# Report of an inspection of a Designated Centre for Disabilities (Adults).

## Issued by the Chief Inspector

| Name of designated centre: | Cashel Downs |
|---|---|
| Name of provider: | S O S Kilkenny CLG |
| Address of centre: | Kilkenny |
| Type of inspection: | Unannounced |
| Date of inspection: | 05 December 2024 |
| Centre ID: | OSV-0005610 |
| Fieldwork ID: | MON-0045603 |

## About the designated centre

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

Cashel Downs is a designated centre operated by SOS Kilkenny CLG. The designated centre provides community residential services to up to four adults, both male and female, with a disability. The centre comprises of a large two storey detached house which is located at the end of a cul-de-sac in a housing estate on the outskirts of Kilkenny city. The house comprises of a kitchen, two living areas, an office, bathroom, four individual bedrooms and a staff room. One of the downstairs bedrooms also has access to a personal living room and en-suite bathroom. The centre is staffed by a person in charge and care assistants.

**The following information outlines some additional data on this centre.**

| Number of residents on the date of inspection: | 2 |
| --- | --- |

## 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 5 December 2024 | 09:00hrs to 17:00hrs | Linda Dowling | Lead |

## What residents told us and what inspectors observed

This inspection was unannounced and carried out with a specific focus on safeguarding, to ensure residents felt safe in the centre they were living in and they were empowered to make decisions on their care and how they wished to spend their time.

Overall, the inspection found that residents were in receipt of good care and support and found positive examples of how residents were supported to make decisions, however there were some areas that required improvements such as premises and use of restrictive practice.

On arrival to the centre, the inspector was welcomed by an agency staff who had just started their shift. There was also a sleepover staff on duty who was due to finish their shift at 09.00am. One of the residents was relaxing on the couch in the activity room. They were dressed and waiting for a second day staff to arrive. The inspector introduced themselves and the resident repeated the staff members name who was coming on duty. This resident engaged with the staff member on duty to seek reassurance about the second staff that was coming on duty. The staff understood the residents form of communication well and confirmed who was coming on shift and that they would be arriving in the next few minutes. The resident nodded their head in response. When the second staff arrived the resident had a big smile and vocalised staff members name.

The second resident was in bed when the inspector arrived and got up at a time of their choosing. Once up they had a shower and got dressed. The resident informed the inspector of their plans for the day which included going social farming where they, fed the cows and went in the tractor. The staff asked the resident what they would like to bring for their lunch, the resident choose bread and jam, they told the inspector this was their favourite.

The two residents had breakfast together they had each made specific choices about what they wanted to eat and were supported by staff to prepare it. While there is a safeguarding plan in place for low level peer to peer incidents between these residents, it was observed that all staff were aware of the control measures in place to prevent any further incidents. This was observed to be working well and happened naturally between the staff and residents. One staff member was present on each occasion when both residents were in the same room.

Staff remained present with both residents while they had breakfast and meaningful conversations took place, staff asked residents about their previous day, their families and their plans for Christmas. Staff and residents were observed smiling and laughing a lot during these conversations.

Both residents were supported to get ready to go in the car, staff informed them of the weather and made suggests to wear a warm coat and a hat, both residents

agreed they got their coats and said goodbye to person in charge and service manager who had arrived to facilitate the inspection.

The inspector had an opportunity to speak with each resident. They spoke about some of the things they like to do in the centre and activities in the community. For example, one resident spoke about going out for a hot drink, swimming and home visits, the other spoke about farming and relaxing watching TV. They both reported that they liked the staff and said that staff were good to them. All residents were observed to be comfortable in the presence of staff and the staff were observed to be person centred in their approach to residents.

## Capacity and capability

Overall, the findings from the inspection were positive. The inspector found that there was a clearly defined management structure in place and regular management presence in the designated centre, with a full time person in charge and a team leader. The provider had established good systems to support the provision of care and support to the residents. There was evidence of regular quality assurance audits of the quality and safety of care.

There was a consistent staff team in place and while some shifts were covered by agency these were very consistent and familiar with the residents. The number and skill mix of staff were appropriate to meet the needs of the residents and in line with current safeguarding plan and statement of purpose.

### Regulation 15: Staffing

The inspector reviewed the rosters for the last six weeks and found the staffing arrangements were as described in the statement of purpose. Staffing in the designated centre consisted of two staff on duty each day when both residents were present and one sleepover staff at night. With the presence of two staff with two residents each day this allowed for residents to engage in activities that interested them and facilitated the implementation of the formal safeguarding by giving residents times on their own.

