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:	Parkside Residential Services Kilmeaden
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	07 March 2024
Centre ID:	OSV-0005106
Fieldwork ID:	MON-0037634

About the designated centre

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

Parkside Residential Services Kilmeaden is a five bedroom two–storey detached house located in a rural area. The centre provides residential care for four men with mild to moderate intellectual disability ranging in age from 28 to 54 and has a maximum capacity for four residents. It is open 365 days of the year on a 24 hour basis. Each resident has their own bedroom and other facilities throughout the centre include a kitchen, a dining room, three living rooms, bathroom facilities and garden areas. Staff support is provided by social care workers and care assistants. the designated centre was within easy reach of local towns and Waterford city.

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
Thursday 7 March 2024	09:30hrs to 16:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

This was an unannounced inspection and the purpose of the inspection was to determine the centres ongoing levels of compliance with the regulations. Overall, poor levels of compliance were found with the regulations reviewed.

There were four male residents living in the centre and the inspector had the opportunity to meet with two residents on the day of inspection. One resident was having their breakfast when the inspector arrived to the centre. The resident said hello and consented to the inspector spending some time in their home for the purpose of the inspection. The inspector spent some time communicating with the resident and they nodded when the inspector asked if they were happy living in their home. The staff supporting the resident told the inspector that they were heading out horse riding together in a local facility that morning. The resident appeared content eating their breakfast and comfortable with the staff member supporting them. The inspector had the opportunity to meet a second resident later in the day. The resident was observed coming home from their daily activities and making themselves a cup of tea in the centres kitchen. This resident spoke briefly with the inspector about staff they liked supporting them and an upcoming trip they had planned. The resident was a smoker and communicated that they would like an outdoor heater where they smoked outside. The inspector did not meet with the two other residents living in the centre as they were out at day services for the duration of the inspection day.

On arrival, the inspector noted that the premises was large and in a picturesque location with countryside scenery overlooking the river Suir. The premises was a two-storey house and the ground floor comprised of a kitchen, a toilet and utility area, along with three separate living rooms. Upstairs, there were two bathrooms and five bedrooms, four of these were residents rooms and one was identified as a staff office and sleepover room. Residents had decorated their own rooms in line with their own preferences and some residents had ordered new furniture, which was arriving on the morning of the inspection. The inspector observed pictures of residents and different trips they had been on, along with personal items such as medals from sporting events.

However, the inspector completed a full walk around the premises throughout the inspection day and found that overall the premises was in a poor state of repair. Some issues were observed such as a number of areas of outstanding paintwork, mould and dampness on a bathroom wall, very marked and scratched flooring throughout the centre, an area of dampness on one residents bedroom wall, chipped and marked doors and door frames, rusting and chipped pipe-work in bathrooms and a stained and dirty window blind. A number of restrictive practices were noted around the centre including locked doors, door chimes, and 24/7 CCTV monitoring in an upstairs hallway. Staff and management communicated that these were all in place due to identified 'peer to peer risks'. Fire safety concerns were

noted around the centre, as detailed further under regulation 28 of this report.

Two residents in the centre were assessed as not compatible to be living together. This had been identified on inspections on a number of occasions in this centre since 2021 and the provider had also self-identified this. The provider had submitted a compliance plan to HIQA following the centres most previous inspection in May 2022. This had highlighted that the provider would source an alternative living arrangement for one resident living in the centre by December 2022, due to peer to peer safeguarding risks. This had not occurred and the two residents were still living in the centre. The residents themselves continued to voice to staff that they did not want to live together. Safeguarding risks were managed daily through high staffing levels, separate living spaces in the home, separate transport, opposite resident routines and restrictive practices. The levels of peer to peer safeguarding incidents were low due to these measures. At the opening of the inspection day, a member of management highlighted that the provider has been continuously endeavouring to address this incompatibility issue in the centre, however to date they had been unable to source a suitable property for one resident to live in.

Residents were supported by a core staff team who appeared to know the residents and their needs very well. High levels of staffing were in place due to the identified peer to peer safeguarding risks. All staff were found to be suitably qualified to provide the care and support that the residents required. Staff had completed training in mandatory areas such as fire safety, safeguarding, manual handling and infection. Some staff were outstanding in refresher training in these areas. The centre was supported by a full time person in charge, who was responsible for one other designated centre. This person was present on the day of inspection and communicated that they visited the centre approximately once per week.

