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:	DC15
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	17 June 2022
Centre ID:	OSV-0005316
Fieldwork ID:	MON-0036995

About the designated centre

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

St John of God Kildare Services DC 15 is a registered designated centre that provides residential care and support for up to seven residents with intellectual disabilities. The designated centre comprises of two community based homes located near each other and situated in community based housing estates outside a large town in County Kildare. Each residential unit that makes up the centre is a modern, spacious home providing residents with their own bedrooms. One residential unit is home to two residents that are provided with one-to-one staffing support and supervision. The second residential unit is home to five residents. A number of residents living in the centre transitioned from a congregated setting operated by St. John of God Kildare Services as part of an overall de-congregation plan for the organisation. Residents living in the centre receive a full-time residential service and are supported by a team of social care workers. A person in charge manages this designated centre and is supported in their role by a social care leader and a senior manager.

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
Friday 17 June 2022	11:15hrs to 16:30hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This inspection was an unannounced risk inspection. It was scheduled subsequent to the high levels of non-compliance identified on the last inspection in August 2021. The inspector of social services returned to one house in this designated centre to review the progress made by the provider in addressing the areas of concern. As discussed throughout the report, improvement was made across all regulations, and the level of incidents that negatively impacted upon other residents had reduced.

When the inspector first entered the home, they spoke with one resident and their support staff. In order to participate in their day service programme, the second resident had already left the centre with their support staff. After a quick introduction to the inspector, the resident resumed their conversation with the staff member in attendance. The resident wanted to establish a plan with staff to leave the house because they were excited to go shopping and buy a certain item that was important to them. The resident was reassured by the staff member, and the communication that was seen was consistent with the resident's support plan. The resident resumed using their smartphone and earphones to play music after appearing to be satisfied with the plan to go shopping.

Given the nature of the assessed needs of residents, there was a requirement for residents to have a positive behaviour support plan in order to help support them in managing behaviours of concern. These residents had access to psychology and multidisciplinary input, and as was already mentioned, it was recognised that the recommendations resulting from these reviews were being carried out. The inspector found that the behaviour support plans, which were routinely reviewed, provided clear guidance for staff. A high degree of familiar staff support and clear transition planning was a key component for the effectiveness of the positive behavioural support measures. From observations made during the inspection and the overall reduction in adverse incidents, it was apparent these plans successfully reduced negative interactions for residents.

Residents meetings were taking place on a weekly basis with topics discussed included menus, activities, COVID-19 and safeguarding. Social stories were also used to explain such topics to residents with copies of these stories seen. Within residents' personal plans there were notes of regular one-to-one discussions between residents and their assigned keyworkers where similar topics were discussed. Easy-to-read versions of residents' personal plans were also provided which were very visual. It was seen that a person-centred planning process was followed in this designated centre which allowed goals which were of importance and meaningful to residents to be identified. Examples of these including going on holidays and outdoor concerts. The inspector was informed one resident had already been on holidays abroad and both residents were attending a musical festival in a weeks time.

Other documentation reviewed during this inspection included incident records for

the designated centre. When reading these, the inspector observed that there had been incidents occurring in the designated centre which has a negative impact for residents. These typically tended to be verbal in nature. Similar interactions had also been noted during the previous Health Information and Quality Authority (HIQA) inspection in August 2021, and it was indicated on this inspection that, overall, circumstances had improved since then. It was seen that residents who had negatively impacted one another also attended activities together. However, it was also indicated that there could still be times when these residents would "frustrate each other".

It was evident that the provider had made significant efforts to meet residents' needs, however, the accommodation and support arrangements was unsuitable in the long term, and redress was required for a more suitable living environment. While the strategies in place to ensure residents' complex, and at times conflicting needs, were met during periods of high anxiety, residents did not have free access to all parts of the home, and a highly rigid routine had to be followed. Moreover, the house's physical layout did not provide ground floor facilities for those with any mobility requirements.