The rosters reflected the staff on duty by their full name and grade. While their was a number of agency staff utilised in the last six weeks this was to cover annual leave and sick leave. The agency staff were for the most part very consistent. Both staff present on the day of the inspection were agency and had worked in the centre for a number of years and were very familiar with the residents assessed needs.

The inspector reviewed three staff files and found that they all contained the relevant information as required by schedule 2 of the Health Act 2007. This included

qualification certificates, vetting, current ID and references.

The inspector was made aware of ongoing recruitment by the provider, this centre recently had two vacancies that are now filled with staff currently going through training, induction and had shadow shifts scheduled before commencing shifts. Theses gaps in the roster had been filled by familiar relief staff which work across the other three centres operated by the same person in charge. This ensured the residents had continuity of care at all times. The provider's focus on consistency and use of familiar agency and relief staff ensure that precursors to incidents were identified and supported before escalating.

Additionally, the inspector reviewed the last 12 months of team meeting minutes. The centre had one team meeting per month, the minutes were printed and available to staff for review. Topics discussed included up date on residents well being, incidents and safeguarding. It was evident the formal safeguarding plan in place was at the forefront of discussion at each meeting.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspector reviewed the training records for all staff in the designated centre. It was found that all staff were provided with the required training to ensure they had the necessary skills to respond to the needs of the residents and to promote their safety and well being. For example, all staff had undertake human rights training as part of their induction process before commencing work within the centre. From observing staff engagement with the residents the benefits of human rights training was evident. For example, staff supported residents to choose their own breakfast, one resident chose to have scramble egg on toast and staff supported them to prepare this.

All staff had up-to-date mandatory training such as fire safety, medication management, people and moving handling along with centre specific training such as diabetes and Feeding Eating Drinking and Swallowing. With the exception of medication management training agency staff were also trained in the above to ensure they had the appropriate skills to support the residents within the designated centre.

The person in charge had a schedule in place to ensure all staff received supervision twice yearly as per providers policy. The inspector reviewed five staff supervision record for the year 2024 and they were found to be up to date and included detailed discussions and actions identified. Staff awareness of safeguarding was an ongoing discussion throughout all supervisions. The person in charge discussed the role and responsibility the staff member holds when safeguarding the residents living in this designated centre.

Judgment: Compliant

## Regulation 23: Governance and management

There were clear lines of authority and accountability in this centre. There was a clearly defined management structure in place which was lead by the person in charge who also had responsibility for three other centres operated by the same provider. They were supported in their role by a full time team leader who was also across the same four centres. The person in charge and the team leader were supernumerary to the roster at all times.

The person in charge held a qualification in social care and management. They were found to have good organisational skills and very knowledgeable of the residents living in the centre. The residents were observed to be relaxed and seeking interaction from the person in charge when they arrived in the centre. The inspector spoke with one staff member who reported they can always go to the person in charge to discuss or report any concerns. They expressed how the person in charge is regularly in the centre and is always available by phone during working hours. This staff member was also aware of the on call system that was in place for support if required at night. The availability of the person in charge and the staff awareness of the lines of authority provided assurance that reporting was welcomed.

The designated centre had been audited as per the requirements of the regulations. An annual review of the service has been completed in February 2024 and two six monthly unannounced visits to the centre completed in May 2024 and November 2024. The audits contained great detail about the centre and actions had been identified for any areas requiring improvements. For the most part these actions had been addressed in a timely manor and were seen on the day to be completed. For example, the annual audit had identified some members of the staff team training had expired, on review of training records on the day of inspection all staff had up to date training. Although, all three audits had identified maintenance works required to the main bathroom this had not yet been completed, this is discussed further in regulation 17.

It was observed that the oversight and management of some peer to peer related incidents and subsequent safeguarding plan in place were reviewed and discussed on a regular bases by the person in change and the staff team. For example safeguarding had been record as discussed at personal planning meetings, team meetings, supervisions and residents meetings. This ensured the plan was implemented and effective at all times, therefore keeping the residents who lived in the centre safe.

Judgment: Compliant

## Quality and safety

Overall, the inspector found that the quality and safety of care provided for residents, were of a good standard. The inspector observed that residents had opportunities to take part in activities and to be involved in their local community. Residents were actively making decisions about how they wished to spend their time, and were supported in developing and maintaining connections with their family and friends.

