time of the meetings and the individuals present. Residents were consulted with respect to their environment and how this at times can be shared with others.

The person in charge had ensured that each resident was supported to develop and maintain an individualised personal plan. These plans incorporated an annual multi-disciplinary assessment of each individual's personal needs. Guidance for staff was laid out in a range of areas such as health, social and emotional supports. This ensured a consistent approach to support and adherence to multidisciplinary guidance. Staff spoken with were aware of the contents of the plan and how to implement the supports as required.

A template was in place to support residents to develop personal goals during an annual person-centred planning meetings. However, these were found not to be individualised in nature with no evidence of progression of these goals in place. A number of goals in place were already part of the residents' daily life and did not allow for progression of interests or development of new skills.

Overall, the provider had implemented effective infection control measures in the centre. Following the November 2022 inspection a deep clean of the centre had been completed. A cleaning schedule was in place which staff evidenced awareness of, the centre specific contingency plan had been updated to reflect the current needs of the centre. However, as part of the centre walk around it was observed that two hand sanitiser unit were not working effectively. This was reviewed by the person in charge on the day of the inspection.

The person in charge had ensured effective measures were in place to support residents at times of challenging behaviour. This included staffing training and awareness. Residents had a behaviour support plan incorporating reactive and

proactive strategies. Improvements were evidenced in the centre with respect to the use of restrictive practices. This include the reduction in the use of some restrictions and the increase in awareness. However, further improvements were required to ensure all restrictions were identified. The organisation policy did require review to ensure guidance in the area was clear. This included the relevant committee restrictions were to be referred to.

The provider had ensured effective processes were in place for the ongoing identification and review of risk within the centre. A risk register had been developed and was regularly reviewed by the person in charge to ensure the current control measures in place ensured the reduction of the impact and likelihood of the risk. Rationale for control measures in place were present and risk ratings were reviewed.

The person in charge had ensured the systems in place in the day-to-day operations of the centre ensured residents were protected from abuse. This incorporated such areas as staff training and awareness.The designated officer had attended a staff meeting to ensure staff members were aware of the correct procedure to adhere to should a concern arise. Any concern relating to the protection of residents was reported and investigated in a timely and efficient manner. The person in charge had also ensured the intimate care needs of residents were set out in their personal plans in a respectful and dignified manner.

Regulation 13: General welfare and development

All residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. Opportunities were consistently provided for residents to participate in a wide range of activities in the centre and the local community.

Resident choice of activities was respected.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk register for the centre and individualised risk assessments for residents. There were control measures to reduce the risk and all risks were routinely reviewed.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had taken adequate measures to protect residents from the risk of infection. The centre was cleaned in line with the providers' guidelines.The provider conducted regular audits of the infection prevention and control practices.

On the day of the inspection two hand sanitizer units were observed not to be working effectively. This was reviewed by the person in charge.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each resident was support to develop and maintain an individualised personal plan. These plans incorporated an annual multi-disciplinary assessment of each individual's personal needs. Guidance for staff was laid in a range of areas such as health, social and emotional supports. This ensured a consistent approach to support and adherence to multidisciplinary guidance.

A template was in place to support residents to develop personal goals during an annual person centred planning meetings. However, these were found not to be individualised in nature with no evidence of progression of these goals in place.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had ensured effective measures were in place to support residents at times of challenging behaviour.

Improvements were required to ensure that all restrictive practices were identified and assessed as such.

Judgment: Substantially compliant

Regulation 8: Protection

Arrangements were in place to ensure residents were safeguarded from abuse. Staff were found to have up-to-date knowledge on how to protect residents. All staff had

received up-to-date training in safeguarding. Systems for the protection of residents were proactive and responsive.
Judgment: Compliant
Regulation 9: Residents' rights
The person in charge had ensured that the centre was operated in a manner which respected the rights of all individuals. Residents were now consulted in the day-to-day operations of the centre through keyworker and house meetings.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No 4 Stonecrop OSV-0005127

Inspection ID: MON-0039572

Date of inspection: 21/06/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that • In conjunction with the PIC, the centre specific auditing schedule will be completed as per schedule and this will be monitored via a standard agenda item for meetings between the PIC and their line manager. Any audits that have not been completed as per schedule to date will be completed (30/09/2023). • The Provider 6 monthly unannounced visit was completed in July2023 and future visits will be carried out in line with regulations. • The annual review of the quality and safety of care and support at the Centre was completed in July 2023 and future annual reviews will include a review and update of the SOP. • The PIC has updated the staffing roster. The roster identifies the senior person on duty on each shift. (8/08/2023). Staff are reminded that they need to check the roster and know the post of responsibility on their shift. • The list of the persons available on-call to the centre will be discussed at staff team meeting in August 2023. The on-call list will be available to staff in the emergency folder and at the Centre's main office. (31/8/2023). • The Person in Charge will ensure that outdated information is archived or destroyed in line with record retention policy.	
Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The provider has updated the Statement of Purpose to accurately reflect the staffing levels of the designated centre. (8/08/2023)
• The Provider will ensure that the SOP will be reviewed and updated as part of the Annual Review of the Centre.
• An application to Vary will be submitted by the provider to reflect the changes to the floor plans along with the updated Statement of Purpose (8/08/2023)

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Person in Charge will ensure that all personal plans are reviewed to ensure that personal goals are individualised to each person and that the goal progression is monitored on a timely and progressive manner. (30/09/2023)

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Provider will ensure that:
• the Organisational policies on Positive Behaviour Support and on the Use of Restrictive Practices, currently under review, are finalised and circulated to the designated centre by 30/09/2023

• The Person in Charge will identify and log all restrictive practices within the designated centre and ensure that that these are referred to the relevant committee for review and sanction in line with the Provider Policies. (30/09/2023) and reported to the Authority.

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)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	08/08/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or	Not Compliant	Orange	30/09/2023

	circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/09/2023
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	30/09/2023

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.	Substantially Compliant	Yellow	30/09/2023