In summary, the inspector found that the governance and management systems had ensured, for the most part, that care and support were delivered to residents in a safe manner and that the service was consistently monitored. However, it was acknowledged that the layout of the house did not fully meet the current or future needs of one resident, and the provider had actively escalated the requirement for an improved placement to the funder through prolonged engagements. During the inspection, the inspector was informed of the advanced plans to secure an alternative home for the resident whilst being supported by the same staff team.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Overall, this inspection identified that the provider had implemented its compliance plan arising from the previous HIQA inspection, and that it had a positive outcome for residents. It was evident that the registered provider and person in charge effectively monitored the quality of care and support for residents. From speaking with residents and staff, it was apparent that every effort was being made to ensure residents were happy and safe in their homes.

This designated centre had last been inspected in August 2021, when inspectors visited the two houses of this centre. During the course of that inspection, concerns were identified in one of these houses, particularly in the areas of compatibility, positive behavioural supports, risk management and the suitability of the centre to meet all residents' physical needs due to the layout of one house. The purpose of

this risk-based inspection was to follow up on the provider's compliance plan to address the issues identified and focus exclusively on the house where concerns were raised. For the purposes of clarity, due to the lines of enquiry that triggered the inspection, only one house was visited by the inspector, upon which the inspection findings are based.

The regulations require the provider to have suitable monitoring systems in place to review the services being provided to residents. Such systems were in operation and overall this inspection found that the provider had responded to the issues raised by the previous inspection. It was seen how the provider had devised an action plan to respond to such concerns in the days after the previous inspection. There was clear evidence that the identified actions were being implemented in practice. For example, the provider had ensured that various assessments of the house in question were carried out while additional staffing had been provided in the house, particularly at night.

In addition, it was seen how the provider had taken measures to improve the level of oversight of the designated centre. New monthly reviews were taking place in areas such as risk and safeguarding by senior management. During the August 2021 inspection, a number of concerning incidents were documented and reviewed by inspectors, which had not been given sufficient consideration as to the impacts that they were having on residents' safety. On the current inspection, it was found that a new protocol for the reporting of incidents had been introduced, which placed more emphasis on safeguarding considerations. The provider ensured an unannounced visit to the centre occurred every six months, on which a report on the quality and safety of the service was produced. This report was found to be comprehensive in scope and assessed the provider's compliance with the National Standards. The provider had self-identified quality improvement issues that had been acted upon. For example, updates to assessments and personal plans, the reviewing of safeguarding incidents/measures during team meetings and supervision, outstanding refresher training and issuing updated contracts of care.

Staff spoken with were aware of the management arrangements for the designated centre. Staff reported that they felt supported in their roles and that senior management was responsive to any concerns they raised in relation to service provision. Workforce planning was found to consider any changing or emerging needs of residents and facilitated continuity of care.

Staff were supervised through formal supervision as well as through monthly staff meetings. Staff told the inspector that staff meetings were held monthly over teleconference and that they felt supported to speak up regarding any concerns or questions they may have at these meetings. A review of staff meeting minutes showed that topics relating to the quality and safety of care were discussed regularly. These included safeguarding, risk management and fire safety. There were mechanisms in place to monitor staff training needs and to ensure that adequate training levels were maintained. Staff received training in areas determined by the provider to be mandatory, such as safeguarding and fire safety. Refresher training was available as required, and staff had received training in

additional areas specific to residents' assessed needs, for example, autism training.

Regulation 14: Persons in charge

The person in charge was found to be suitably skilled, qualified and experienced to fulfil the role. The person in charge was full-time and was supernumerary to the roster. They was found to have in-depth knowledge of the residents and their assessed needs.

The provider had ensured appropriate operational management oversight arrangements were in place in the absence of the person in charge by appointing a social care leader to manage the service in their absence with additional oversight by a senior programme manager.

