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:	Carrowkeel Lodge
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	29 May 2024
Centre ID:	OSV-0008110
Fieldwork ID:	MON-0034693

About the designated centre

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

Carrowkeel provided full-time care and support to up to four residents with an intellectual disability and sensory impairments. The house was a large four bedroom bungalow and had ample communal areas for residents to enjoy including; a large living room, kitchen and dining area and a room that was used for visitors and doing activities. Each resident had their own bedroom and there were level access shower rooms available. There was a large garden area surrounding the house, and the exit points had ramps and handrails available for ease of access and exit. The house was located in the countryside and there was a large town nearby. The centre had transport available to support residents to access community activities in line with their individual needs and preferences. The staffing arrangements consisted of a skill mix of nursing staff and healthcare assistants. Waking night cover was provided by a nurse and healthcare assistant each night to support residents with their needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 29 May 2024	09:40hrs to 17:10hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection to monitor compliance with the regulations and as part of the monitoring for the renewal of the registration of the designated centre. As part of the announcement, an information leaflet about the name of the inspector that was visiting was provided. In addition, questionnaires were provided so as to establish the views of residents living in the centre. These questionnaires were completed by, and on behalf of, four residents living in the centre, and were reviewed as part of the inspection.

The inspector got the opportunity to meet with all residents and staff supporting them throughout the inspection. In addition, the person in charge was met with and available throughout the inspection.

On arrival, two residents were observed having breakfast supported by staff members. Two residents were having a lie-in in line with their preferences. Residents met with acknowledged and communicated with the inspector in their own way. All residents required supports with communication, and staff were observed to be knowledgeable about these supports. Staff spoken with described about using pictures and objects of reference to communicate with some residents and described about how residents made choices in their daily lives.

Through observations, a review of documentation and discussions with staff, it was clear that residents were well cared for and that their health needs were supported. The inspector found that residents were supported to engage in activities that were meaningful to them and that were appropriate to their stage of life. Residents were also supported to identify and achieve personal goals for the future. Some of these goals included; going on holidays, going on day trips and gardening projects. Photographs in place in books called 'my goal book' demonstrated residents' enjoyment of their chosen activities. Residents had the option of attending a day service external to the centre during the week. The staffing arrangements supported them in their choices to go to the day service, or to stay at home, in Carrowkeel.

There were three staff on duty each day to support residents to take part in activities and individual interests. Residents were observed freely moving around their home and were supported by staff where required. Residents had access to a service vehicle also to enable community based activities to be carried out. Two residents were supported by two staff to go on an outing and have their lunch out on the day of inspection. Two other residents were supported to do activities in their home. They were observed to be engaging in preferred activities with staff. Observations were that there was a relaxed and jovial atmosphere and residents appeared comfortable and relaxed with staff supports.

Staff spoken with appeared knowledgeable about the individual needs of residents. Some residents' needs had changed in recent times, and staff talked about various supports required. This was also observed in practice. Staff undertook 'human rights

training' which was noted to be part of the centre's site specific training plan. Staff members spoken with said that this served as a good refresher on promoting human rights.

The centre had a range of easy-to-read notices on display such as: fire evacuation procedures, photographic staff roster and an album of pictures to support meal choices. In addition, there were easy-to-read documents available to residents in topics such as making complaints, advocacy services, human rights, assisted decision making and staying safe online.

The house itself was spacious for the needs and numbers of residents. Residents' bedrooms were nicely decorated and were personalised with artwork, photographs, individual personal items and soft furnishings. The house was well ventilated, clean and spacious. Outdoors, there was an accessible garden with large green areas surrounding the house. This was well maintained. Since the last inspection by the Health Information and Quality Authority (HIQA) in November 2022, one resident had sadly died. Their photograph was framed and located on the hallway table. Compliments had been received from the resident's family members about the care and support their family member had received during their illness. A new resident had transitioned into the service in June 2023. Staff reported that they had settled in very well and were very compatible with the other residents. This was observed also on the day.

Questionnaires were received on behalf of all residents. All responses indicated that residents were happy with the supports provided, their home, their bedrooms, about how they make choices and about staff supporting them. One survey completed on behalf of a resident by a family member said that; 'staff are excellent' and they 'could not ask for better'.