Residents all had individual activation schedules and enjoyed attending different daily activities such as farm work, horse riding, day services, and day trips. However, daily schedules and meal times were altered and tailored to prevent some residents from meeting or being in contact regularly and this was found to impact residents choice and control in their daily lives. Furthermore, following a review of residents care records, the inspector found that some residents care plans were not up-to-date and some residents personal care plans and social goals had not been reviewed since 2022.

The next two sections of the report present the findings of this 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. Overall, a number of issues were noted in areas including resident compatibility, staff training, governance and management, premises, fire safety, personal planning and resident rights.

Capacity and capability

Compatibility issues between two residents, continued to impact a number of areas of service provision to all the residents living in the centre. This had been an ongoing issue in the centre since 2021 and had been identified as an area of non compliance in the centres previous inspections in 2021 and 2022. Progression of the transition of one resident to a new home or a different separate living arrangement to their peer, was required to ensure the designated centre was suitable to meet the assessed needs of all residents and to ensure that the service provided was in line with the residents own wishes. The provider had failed to adhere to their own compliance plan response following the centres previous inspection in May 2022. This had detailed that resident compatibility issues would be addressed by December 2022. This did not occur.

There was a clear management system and structure in place, however oversight systems in place were not appropriately self identifying areas in need of improvements in the centre. Areas in need of improvements included staff training, premises, fire safety and residents personal plans. The provider had failed to address a number of outstanding actions from a fire safety audit completed by the service health and safety officer in May 2022.

The inspector found that there was a sufficient number of staff in place and a core staff team in the centre who supported the residents and who were managing the potential safeguarding risks well on a daily basis. However, the compatibility issues and the safeguarding risks continued to mean that residents could not access areas of their home which were monitored on a 24/7 basis in one area by CCTV.

Regulation 15: Staffing

The staff team comprised of social care workers and healthcare assistants and there were sufficient staff numbers in place to meet the needs of the residents. High levels of support were in place due to identified risks in the centre. Staff in the centre appeared to know the residents and their needs very well and some staff had worked with residents for a number of years. There was a staff rota in place and this accurately identified staff on duty on the day of inspection. Staff support hours were tailored to suit the needs of the residents and specific identified risks. Appropriate skill mixes were in place to meet the needs of the residents. Staff meetings took place in the centre every six weeks, where residents needs and ongoing issues in the centre were discussed. Staff members on duty completed daily handovers with the person in charge when dropping residents to their different day services.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed training in a number of mandatory areas including safeguarding, medication management, manual handling, fire safety and infection control. Following a review of staff training records it was found that five different staff members were due refresher training in some of these mandatory areas. This was an overarching issue with the registered provider and availability for staff to attend overdue refresher training appeared to be limited at times. This posed a risk to residents at times as some staff supporting them did not have up-to-date training in areas of service provision.

The person in charge was completing one to one supervisions with all staff on a yearly basis in line with the providers own policy.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clear management structure in place with a full time person in charge, who was responsible for one other designated centre. This person was present on the day of inspection and communicated that they visited the centre approximately once per week. The centre was also supported by a senior area manager. However, some improvements were required in the overall governance and management of the designated centre. The provider had failed to adhere to a compliance plan response submitted to HIQA following the centres most previous inspection in May 2022. This had detailed that resident compatibility issues would be addressed by December 2022. At the opening of the inspection day, a member of management highlighted that this had not yet happened and that the provider has been continuously endeavouring to address this incompatibility issue in the centre, however to date they had been unable to source a suitable property for one resident to live in or sufficient funding.

A number of areas of concern were noted on the day of inspection which had not been fully highlighted through the centres own oversight and audit systems. These included outstanding premises works, fire safety issues, and care plans requiring review. A health and safety officer had completed a fire safety audit in the centre in May 2022. A number of issues were identified by the assessor following this audit and the provider had failed to address many of these outstanding actions since then.

Judgment: Not compliant

Quality and safety

A number of improvements were required to ensure that the quality of the service provided was appropriately monitored and to ensure that the residents could enjoy a safe service in their home.