Judgment: Compliant

Regulation 15: Staffing

As previously discussed, maintaining a consistent roster and having familiar staff were essential to residents and their wellbeing. Due consideration was found to be given by the provider to ensure that the centre recruited staff that could effectively support the residents' specific needs. This house within the designated centre was operating with one whole time equivalent staff vacancy at the time of inspection. The inspector found that two long-term regular agency staff had been filling any gaps in shifts created by this vacancy, providing continuity of care to residents which was important for the well-being of residents living in this house.

Also, since the previous inspection, a waking night staff had replaced a sleep-over staff. Staff reported that the increased staffing levels, enhanced the capacity of staff to respond to residents' needs in a timely and person-centred manner.

Judgment: Compliant

Regulation 16: Training and staff development

There was evidence of a very high level of compliance with mandatory and refresher training for staff in the designated centre. All staff were up-to-date in mandatory training in areas such as infection prevention and control, fire safety, safeguarding and manual handling.

Staff were appropriately supervised through both formal supervision meetings and

regular staff meetings. Staff reported that members of the management team were responsive and easy to contact.

Judgment: Compliant

Regulation 23: Governance and management

The provider had significantly enhanced the governance and management arrangements for the designated centre subsequent to the last inspection. There was a clearly defined management structure in the designated centre. The day-to-day running of the centre was overseen by a suitably qualified and experienced person in charge. The person in charge demonstrated a significant knowledge of the residents' needs and of their own regulatory responsibilities. The person in charge was supported on the ground by a social care leader.

Staff were aware of their roles and responsibilities and of the reporting structure. The inspector saw that the provider had in place a series of audits to support oversight of the centre and accurately reflected the issues and risks presenting in the service. Comprehensive, time-bound action plans were derived from these audits. An annual review had recently been completed as well as an unannounced six-monthly provider audit. These audits reflected the progress made in the service and highlighted areas for ongoing improvement through a comprehensive action plan.

There were effective arrangements in place to support, develop and performance manage all members of the work-force and to facilitate staff to raise concerns about the quality and safety of care and support provided to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector found that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements action from the previous inspection had been completed.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspector was aware that representatives for one resident had repeatedly voiced concerns over the previous year about the centre's suitability for their family member and requested alternative accommodation that was based on the resident's individual assessed needs. Additionally, the provider had also determined that the current living environment was not optimal and had escalated the matter to the funder. The inspector was satisfied that appropriate measures had been taken in the interim to ensure the resident could safely live within the centre until their new home was ready to move into.

Both residents were in receipt of one-to-one staffing supports and also attended separate day services three days a week.
In addition to centre-based activities, residents were supported to engage in activities in the community. The inspector reviewed the detailed daily progress notes that were completed by staff that were emailed to management every morning. These records demonstrated that residents were supported on a daily basis to engage in activities of their choice and at times of their own choosing. For example, residents attended local gyms, shopping centres, restaurants and played golf at a pitch and putt club.

Many systems were also in place to support residents in maintaining contact with their families and friends. It was apparent that staff and management had strived to preserve and develop relationships with family members. For example, one resident was supported in visiting family members abroad by staff travelling with the resident. Video-calling and phone calls were also promoted and encouraged, especially during periods of travelling and visiting restrictions.

As required by the regulations, residents had individual personal plans provided for. Such plans should reflect the needs of residents and provide guidance for staff in supporting these needs. The inspector reviewed a sample of these plans and noted that residents were involved in the development of these plans through a person-centred process. For example, it was seen that one resident had a meeting around their personal plan, which involved staff and their family. From the sample of personal plans reviewed it was also seen that they provided a good level of information around how residents' assessed needs were to be supported. For example, residents with particular health needs had specific plans in place outlining how residents were to be supported in such areas, with residents also facilitated to access various health and social care professionals as required.