The premises was spacious and suitable for the needs of the residents living there. The centre had a large sitting and dinning area along with a spacious activity room this supported the safeguarding plan in place and allowed residents to have their own space. However, improvements were required in some areas of the premise including the main bathroom and garden to the rear of the house.

The management and staff team were striving to provide person centred care to the residents in the centre. This meant that residents were able to express their views, were supported to make decisions about their care and that the staff team listened to them.

Safeguarding concerns were being identified, reported to the relevant authorities and managed well within the centre. However, improvements were required in the use of restrictive practice for each resident in the centre.

### Regulation 10: Communication

Residents communication needs were outlined in their personal plans and throughout their behaviour support plans. Staff were familiar with their communication requirements and this was observed by the inspector on the day of inspection. One resident had a specific preference as to how requests were phrased and staff done this with ease through their conversations with them. For example, these bins are heavy do you think you could give me a hand instead of will you take the bins out was found to be very effective. Staff were aware of the facial expressions of one residents that can have a negative impact on the other residents in the centre. As part of the safeguarding plan in place when both residents were in the one area staff positioned themselves in the direction of this residents which reduced the risk of them making such facial expressions that might upset the other resident.

The inspector reviewed 12 months of residents meetings and it was clear this form was being used to allow residents communicate their needs and wishes on a weekly bases. Sometimes these meetings were held individually with residents and sometimes with both present, staff followed the lead of residents and when they wished to engage in the meeting. Topics such as meal planning and activity options

along with personal wishes such as redecorating their room were all discussed and recorded. Actions were set out, followed and were seen to be achieved week on week. Residents also had the opportunity to look at easy read policies during residents meetings. For example,one week an easy read document on restrictive practice was discussed. It contained pictures of restrictions such as, window restriction's, locks and chemical presses, residents responses were recorded one of which was "these keep me safe".

Judgment: Compliant

## Regulation 17: Premises

The premises was laid out to meet the assessed needs of the residents and generally kept in a good state of repair. The property was well ventilated throughout, with the provision of adequate lighting and heating so as to ensure a comfortable and safe living environment for the residents.

Each resident had their own bedroom which were decorated to their individual style and preference. One resident had recently requested to update their bedroom decor and this was facilitated. Their rooms provided a safe and private space for them to relax in and spend time by themselves. One residents had an en-suite bathroom that was found to be in good condition and kept clean. The other resident used the main bathroom which was in need of maintenance works, there was evidence of dirt build up on the floor covering especially around the shower and toilet area. Furthermore, there was evidence of rust around the toilet and the top of the radiator. As previously mentioned the provider had already identified these issues in their internal audit but the works had not been completed several months later.

The centre had a front and rear garden as part of the property. The garden to the rear included a pathway around the rear of the property with access to a garden shed and a patio area with garden furniture for residents. This area required some attention, there was build up of moss making it slippery and increasing the risk of falls for the residents.

The downstairs of the property had an accessible kitchen, a large sitting and dinning area along with an activity room which had an additional table where residents could eat meals if they wished. This supported the current safeguarding plan as residents could have time apart.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

There were systems in place to identify, manage and review risks in the centre with a focus on residents safety. The inspector reviewed all risk assessments available on the provider's online system. This included both centre specific and individual risk assessments. From review of the documentation and discussion with the person in charge it was clear that they had good oversight of the current risks within the centre. The inspector reviewed the formal safeguarding plan in place for low level peer to peer incidents between the two residents. This plan was reflected in the risk assessments and the same control measures were in place. Risk assessments were also developed to reflect any restrictive practices that were currently in place within the centre.

The person in charge reviews all risk assessments every three months or as the need arises.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

The inspector review each residents personal plan and found them to be clearly laid out and contain good guidance. For example one sections is titled how I consent and how I do not consent. This section goes into great detail about the residents tone of voice, facial expressions, presentation and phrases they use to indicate if they would or would not like to do something. This offers good guidance for staff to support the residents to make everyday choices.

Each person plan had been reviewed yearly or sooner if required. For example, one resident had a recent change in home visits and this was reflected in their person plan and discussed at the staff team meeting to ensure the resident received consistent response and reassurance's about home visits. It was also noted that relevant clinical professionals were involved to support this recent change for the resident.