Overall, Carrowkeel was found to provide high quality, person-centred and individualised care and support to residents. Observations throughout the inspection were that residents were treated in a caring and respectful manner by staff who appeared to know them well.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

This inspection found that Carrowkeel had a good management structure with systems in place for the ongoing monitoring of the quality and safety of care. Audits and assessments were found to identify areas for quality improvement. Any actions identified were found to be acted on in a timely manner.

The governance structure ensured clear lines of accountability for the management

team. The local management team consisted of a person in charge who reported to the regional Assistant Director of Nursing (ADON) .The person in charge had responsibility for one other designated centre located a few kilometres away. The arrangements in place, to include full-time supernumerary hours, supported them to effectively fulfil their role.

The centre was staffed with a skill mix of nurses and healthcare assistants. There were enough staff on duty to meet the assessed needs of residents. However, there were some vacancies that were required to be completed and at the time of inspection gaps in the roster were covered by regular agency staff to help ensure continuity of care.

Staff were provided with a range of training to equip them with the competence and knowledge to support residents with their needs. Some training was due to be completed and the management team were aware of this and dates were set. In addition, additional training to support the changing needs of residents had been identified and was being followed up by the management team. This would further support staff in supporting residents with dementia for example.

There was a schedule in place for a suite of audits to occur at set intervals during the year to monitor the quality and safety of care in the centre. The management team also completed monthly reviews of incidents that occurred. There was evidence that learnings were taken from the reviews completed. For example: multidisciplinary team (MDT) support was requested following a near-miss choking incident. A review of incidents found that all the notifications that were required to be submitted to the Chief Inspector of Social Services had been completed.

The provider ensured oversight by completing six monthly unannounced visits as required in the regulations, and of which detailed reports were generated and available in the centre. Actions identified were included on a service quality improvement plan (QIP). The progress of actions were reviewed regularly by the person in charge.

Overall, the arrangements in place ensured good oversight and monitoring of the centre. Audits were found to be effective in identifying areas for improvement. The progression of specific training to support residents' changing needs, and the recruitment of permanent staff would further ensure a safe and high quality service was provided to residents.

Registration Regulation 5: Application for registration or renewal of registration

A complete application to renew the registration of the designated centre was completed by the provider within the time frames required.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge had the skills, experience and qualifications to manage the centre. They worked full-time and they had responsibility for one other designated centre. The arrangements in place supported them to effectively manage the centre.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual roster in place, which was well maintained and reflected who was working on the day of the inspection. The centre was resourced to meet the assessed needs of residents, with three staff working each day and two staff providing waking night cover each night. The skill-mix consisted of nurses and healthcare assistants.

A sample of staff files were reviewed and found to contain all information as required in Schedule 2 of the regulations.

There were three care staff vacancies at the time of inspection, which were covered by regular agency staff. This helped to ensure continuity of care to residents. The recruitment of these posts were in progress and this required completion. This action is covered under regulation 23: governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

The local management team maintained a training matrix, which recorded all mandatory and site specific training undertaken by staff and highlighted the dates due for refreshers. some refresher training was due at the time of inspection for some staff and dates had been set for this to be completed. Site specific training included training required to support the specific needs of residents living in Carrowkeel. The following was found;

- Due to the changing needs of residents in recent times, training in dementia care was identified as being required. The local management team were aware of this, however a date had not yet been set for this to occur.

Staff received support and supervision through annual personal development meetings with their line manager. In addition, the person in charge met regularly

with their line manager and attended meetings with peers for shared learning and support. A sample of meeting records reviewed demonstrated that this was occurring. All staff spoken with said that they felt well supported in their role.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider ensured that there was up-to-date insurance in place for the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were good arrangements in place for the management of the centre. There were systems in place for reviewing and monitoring the centre and for ensuring that actions to improve the service were identified and kept under review for completion.

The provider ensured that an annual review of the quality and safety of care provided in the service occurred which included consultation with residents and their representatives, as relevant. In addition, unannounced visits by the provider were completed as required in the regulations.

Staff were supported through ongoing training and annual meetings with their line manager. In addition, staff had opportunities to raise any concerns that they have about the quality and safety of care and support in the service through regular team meetings.