The centre was also equipped with fire safety systems, including a fire alarm, emergency lighting, fire extinguishers and fire doors. Such fire doors are important in containing the spread of fire and smoke while also ensuring that a safe evacuation route is provided. During the inspection, it was noted, though, that the self-closure device of one of these doors was damaged. Other fire safety systems were being serviced at regular intervals by external contractors to ensure that they were in proper working order. Fire drills were being carried out regularly, including to reflect times when staffing levels would be at their lowest. The fire evacuation procedures were on display in the centre, and records provided indicated that all

staff had undergone relevant fire safety training.

Regulation 28: Fire precautions

It was observed that the designated centre was equipped with appropriate fire safety systems, including a fire alarm, emergency lighting, fire containment measures, fire extinguishers and a fire blanket. Such systems were being serviced at the required intervals by external contractors to ensure that they were in proper working order. The action from the previous inspection relating to fire containment measures had been addressed. The inspector did observed a damaged self closure on one fire door during the walk-about of the centre. In addition, the locking mechanism of a fire exit door required review.

The inspector was informed that an extensive fire risk assessment had been completed for the centre by a competent person, which identified areas of good practice and areas for modification, including the above observations. Improvements were required to the centre as laid out in the fire risk assessment report.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that all residents had an assessment of need and a personal plan in place that was subject to regular review. The input of residents and family representatives was evident and goals were identified in line with residents' wishes.

Residents' personal plans included an assessment of each resident's health, personal and social care needs and overall, arrangements were in place to meet those needs. Staff present in the centre demonstrated a good understanding of residents' needs and were seen to provide support in line with the information contained in residents' personal plans.

Due to emerging and changing needs it was found that the centre did not fully meet the assessed needs of all residents.

Judgment: Substantially compliant

Regulation 6: Health care

From reviewing residents' health management plans and recent consultations with

allied health professionals, it was evident that residents' changing needs were being closely monitored and supported. Staff who spoke with the inspector were knowledgeable in relation to residents' healthcare needs which included , mobility and dental needs.

There was evidence of ongoing review by internal and external medical and allied health review as escalated and referred by the person in charge and the staff team.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, residents had a behaviour support plan to guide staff on how best to support their assessed needs and was subject to a suitably professional review. A function-based assessment was used to identify possible functions of behaviours, and there were clear proactive and reactive strategies to guide staff practice to support the resident appropriately. Part of the plan also included skills teaching as part of the proactive strategies.

Staff members' were provided with relevant training in de-escalation and intervention, staff members spoken with demonstrated a good knowledge of these.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to ensure residents were protected from harm. This included staff training and care plans for personal and intimate care which were developed in consultation with the residents.

Since the previous inspection there had been further incidents of a safeguarding nature that had taken place in the house that was the focus of this inspection. However, it was noted that the provider had taken action to reduce the potential for these to happen such as by providing additional staff with further safeguarding training.

There were active safeguarding plans in place at the time of the inspection and the provider had ensured incidents had been reviewed and investigated where required with actions completed.

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	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC15 OSV-0005316

Inspection ID: MON-0036995

Date of inspection: 17/06/2022

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 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The damaged door closure has been reported for assessment and repair and this will be completed by 04 September 2022. A Health and Safety Officer has commenced in post and will be creating a schedule of works based on the fire assessment for this and all other designated centres and the identified priorities within that. Visits to centres are commencing and the schedule will be completed by 03 October 2022.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: As described in the report full input such as detailed routines, additional staffing and assessments have been put in place to support the needs of residents as much as is possible. This is ongoing and any additional needs will be responded to in a timely manner. Ongoing. The detail of the changing needs has been escalated to the funding body. A number of options were explored in the last year but were unsuitable to meet the needs identified. Work has progressed securing a more suitable environment to meet the changing needs described in the report, and is being finalised. Once completed a formal transition will be devised and implemented and will be supported by the familiar team and governance for consistency. The Authority will be advised as to the progress of this. 30th of September 2022	

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 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	04/09/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2022