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:	Comeragh Services Tus Nua
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	13 February 2024
Centre ID:	OSV-0007383
Fieldwork ID:	MON-0038163

About the designated centre

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

Comeragh Services Tus Nua consists of a bungalow located in a rural area. The designated centre provides a full-time residential service for a maximum of three male residents with intellectual disabilities, between the ages of 40 and 65. Each resident has their own bedroom and other facilities in the centre include a kitchen, a dining room, two sitting rooms, a staff office and bathroom facilities. Residents are supported by social care workers and care assistant staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Tuesday 13 February 2024	09:25hrs to 17:10hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to monitor the centre's level of compliance with the associated standards and regulations. Overall, the findings of this inspection were that a number of improvements were required across a number of regulations to ensure the service provided to residents was safe, consistently monitored, and promoted good quality outcomes for all residents that lived in the centre. Resources such as staffing and access to transport required review. The impact of the lack of resources meant that some residents were spending the majority of the time in their home with minimal access to the community and meaningful activities.

The inspector arrived to the centre on the morning of inspection. On arrival at the centre there were building works taking place in the kitchen/living area. Brick work was being completed and there was a wheel barrow full of cement in the kitchen. There were dishes present on the kitchen table and one resident was up and about for the day. They were going in and out of the kitchen area to get items for their day. Although the building works would allow more space in the area it was found that the risks associated with completing building works in the home was not appropriately risk assessed. This is discussed further in the relevant section of the report.

The resident that was up and about, greeted the inspector and asked some repetitive questions in relation to their routine. This was in line with their communication needs. The resident appeared eager to leave the home to attend their day service. They attended day service five days a week. During this time staff were seen to support the resident in a kind a caring manner. They answered the resident's questions and helped them to get their belongings to leave the home. A staff member left with the resident to bring them to the day service. The staff member returned later in the morning with some shopping.

The other two residents were in bed. Neither resident attended a day service. This was due to their changing needs and associated cognitive decline. The residents were helped to get up out of bed at mid-day. Two staff were in the home at this time to support the residents with these tasks. Both residents required two-to-one support to transition from the bedroom to the sitting room or kitchen due to declining mobility and associated risks of falls. The residents spent the day in the kitchen/living area. One resident sat in the living room and a movie was playing on the television. Staff placed two sensory items in front of the resident. When the second resident got up for the day they sat at the kitchen table. The residents remained in these seats for the entirety of the inspection day. Although staff were kind in their interactions and support there was limited range of activities for the residents to complete. They did not leave the home. There was limited opportunities for the residents to leave the house and this is discussed further in the report.

As part of the inspection process the inspector completed a walk around of the

home. The designated centre comprises a detached bungalow building in a rural area of Co. Kilkenny. Residents each had their own individual bedroom. There was a bathroom available for resident use, with an accessible shower. Residents also had access to a sitting room and a separate living/kitchen area. In addition there was a room allocated to store items, a staff office and a second small bathroom with a toilet and sink. The house was clean and overall well maintained. Storage was an issue within the home due to the size of the property. However, for the most part it presented as well organised and comfortable. Bedrooms had some personal items on display but due to the size of the rooms this was limited. Residents had televisions in their bedrooms.

On the day of inspection, two of the residents had no scheduled or pre-planned activities to engage with. Although some in-house activities such as music therapy and reflexology were in place, this occurred on two set days of the week. For the other five days there were limited plans in place for the residents and they spent the majority of time in the home. It was discussed with the inspector that the residents left the centre on occasion to visit a coffee shop, however, this had to be pre-arranged due to issues with transport. Although there were vehicles allocated to the centre these were not suitable as they were not wheelchair accessible.

The next two sections of the report outline 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 residents.

Capacity and capability

Overall, the inspection findings indicated that the centre did not have adequate resources in place nor adequate governance and management systems, to ensure residents were in receipt of a service that was promoting good quality of care. It was found that residents access to meaningful activities and access to community were very limited at the time of inspection. In addition, risk management and medication management was not in line with best practice. Management and oversight of these areas of care and support was not sufficient to identify areas of poor practice in a timely manner.