However, as mentioned earlier in the report the following required completion to ensure that the centre was fully resourced in line with the statement of purpose:

- The recruitment process for three staff vacancies required completion which would help to ensure continuity of care for residents now and in the future.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider ensured that there was a policy and procedure in place that outlined the criteria for admission to the service. The person in charge ensured that a resident was supported in their transition to the centre and that they, and their

representatives, had opportunities to visit the centre prior to admission if they so wished.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider ensured that there was an up-to-date statement of purpose in place that included all the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of incidents that occurred in the centre found that the person in charge had submitted all the required notifications to the Chief Inspector of Social Services as required under the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy and procedure in place that outlined the process for making complaints, including who the person handling the complaint was. This also included information about how to appeal the outcome of complaints.

The centre had developed a local complaints protocol and there was an easy-to-read version of complaint procedures for residents to aid with understanding. Audits were completed regularly on complaints received in the centre. There were no open complaints at the time of inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider ensured that all the polices and procedures that are required under Schedule 5 of the regulations were in place, up to date and available for review.

Judgment: Compliant

Quality and safety

Overall, the service was found to provide a high quality and safe service to residents. Residents' needs were regularly reviewed and residents' heath and wellbeing were found to be monitored for changes.

A comprehensive review of residents' health, personal and social care needs were completed. A range of care and support plans were in place to guide staff in the supports required. These included; behaviour support plans, feeding, eating, drinking and swallowing (FEDS) plans, and protocols for managing medical conditions such as epilepsy. These were kept under review and updated if there was a change in need and circumstances. Staff spoken with were familiar with residents' needs and were observed supporting them in line with their assessed needs.

Residents' health and wellbeing were promoted in the centre. Residents were supported to attend appointments and consultations with various healthcare professionals as required. In addition, residents had access to MDT members as required. Staff spoken with reported that some residents' needs were changing. There were good systems in place to monitor this and appropriate and prompt responses to support this was evident..

Residents were consulted about the running of the centre through regular residents' meetings. Easy-to-read documents, objects of reference and visuals were used to support residents make choices in their day-to-day lives.

The protection of residents were promoted through adherence to the provider's policies and procedures and through staff training. In addition, incidents were kept under review and where possible protection concerns were identified, these were followed up in line with the procedures.

Overall, Carrowkeel was found to promote a rights based service where residents' care and support were kept under ongoing review to ensure that the most appropriate supports were provided.

Regulation 10: Communication

The provider had an up-to-date policy and procedure in place for communication. Residents had access to technological devices, the internet, televisions, music players and telephones in line with their individual preferences.

All residents living in Carrowkeel required supports with communication. Residents'

communication needs were assessed and kept under ongoing review. Communication care plans were in place and included speech and language therapist's input.

Through observations on the day, a review of care plans and discussion with staff members, it was clear that various forms of augmented communication were used with residents to consult with them and to help them to make choices in their day-to-day lives. For example; staff members described the use of particular objects of reference to support one resident to make choices about going horse-riding.

Judgment: Compliant

Regulation 11: Visits

There was a policy and procedure in place for visitors. The centre had a warm, homely and welcoming atmosphere. Residents received visitors to the house regularly. There were ample communal rooms and space for residents to meet with their visitors in private if they so wished.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to take part, and get involved, in a range of leisure and recreational interests in line with their interests. These included activities in the house such as; gardening, baking and art. Some residents attended a local day service on set days in the week also. In addition, residents enjoyed spa treatments, reflexology, horseriding, going on day trips to various locations, going on shopping trips and having meals out. There were plans for two residents to go on an overnight break away during the Summer.

Links with family members and the wider community were promoted and encouraged. For example; a priest known to residents in their previous home was a regular visitor to the house and this link was maintained and supported by the service.

Judgment: Compliant

Regulation 17: Premises

The premises was designed and laid out to meet the needs of residents. The house

was clean, homely, spacious and well maintained. There were suitable facilities for completing laundry and for preparing and cooking meals.

Residents had their own bedrooms which were personalised and which had space for the storage of personal possessions. There were ample communal rooms for residents to relax in individually and to receive visitors. Outside, the garden space and grounds were spacious, well maintained and accessible.

Residents had aids and appliances as required in line with their assessed needs. External advice and guidance was sought to enhance the environment for a resident who had a vision impairment, and alterations to the house that was recommended were in progress.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide in place which contained all the information for residents that was required under this regulation.

