Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Ardnore
Centre ID:	OSV-0003412
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	S O S Kilkenny Company Limited by Guarantee
Provider Nominee:	Francis Coughlan
Lead inspector:	Lorraine Egan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 July 2017 08:10	12 July 2017 18:30
13 July 2017 09:45	13 July 2017 12:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This monitoring inspection was carried out to monitor compliance with specific regulations and to assess if the provider had addressed the actions from the previous inspection.

How we gathered our evidence:
As part of the inspection, the inspector met with the eighteen residents living in the centre. The inspector spoke with all residents and had individual meetings with six residents. All residents spoken with said they were happy living in the centre, felt safe, liked staff and could speak with the person in charge or staff if they had any concerns or complaints.

The inspector observed respectful interaction between residents and staff. It was evident that staff knew residents' needs and supported residents to maximise their independence.

The inspector also spoke with staff, the person in charge of the centre and a person participating in management and reviewed documentation such as residents' support plans, medical records, accident logs, policies and procedures and staff files.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. In the areas inspected, the inspector found that the service was provided as described in that document.

The centre comprised three houses which were located within close proximity to amenities. Residents were supported by staff to access amenities and the centre had the use of the provider's vehicles to support residents to access community based activities.

The houses contained adequate private and communal space to meet the needs of residents. Residents had individual bedrooms and shared bathrooms, kitchen/dining rooms and living rooms. The centre met residents' assessed needs in regard to the physical premises.

The service was available to adults with a mild to moderate intellectual disability. The centre provided a 'home from home' environment with a focus on supporting people to participate in their communities.

Overall judgment of our findings:
Overall, the inspector found that residents were supported to have a good quality life in the centre and the provider had arrangements to promote the rights and safety of residents.

The inspector found the provider had put a system in place to meet the requirements of the regulations. Seven outcomes were inspected and the inspector found the provider was compliant or substantially compliant in five outcomes.

Outcome 7 was judged as major non compliant as the systems to ensure all required fire control and evacuation measures were not implemented. The person in charge responded appropriately to the immediate risk identified on the days of inspection. Outcome 8 was judged as moderate non compliant as there was no arrangement to ensure a chemical restraint was administered as a last resort and some systems for supporting residents with their finances did not ensure that all residents would be protected from the risk of financial abuse.

The reasons for the findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents' health, personal and social care needs were assessed on an annual basis and reviewed annually or more frequently where required. Improvement was required to ensure the supports required to maximise residents' personal development were identified in plans and plans were reviewed for effectiveness.

The inspector reviewed a sample of residents' personal plans. Each plan contained an assessment and corresponding support plans where a support need was identified. Although residents had identified goals it was not clear that goals were focused on improving residents' quality of life. For example, many goals were one off activities.

The provider nominee had previously told the inspector the assessment documentation was being reviewed as it had been recognised that the format did not provide the best possible support for staff to carry out the assessments. The provider said the new tool would focus on identifying residents' social roles and supporting residents to identify new social roles and live meaningful lives. The projected date for completion of this was October 2017.

Notwithstanding the improvement required to documentation the inspector noted that residents were supported to live meaningful lives which were consistent with their assessed needs and wishes. Residents said that they had opportunities and were supported to engage in employment, attend training programmes and take part in leisure activities.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were systems in place to protect and promote the health and safety of residents, staff and visitors. Improvement was required to the systems to ensure all required fire control and evacuation measures were implemented.

The risk management policy outlined the measures and actions in place to control risks in the centre. The inspector viewed a sample of risk assessments and saw risks had been identified by the provider and control measures had been implemented to address or minimise risks.

The inspector viewed some residents' risk assessments. The risk assessments outlined the individual risks to residents and the associated control measures to mitigate the identified risks. In the sample viewed the inspector found the control measures identified were implemented.

There was a fire safety folder in the centre. The folder contained the system and documents to show all equipment was serviced and regular checks were carried out on all aspects of fire safety.

The fire fighting equipment and emergency lighting had been serviced. A service contract was in place with an external company to ensure this was carried out as frequently as required.