There was a clear management structure in place. The centre was managed by a full-time person in charge who was solely responsible for the designated centre. The person in charge was not supernumerary to the staff team. The provider had allocated 12 hours per fortnight to the person in charge. These hours were earmarked for the person in charge to complete their relevant managerial responsibilities. However, due to insufficient staff the person in charge was mainly using these hours to provide direct support to residents. This meant that there was limited time for the person in charge to complete relevant tasks accordingly.

On the day of inspection the inspector requested the whole-time equivalent staffing needs of the centre. This information was not available to the inspector on the day

of inspection and was later emailed subsequent to the inspection. It was unclear if this information was based on the assessed needs of residents. From speaking with staff and reviewing relevant documentation there was insufficient staff numbers in place to support residents effectively and to promote a good quality of life.

Regulation 15: Staffing

There was a staff rota in place and this was reflective of the staff on duty on the day of inspection. Residents were supported by a skill-mix of a social care worker and care assistants. The person in charge was responsible for the upkeep of planned and actual rosters and these were well maintained. Overall, continuity of care was demonstrated with use of agency staff and relief staff as required to cover unexpected and planned absences of staff. The person in charge had oversight of the agency staff and chose regular staff when possible.

The residents were supported by two staff during the day and one waking staff member at night. However, it was not demonstrable that this was sufficient to meet all the needs of the residents. For example, two residents were assessed as needing two-to-one support to transfer in the home environment due to declining mobility needs. As only two staff were present this meant access to the community had to be limited as the staff were required to be in the home to ensure basic care needs could be met. This directly impacted residents general welfare and development which is discussed further under Regulation 13.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were completing training and refresher training in line with the provider's policy and the residents' assessed needs. For example, the team where required had completed dementia awareness training. There was a training matrix in place that identified when staff required refresher training in relevant areas.

A new person in charge had been appointed to the centre in the latter half of 2023. They had ensured that they had completed a formal one-to-one supervision with each staff member. A sample of notes were reviewed and it was found that staff were discussing issues directly relating to the care and support of residents to ensure they were supported in relevant areas.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the centre was resourced to ensure the effective delivery of care to residents. The provider had further failed to ensure that the management systems in the centre were sufficiently robust to ensure that the service provided was consistently safe, appropriate to resident's needs, consistent and effectively monitored.

The centre did not have sufficient staffing in place to meet the needs of all residents. As previously highlighted under Regulation 15 only two staff were present for day time support. This meant that staff were only available to ensure residents' care needs were met. If residents wanted to access the community or attend an appointment a third staff member would have to be sourced. For the most part the person in charge was using their supernumerary hours to complete some of these activities with the residents. Therefore the resources of supernumerary hours were not being allocated to managerial and oversight responsibilities. This was having a direct impact on levels of local oversight discussed further below.

In addition, although there were vehicles assigned to the centre, two of the three residents could not use these vehicles as they were not wheelchair accessible. If residents required transport it had to be requested from another centre operated by the provider or wheelchair accessible taxi's had to be sourced. This was a barrier to residents accessing the community on a frequent basis.

The provider completed audits of the quality of care and support provided to residents as required by the Regulation. These included the six-monthly unannounced audits and annual review. However, some local audits such as the person in charge monthly audit and infection prevention and control audit had not been completed in a number of months. For example, the most recent person in charge monthly audit available was dated May 2023.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of notifications submitted to the Office of the Chief Inspector occurred. For the most part all notifications were submitted as required.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and the majority of care was provided in line with each resident's assessed needs. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. This included meeting residents and staff, a review residents' documentation around healthcare needs, risk documentation, fire safety documentation, and documentation around the administration of medicine. A number of improvements were required in a number of areas to ensure the requirements of the regulations were met. Due to the improvements required it was found that residents' quality of life in terms of community access had been negatively impacted. In addition, poor medication practices had been in place in the centre which also posed a risk to aspects of residents' health and well being.