Since the centres most previous inspection in May 2022, there continued to be safeguarding plans in place to ensure residents were protected from suspected/confirmed abuse. In line with safeguarding plans, two residents lived separate lives and avoided spending any time together in their home. Both residents went home to family on alternate weekends to minimise shared time spent in their home. When in the centre at the same time, residents used separate living areas and did not engage in any shared activities. This included separate meal times, separate separate living spaces in the home, separate transport, opposite routines. The inspector noted that these measures had worked well to minimize physical safeguarding incidents in the house, and safeguarding incidents had been minimal in the centre in recent months. However the measures were restrictive and continued to impact residents choice and control in their daily lives in their home. In line with the wishes of both residents, one resident's transition to a new home or a different separate living arrangement to their peer was required. The residents themselves, had voiced this with staff and management on a number of occasions.

A number of areas of concerns were noted around the premises including outstanding refurbishment works such as paintwork and worn chipped doors and door frames. Areas of dampness and mould were observed in one bathroom and an area of dampness was observed in one bedroom. Furthermore, a number of fire safety concerns were noted.

Regulation 17: Premises

The inspector found that there was a substantial amount of outstanding premises works in the centre. The property was a two-storey house and the ground floor comprised of a kitchen, a toilet and utility area, along with three separate living rooms. Upstairs, there were two bathrooms and five bedrooms, four of these were residents rooms which were personalised and decorated in line with their personal preferences and one room was identified as a staff office and sleepover room.

The inspector completed a full walk around the premises throughout the inspection day and found a number of issues such as areas of outstanding paintwork, mould and dampness on a bathroom wall, very marked and scratched flooring throughout the centre, an area of dampness on one residents bedroom wall, chipped and marked doors and door frames, rusting and chipped pipe-work in bathrooms and a stained and dirty window blind.

Judgment: Not compliant

Regulation 28: Fire precautions

High levels of fire safety concerns were noted in the centre on the day of inspection. A health and safety officer had completed a fire safety audit in the centre in May 2022. A number of issues were identified by the assessor following this audit and the provider had failed to address many of these issues, including:

- The location of waste storage facilities outside of the centre.
- An upstairs loft door which was identified as not fire proof.
- Compromised door frame/doors integrity and therefore containment abilities.
- Residents smoking facilities.

Furthermore, the inspector noted that fire safety checks of fire doors and escape routes were not being completed consistently by staff working in the centre daily. Records noted a gap of almost a whole month from December 2023 to January 2024 where staff had not signed that they had completed any of these checks in line with fire procedures. Two staff members were also out-of-date in their fire safety training.

The inspector noted a hot-press and boiler room in the centre where appropriate containment measures were not in place. These were potential areas of high risk. The inspector observed the area outdoors where one resident usually smoked and found that this area was not in line with fire safety guidance. For example, there was no safe disposal area for cigarette butts and the seating area provided was not fire retardant.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Two residents were not compatible living together and therefore their current living arrangements were not suitable to meet their assessed needs. Following a review of residents care records, the inspector found that some residents care plans were not up-to-date and some residents personal care plans and social goals had not been reviewed since 2022. The service used a "circle of support" model to fully review an annual plan of care in conjunction with the residents, the multi-disciplinary team and their chosen attendees. This had not happened for two residents since May 2022. This meant that these residents did not have up-to-date personal plans/social goals in place.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Some residents presented with behaviours that challenge and they were well supported by a number of behavioural support professionals including psychologists, psychiatry and a behaviour support specialist. All residents had individualised behaviour support plans in place which were subject to review with the multi-disciplinary team. A number of restrictive practices were noted around the centre to manage behaviours, including locked doors, door chimes, and a 24/7 CCTV camera in an upstairs hallway. These were in place secondary to identified safeguarding risks and these were highlighted in the centre risk management documentation. While these managed safeguarding risks well, these impacted residents choice and control in their home and in their daily lives as highlighted under regulation 9. It was evident that the residents environment would not be this restrictive if they did not live with their peers

Judgment: Substantially compliant

Regulation 8: Protection

While potential safeguarding risks were high in the centre, staff working with the residents daily were managing them well and for this reason, there were low levels of safeguarding incidents in the centre. Safeguarding risks were managed daily by staff through high staffing levels, separate living spaces in the home, separate transport, opposite resident routines and restrictive practices. There was a designated safeguarding officer within the service to manage any safeguarding concerns. Open safeguarding plans were in place for the residents which detailed mitigating safeguarding measures in place daily and staff were familiar with these.