The majority of fire doors in one house did not have intumescent strips or cold smoke seals. This included resident bedroom doors which were located on the first floor and the staff bedroom door which was located on the ground floor. This raised concern that the doors would not provide effective protection for residents in the event of a fire. This was brought to the immediate attention of the person in charge. The person in charge arranged to have this addressed immediately. The inspector received email and photographic confirmation that this had been addressed the day after the inspection.

The back garden of one house could not be exited as the lock was on one side only. This raised concern if an evacuation of the centre was required as residents would be unable to exit the back garden. This had been identified in a fire drill in April 2017 and had not been addressed. This was brought to the attention of the person in charge. The

inspector received email and photographic confirmation that this had been addressed the day after the inspection.

The inspector viewed the fire drill records in one house. Fire drills were a mechanism the provider used to assess if the centre could be evacuated safely. Residents and staff had taken part in fire drills and fire drills had taken place in the early morning, when residents were in bed, to assess if the house could be evacuated at night. However, two thirds of staff in one house had not taken part in a fire drill in the house. This was brought to the immediate attention of the person in charge who stated that all staff working in the centre will take part in a fire drill to ensure that staff are familiar with the procedure for evacuating the centre.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. Measures to ensure that residents received support with any behaviour which may impinge on their quality of life and on other residents were implemented. Improvement was required to the measures in place to ensure behaviour support plans included all identified interventions and to ensure residents were safeguarded from the risk of financial abuse.

There were measures in place to keep residents safe and protect them from abuse. Staff and the person in charge were knowledgeable of the procedures for safeguarding residents and reporting any suspected or confirmed allegations of abuse. Staff had received training in safeguarding residents.

Residents who required support with behaviours that challenge had support plans in place. Staff were observed supporting residents in a manner consistent with their positive behaviour support plans. However, the inspector noted that a resident's support plan did not reference a PRN medicine (a medicine only taken as the need arises) which

was prescribed in July 2017 to support the resident. This had not been identified prior to the inspection. While the inspector noted that this medicine had not yet been administered there was no guidance for staff to ensure the medicine was administered as a last resort.

The inspector reviewed the arrangements for supporting residents to manage their finances. There were clear procedures which were audited regularly by a person participating in the management of the centre. A record of incoming money and expenditure was maintained and receipts were in place for all expenditure in the sample viewed. However, the records were not reconciled with residents' bank account statements and therefore it was not evident if the amount documented as deducted from residents' accounts was consistent with the amount documented as received in the centre.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents were supported to achieve and enjoy the best possible health. There were systems to ensure residents' healthcare needs were identified and responded to.

Residents were supported to access a general practitioner (GP) of their choosing and allied health professionals such as psychology, psychiatry, chiropody and dietitian where required. Each resident attended the dentist for an annual review.

Residents had blood tests on an annual basis and more frequently where there was an identified need.

Documentation outlining the assessment of residents' healthcare needs was maintained and staff were knowledgeable of the interventions outlined in residents' support plans.

Residents were supported to access health professionals and support was provided to the extent required by residents.

Judgment:

Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were written policies relating to the ordering, prescribing, storing and administration of medicines to residents.

The inspector viewed the management of medicines. Medicines were stored in locked cabinets which were located in the staff offices. Staff on duty were knowledgeable of the medicines which were prescribed for residents.

Prescription sheets contained all required information to guide staff when administering medicines with the exception of the route some medicines were prescribed to be administered. The inspector noted that this related to one type of prescription sheet used in the centre.

Staff who administered medicines had received training. This included refresher training at regular intervals. The provider employed nurses who were available if staff had any queries or concerns.

There were procedures in place to ensure all medicines which were received were administered to the resident for whom it was prescribed or returned to the pharmacy for disposal.

There was a system for reviewing and monitoring safe medicine management practices. Audits were carried out and corrective action taken where required.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and

responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were clear lines of authority and accountability. The person in charge and a person participating in management were present and available on the days of inspection. It was evident that members of the management team knew residents and were aware of their needs.

There were systems to ensure the centre was governed on a regular and consistent basis. There was a frontline manager who reported to the person in charge. The frontline manager was responsible for the day to day operational management of the centre. There were systems to ensure this role was filled in the absence of the frontline manager. The person in charge held the role and residents and staff were aware of this.