When speaking with staff it was discussed with the inspector that a residents prescribed medication for thickening fluids had been increased. This increase had occurred in November 2023 and was only reviewed by an appropriate health and social care professional the day prior to the inspection. This was not in line with best practice and could have posed a significant health risk to the resident.

As previously discussed some residents access to the community was impacted by insufficient staff and access to vehicles. Although the provider had taken some action on this by providing in house activities two days a week. The findings of the inspection indicated that residents were afforded very little opportunities for activities. For example, on the day of inspection, both residents remained in the home with the same activities in front of them for the majority of the time the inspector was present.

The approach to risk management in the centre required review. Risks were not always identified or assessed in line with the providers policy and best practice. In addition, risk assessments that were present were not relevant or in line with residents' specific assessed needs. Oversight of these procedures required improvement to ensure residents' access to safe services was considered in a robust manner.

Regulation 13: General welfare and development

Some residents activation and stimulation levels were observed to be poor in this centre and required significant review. Some residents left the service to attend day services whilst others remained in the centre. A number of residents were observed having very limited levels of activation, interaction and social engagement in their lives. For example, some residents did not leave the centre and were left to sit in the same area of the home for the majority of the inspection. Rotation of activities presented to the resident did not occur. In reviewing these residents progress notes, the inspector found this was their typical day. Residents were observed spending large periods of time sitting in chairs with limited daily activities planned and offered. For example, on review of one resident's recent progress notes it was

indicated they had left the home on two occasions in a six week period.

Judgment: Not compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and well maintained. The designated centre comprises a detached bungalow located in a rural area in Co. Kilkenny. All residents had their own bedrooms which were decorated to reflect their individual tastes with had some personal items in display. Although rooms were small, overall they were well kept and residents current care needs could be adequately met.

Judgment: Compliant

Regulation 26: Risk management procedures

It was found that risk management within the centre required significant improvements. There were systems in place to manage risks, however, they were not effective. For example not all risks were being identified. For example, the recent building works that had commenced had not been effectively risk assessed although residents were entering this area and food was being prepared in the area. In addition, there were no risk assessments around the risk of choking despite two residents requiring modified diets. Poor practices in relation to the use of a prescribed fluid thickener were in place as there was no risk guidance for staff.

A number of risk assessments that had been in place had not been updated in a timely manner. For example, risk assessments in relation to falls had been reviewed in December 2022. Residents mobility had significantly deteriorated in the last 12 months and some falls had occurred. Despite these changes risk assessments had not been updated to reflect additional control measures. Therefore these risks were not been managed through the appropriate risk management procedures.

A number of risk assessments made available to the inspector were irrelevant due to residents changing needs. For example, there was a risk assessment in place in relation to a resident having access to a cooking appliance. As this resident now required full staff supervision this was not longer a risk.

Judgment: Not compliant

Regulation 28: Fire precautions

The designated centre was provided with fire safety systems which included a fire alarm, emergency lighting, and fire containment measures. There were systems in place to provide regular internal checks to the fire safety systems. However, on review of the documentation it was found that one document did not direct staff on what element of fire safety checks they were completing. Although staff had signed this document it did not provide assurances that all fire safety systems were being checked in a robust manner.

In addition, a hot press located in a kitchen area had items stored beside the heated water tank and posed a risk in terms of fire safety. This had not been identified as a potential fire risk. The items were removed on the day of inspection. The practice of storing items in this area required review from a fire safety perspective.

Although residents had personal evacuation plans, these documents were not updated following risks identified in fire drills. For example, a recent fire drill had identified that a resident had re-entered the building following an evacuation practice. Although this risk was identified, it was not accounted for in their personal evacuation plan.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had a policy, procedures and systems in place for the receipt, storage, return and administration of medications. However, on the day of inspection it was discussed with the inspector that a prescribed fluid thickener had been increased for one resident in November 2023. There was no evidence that a health and social care professional had been involved in this decision. There was no documentation in relation to this increase to guide staff practice. This was poor practice in relation to the administration of a prescribed medication. The day prior to the inspection a health and social care professional had consulted with the staff team in relation to this. They had advised that the resident thickener was to remain at a certain level for 48 hours and they had to be consulted following this period. Although the immediate risk has been mitigated because of this, staff practices were not in line with evidence based practice and the provider had insufficient oversight in place in relation to this.