From the inspectors conversations with residents, it was clear resident were supported to make choices about how they wanted to live. For example, one resident informed the inspector they like to have a rest in the morning and get up when they are ready. This was observed on the morning of inspection and staff were respectful of their decision.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Both residents had detailed positive behaviour support plans in place. These plans

discussed the history of the residents support needs along with proactive and reactive strategies to use when the residents requires support. These plans were individual and specific to the residents assessed needs. For example, to maintain good health and well being one resident was advised by their GP to walk one kilometer per day, if the residents declines to go for a walk staff offer to go into town with them to look around the shop, therefore, still completing their exercise programme but less focus is on the walk specifically which is a know trigger for behaviour.

The behaviour support specialist (BSS) has known both residents for a number of years and is very familiar with their support requirements and preferences. Both residents have weekly visits with the BSS which they enjoy. Alternative arranges are made when the BSS is on leave to ensure these visits remain in place. From review of daily notes the inspector observed where one resident requested staff to contact the BSS. The resident wanted to request an additional visit that week as they had something they wanted to talk about. Staff member followed up with the request and an additional visit was arranged for the resident the following day.

However, while restrictive practices that were currently in place within the centre were identified, recorded and reviewed recently by the restrictive practice committee the inspector found them not to be the least restrictive. A door into an empty bedroom was locked and all four external doors leading into an enclosed back garden were also locked on an ongoing bases. These were recorded as necessary due to the risk of absconding by both residents. Staffing ratios of 1:1 were in place through the day from 09.00-20.00 as per safeguarding plan and the side gate to the property was also locked at all times to ensure residents couldn't abscond and wander out to the main road. This required review by the provider to reduce the impact on the residents. Actions were taken by the person in charge to unlock these doors on the day of the inspection.

Judgment: Substantially compliant

## Regulation 8: Protection

The inspection found that, safeguarding concerns were being identified, reported to the relevant authorities and managed with appropriate control measures in place within the centre. There was ongoing review of the safeguarding plan to sure it was effective.

From review of the documentation it was evident that there was consistent guidance for staff across all documentation such as safeguarding plan, risk assessments, personal plans and positive behaviour support plans and ongoing discussions at supervision and team meetings on the topic of safeguarding. This ensured staff were aware of their role in keeping the residents safe. All staff had received training in the safeguarding of residents, and were aware of the various types of abuse, the signs of abuse that might alert them to any issues, and their role in reporting and

responding to those concerns. The residents were also kept informed about their right to raise a concern and how to make a complaint to the staff team or the person in charge through your say conversations and residents meetings.

Each resident had detailed intimate care plans in place. These plans guided staff in the areas the resident required support and their preferences around these supports.

Judgment: Compliant

## Regulation 9: Residents' rights

From review of documentation, discussion with staff members on duty on the day of the inspection and the person in charge and from the inspectors observations, residents were supported to exercise their rights. Residents were provided with relevant information in a manor that was accessible to them and given time to make a decision. They were supported to make choices about how they wished to spend their day. For example, in the past each resident had a weekly planner in place which they did not respond well to, this planner was removed and now each resident is supported by their staff member to discuss their options for the day make a plan that suits them on each given day.

There was a culture of openness in the centre, residents and staff had regular 'your say' conversations to reflect conversations that were had on a specific topic. For example, restrictive practices within the centre, advocacy or staying safe.

The provider had ensured that residents were informed of their right to access independent advocacy services this was on display within the centre and discussed at residents meetings and as mentioned your say conversations.

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 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Cashel Downs OSV-0005610

## Inspection ID: MON-0045603

## Date of inspection: 05/12/2024

**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 17: Premises | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>PIC has emailed the maintenance team to complete all identified works highlighted in this inspection, with a timeframe of 1 month to be completed. 31.01.2025 items highlighted in this report will be completed. PIC also has informed maintenance that all identified items in the future will be completed by staff on the DMS system and the PIC will follow up with maintenance to set up a completion date in a timely manner. | |
| Regulation 7: Positive behavioural support | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>On the day of the inspection the PIC had identified restrictive practices removed and has since updated the restrictive practices and risk assessments, these restrictive practices have been permanently removed and will be fully removed at the of quarter 1 in 2025, This action has been completed (3.1.2025) | |

## 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 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. | Substantially Compliant | Yellow | 31/01/2025 |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 03/01/2025 |