The person in charge was knowledgeable of her role, responsibilities and had experience of working with people with disabilities and managing services. She held the role of person in charge of a number of the provider's designated centres.

It had been acknowledged by the provider that the system for auditing the service provided required improvement. This was in the process of being addressed at the time of the inspection.

The provider had carried out unannounced visits to the centre and prepared reports on these visits. An annual review of the quality and safety of care had taken place in 2016. These included action plans arising from the visits and there was evidence actions had been addressed. A family and resident satisfaction survey had taken place.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were appropriate staff numbers and skill mix to meet the assessed needs of residents. Staff were supervised on a day to day basis by the frontline manager and by the person in charge when the frontline manager was absent from the centre. In addition, there were arrangements for formal appraisal meetings and supervision meetings were due to commence in the centre.

The staffing levels were based on the assessed needs of the residents and the inspector was told these were continually reviewed to ensure the needs of residents were met. The inspector noted examples of this in the months prior to the inspection and noted that some residents were supported to stay in the centre rather than going to their day programme when they wished to semi-retire.

There was a staff rota which identified staff working in the centre. In addition, there was a photograph roster to ensure residents knew the staff member who would be working in the centre each day and night.

Staff had received all required training and refresher training was arranged as required. This included training in fire safety, administering medicines, adult protection and the management of behaviour that is challenging. It had been acknowledged that manual handling training was required for staff and the provider was in the process of addressing this.

The inspector found that some residents required support with bereavement and loss. This had been acknowledged by the person in charge who outlined the difficulty with finding appropriate supports. The person in charge said that training would be sourced for staff to support residents in this area.

The inspector viewed a sample of staff files. The files contained all information required by Schedule 2 of the regulations.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Lorraine Egan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by S O S Kilkenny Company Limited by Guarantee
Centre ID:	OSV-0003412
Date of Inspection:	12 and 13 July 2017
Date of response:	11 August 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supports required to maximise residents' personal development in accordance with their wishes were not identified in all personal plans.

1. Action Required:

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
The organisation is reviewing the documentation being used in person centred planning as the existing format does not meet the criteria required.

The revised document will focus on identifying residents' social roles and supporting residents to identify new social roles and live meaningful lives.

Proposed Timescale: 31/10/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews did not assess the effectiveness of each plan.

2. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The organisation is reviewing the documentation being used in person centred planning as the existing format does not meet the criteria required.

The revised document will focus on identifying residents' social roles and supporting residents to identify new social roles and live meaningful lives.

Proposed Timescale: 31/10/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff had not taken part in a fire drill in the centre.

3. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Staff who have not part taken in a fire drill in the centre will do so.

Proposed Timescale: 31/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some bedroom doors did not contain cold smoke seals and intumescent strips.

4. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
All seals and strips have been replaced.

Proposed Timescale: 14/07/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were ineffective measures to ensure that a chemical restraint was applied in line with national policy.

5. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
An additional protocol has been put in place.

Proposed Timescale: 04/08/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One aspect of the arrangements for protecting residents from the risk of financial abuse was not adequately effective.

6. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
The finance Policy was reviewed to include auditing procedures to ensure records are reconciled with the resident's bank accounts. This new procedure is being rolled out in the Centre.

Proposed Timescale: 31/08/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some medicine prescription sheets did not specify the route medicines were prescribed to be administered.

7. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
We consulted with the pharmacist who confirmed that the biodose suppliers documentation is in line with current legislation and the pharmacist has issued us a letter to be placed in each location which states that "All medication included in the Biodose pods are to be administered orally. The biodose pod system is used exclusively for oral preparations". This letter will be copied to each location in the Centre.

Proposed Timescale: 21/08/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff required training in manual handling and in supporting residents with bereavement and loss.

8. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional

development programme.

Please state the actions you have taken or are planning to take:
A training plan is being put in place to provide manual handling training for all staff in the Centre. Appropriate training is being sourced for bereavement and loss and this will be rolled out to staff in the Centre.

Proposed Timescale: 28/02/2018