In addition, although the provider had clear procedures in place around the storage of prescribed medication, the storage of fluid thickening agents was not occurring in line with the relevant policy. This required review.

Judgment: Not compliant

Regulation 6: Health care

Although the registered provider took measures to ensure residents healthcare needs were met, improvements were required in the documentation of healthcare plans. It was found that healthcare plans lacked information or had conflicting information or information that was not in line with relevant practices. As highlighted previously in the report a resident's prescribed thickener for fluids had been increased. There was no corresponding guidance in place for this. In addition, on file there was documentation in place with differing amounts of thickener stated. For example in a swallow care plan it stated that the resident was to receive Level 1 fluids, however in a document entitled 'This is me' it stated the resident was to have Level 2 fluids. Epilepsy care plans also had incorrect guidance for staff that was not being followed at the time of inspection. Overall, the inspector was concerned that documentation related to residents care and support needs created a risk for residents as the information and directions to staff were not clear or consistent.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to ensure that residents were safeguarded from abuse in the centre. Staff had completed training in relation to safeguarding and protection.Staff spoken with, were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. Staff were also familiar with who the designated officer for the centre was. Residents had intimate care plans in place which detailed the level of support required. Where there were safeguarding concerns, for the most part, there was evidence that appropriate safeguarding plans were in place which were monitored, reviewed and dealt with appropriately.

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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Comeragh Services Tus Nua OSV-0007383

Inspection ID: MON-0038163

Date of inspection: 13/02/2024

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • An up to date mobility assessment will be completed for two residents to ascertain the current potential changed needs. • The provider will ensure adequate staffing levels and skill mix are provided in line with the assessed needs of the residents.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A review of supernumerary hours will be undertaken by the Service Manager with the PIC to ensure that the allocated hours provide adequate opportunity for oversight of the designated centre. • The provider will ensure adequate staffing levels and skill mix are provided in line with assessed needs of the residents. • A wheelchair accessible transport has now been allocated to the designated centre to ensure residents have daily access to the community. • The PIC will ensure that monthly audits and infection prevention and control audits are completed and available for inspection in line with policy.	

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
An individual daily activity schedule will be developed for each resident with support from psychology and in line with needs and preferences.

• A recording sheet to document levels of participation in activities and social engagement will be maintained

• The residents will be provided with opportunities to engage in social activities outside the designated centre in line with their preferences

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A review of the risk register has occurred and this is reflective of the current potential risks identified in the designated centre.

• All staff will be refreshed in the falls pathway documentation that is in place by the provider.

• Training will be provided to the PIC and staff team by the Health and Safety Manager around risk management.

• A risk assessment in relation to choking has been completed for residents on swallow care plans

• Swallow care plan for one resident and has been reviewed by SLT with the guidance implemented by all staff.

• A referral to SLT has been made for the review of a swallow care plan for the second resident.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The documentation for fire safety checks will clearly reflect the elements of fire safety being assessed and recorded by staff.

• The hot press will not be used as a storage space for any items.

• Personal emergency evacuation plans have been updated to reflect the support needs of residents as identified in fire drills.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Swallow care plan for one resident has been reviewed by SLT with the guidance implemented by all staff. This information is recorded in relevant care plans.

• A referral to SLT has been made for a review of the swallow care plan for the second resident.

• The prescribed fluid thickener is now stored in line with medication policy.

• The provider will ensure that staff team are refreshed on the medication policy and practices.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The health care plans and documentation of the residents supported in the designated centre will be reviewed and updated to reflect current support needs.

• The health care plans will be reviewed for all residents to ensure no conflicting information remains.

• The guidance on the use of thickener as prescribed by SLT is reflected in swallow care plans and in all other relevant documents.

The epilepsy care plan now accurately reflects the management of seizure activity for one resident.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/04/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/05/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	31/05/2024

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/05/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/03/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/03/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable	Substantially Compliant	Yellow	31/03/2024

	practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/05/2024
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/04/2024