Judgment: Compliant

Regulation 28: Fire precautions

There were arrangements in place for fire safety and for the ongoing monitoring of fire safety arrangements in the centre. These included; fire containment measures, fire fighting equipment, fire alert system, fire safety checklists and evacuation plans.

Fire safety measures in the centre were kept under review through daily, weekly and monthly checks. Each resident had a personal emergency evacuation plan (PEEP) in place which provided guidance to staff on the arrangements to ensure a safe evacuation from the centre.

Fire drills took place regularly and demonstrated that residents could be evacuated to safe locations in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that a comprehensive assessment of the health,

personal and social care needs of residents was completed and kept up to date. Where the need was assessed, care and support plans were developed. These were kept under ongoing review and updated as required.

In addition, residents were supported to identify and set goals for the future. These goals were found to be kept under ongoing review and each resident had an accessible plan called 'my goal book' which included photographs of activities enjoyed and goals achieved.

Annual review meetings were held to review residents' care and support and they included the maximum participation of residents and their family representatives, as relevant.

Judgment: Compliant

Regulation 6: Health care

Residents' health and wellbeing were promoted and there were good arrangements in place for monitoring residents' health for any changes or additional needs. Residents were reported to have developed a good relationship with their general practitioner (GP) since their move to Carrowkeel. Residents had access to healthcare professionals and MDT supports as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were policies and procedures in place for behaviour support and for restrictive practices. Staff received training in behaviour management. Staff spoken were found to be knowledgeable about the specific supports that residents required with behaviour management and stress reduction.

Behaviour support plans were developed as required with input from MDT. These were found to be kept under ongoing review and it was evident that every effort was made to establish the causes of behaviours.

Restrictive practices in use in the centre had been assessed and there were protocols in place with clear rationales on their use for safety reasons. These were found to be kept under ongoing review to make sure that they were the least restrictive option for the shortest duration. This monitoring also included a review of the use of PRN medicine (medicine only taken as required) to include monitoring of increases or decreases in their use each month.

Judgment: Compliant

Regulation 8: Protection

There was an up-to-date policy and procedure in place for safeguarding. Staff completed training in safeguarding vulnerable adults and audits were completed to assess staff knowledge in safeguarding.

Safeguarding was a regular agenda item at staff meetings. Staff were knowledgeable on how to ensure residents' protection.

Safeguarding was regularly audited in the centre. In addition, the oversight and monitoring arrangements by the management team helped to ensure that potential safeguarding concerns were not missed. For example; a review of incidents recently resulted in the identification of some potential concerns which were then screened in line with the provider's policy to establish if there were grounds for concern or not.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was found to promote a rights-based service. Residents were consulted in the running of the centre through regular meetings, where day-to-day choices were discussed and consultation about the centre occurred. Residents were provided with information on rights and advocacy services in an easy-to-read format.

There were a variety of easy-to-read documents on various topics and pictorial aids for making choices. For example; the use of a pictorial meal options were used to support residents in making choices about their meals. Residents were also supported to practice their faith and enjoyed visiting religious amenities in line with their wishes.

One resident who had a preference not to use the service vehicle was supported to use alternative transport and a hire car was available in line with their preferences for travelling in a particular type of vehicle.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Carrowkeel Lodge OSV-0008110

Inspection ID: MON-0034693

Date of inspection: 29/05/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge has ensured that all staff nurses have completed the ELearning Module in Dementia on HSE Land. (Completed 02/07/2024) • The Person in Charge has agreed a date for site specific training for all staff in the designated Centre with the Clinical Nurse Specialist (CNS) in Dementia. (Completed 02/07/2024)	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The register provider has escalated the recruitment of staff for the designated centre to Human Resources to ensure that staffing levels are in place in line with the Statement of Purpose. (Completed 26/06/2024) • The Person in Charge has updated her risk assessment in relation to the use of agency staff in the centre to maintain staffing levels in line with Statement of Purpose. (Completed 26/06/2024) • The Person in Charge has received approval for three Health Care Assistant posts within the Designated Centre in March 2024. The recruitment process for these positions is ongoing. A target date for postions to be in place is the 30/09/24.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	02/07/2024
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.	Substantially Compliant	Yellow	30/09/2024