While safeguarding measures meant that peer to peer safeguarding incidents were minimal in recent months, these impacted the residents choice and control in their daily lives and meant that their home was quite a restrictive environment. Residents could not access specific rooms in their home and one hallway was monitored 24/7 by CCTV due identified safeguarding risks. Residents had set schedules in place to ensure that they never met with their peers. This impact is discussed further under regulation 9.

Judgment: Compliant

Regulation 9: Residents' rights

Daily schedules and meal times were altered and tailored to prevent some residents from meeting or being in contact regularly and this was found to impact residents

choice and control in their home and in their daily lives. There were four residents living in the centre and there were three separate living rooms for different residents to use. Some residents could not enter certain living rooms due to safeguarding risks. A number of restrictive practices were in place in the centre for the safety of the residents and this included 24/7 CCTV monitoring in one hallway in the centre. The service had a human rights committee who had advised reviewing the use of this, with a view to reducing its use. However, to date, this had not been possible due to identified risks. Residents meetings were held weekly with staff, however some residents attended these separately due to identified risks.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not 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	Not compliant

Compliance Plan for Parkside Residential Services Kilmeaden OSV-0005106

Inspection ID: MON-0037634

Date of inspection: 07/03/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has met with the training dept and developed a plan to bring training at the centre in line with compliance. • Fire training for all staff is now complete at the centre. • Safegaurding training for all staff will be complete by 10/05/2024 • Personal outcome measures will be complete by 16/05/2024. • Safe administration of medication training has been scheduled. • Manual handling training has been scheduled. • Behaviour management training has been scheduled.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The provider is currently developing a system of reporting which will be rolled out across the region to address the issue of oversight of actions from all audits.	

• The Compliance Manager has revised guidelines for six monthly internal audits and is currently in the process of improving overall quality of internal auditing.

• The Person in Charge arranged for the H&S officer to visit the centre and review all fire containment practices. All actions from review and previous audit will be completed by 30/05/2024.

• A review is underway of the current residents needs, risks and supports and the outcome of this review will guide the provider around the best course of action for living arrangements going forward.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Person in Charge will ensure all outstanding works are completed in a timely manner, these include the following:

• All outstanding paintwork is now complete.

• Installation of a more robust ventilation system to ensure the mold and dampness on the bathroom and bedroom wall does not return will be completed.

• Repairs to marked and scratched flooring throughout the centre is now complete.

• Repairs to chipped and marked doors and door frames is now complete.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Person in Charge will arrange for the fire safety officer along with the building facilities manager to visit the centre to review and schedule works for the following:

• Waste storage facilities have now been relocated in line with fire regulations.

• Works are scheduled for completion around all fire containment issues highlighted and will be completed by 30/05/2024.

• A designated smoking area with suitable facilities for the safe disposal of cigarette ends

will be provided at the centre.

• The Person in Charge will ensure that all fire safety checks are complete and has oversight of same.

• Staff members who were out of date in fire training have now completed the course.

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:
• Circle of support meetings for 2024 have now taken place for three residents at the centre and one is scheduled for completion.

• A schedule is now in place to review all residents care plans in line with policy.

• A review is underway of the current residents needs, risks and supports and the outcome of this review will guide the provider around the best course of action for living arrangements going forward.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• A review is underway of the current residents needs, risks and supports and the outcome of this review will guide the provider around the best course of action for living arrangements going forward. This will include a review of any restrictive practices that occur at the centre.

• The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A review of all restrictive practices at the centre has been completed by the multi disciplinary team on 11/04/2024. A report has been forwarded to the human rights committee for review. Any recommendations arising from this review will be completed in a timely manner by the Person in Charge.

• A review is underway of the current residents needs, risks and supports and the outcome of this review will guide the provider around the best course of action for living arrangements going forward.

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	30/09/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/05/2024
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	Not Compliant	Orange	31/07/2024

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/05/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/05/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/06/2024
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).	Not Compliant	Orange	30/06/2024

Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	31/07/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/07/2024