Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Shalom
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	06 February 2019
Centre ID:	OSV-0002619
Fieldwork ID:	MON-0023341

About the designated centre

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

Shalom provides both full-time and shared care residential services to adults with a low to moderate intellectual disability. The centre is managed by the Health Service Executive (HSE) and is located on the outskirts of a town in Co. Sligo. This centre comprises of a bungalow dwelling and accommodates up to four residents. Residents have their own bedroom and also have access to a communal kitchen dining area, utility room, shared bathroom and sitting room. Residents also have access to a well-maintained garden space both to the front and rear of the centre.

The following information outlines some additional data on this centre.

Current registration end date:	06/11/2020
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 - 2015 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
06 February 2019	09:30hrs to 16:30hrs	Thelma O'Neill	Lead

Views of people who use the service

The inspector did not meet residents living at the centre as they were attending their day services on the day of inspection. Residents were offered the opportunity to meet the inspector during the day, however they chose not to do so.

Capacity and capability

The inspector found that the provider had ensured that residents living at the centre received individualised and person centred care. The service provision and quality of care delivered was found to be of a high standard in most of the areas inspected. However, improvements were required in the governance and management and oversight of the centre.

There were arrangements in place for the governance, leadership and management of the centre. However, on the day of inspection there was a vacancy within the current governance structure which impacted on the effectiveness and oversight of the service being provided. The inspector found gaps in the management and leadership arrangements, as the person in charge was directly managed by the Director of Service, who had a very large geographical remit with responsibility for over 35 designated centres. As a result of this and the vacant management position, there was an absence of senior management oversight at the centre . The inspector found that regular supervision arrangements were not in place to support the person in charge, and actions identified in the provider's unannounced six monthly audit in March 2018 and the annual review of the care and support provided had not been addressed. Furthermore, the provider had not ensured that unannounced visits to the centre were undertaken every six months as required under the regulations, with the centre's last visit being the aforementioned visit in March 2018.

There was a consistent staff team working in the centre that were familiar with residents' care and support needs. All staff working at the centre were recruited and supported through education and training as per the organisation's policies and procedures. The person in charge was responsible for a further two designated centres in the local area, and had arrangements in place which ensured they were regularly present at the centre. However, the person in charge had not ensured that all required documentation under the regulations were kept up-to-date and appropriate system audits were completed as required.

Residents' rights were actively promoted in the centre. The person in charge was very respectful of residents and knowledgeable of each resident's needs. Weekly meetings were held with residents in the centre. These meetings provided residents with an opportunity to discuss areas such as activity planning, meal planning and any other topics of interests to them. Evidence reviewed showed that residents were

very complementary of the care and support they received at the centre. A complaints register was maintained by the person in charge, however no complaints had been received to date at the centre.

Regulation 14: Persons in charge

The person in charge was full-time and met the requirements of Regulation 14.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that appropriate numbers of suitably skilled staff were in place at the centre to meet residents' assessed needs in a timely manner and support them to participate in activities of their choice.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had arrangements in place which ensured that staff had regular access to training to meet both the assessed needs of residents and regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The provider's management arrangements had not ensured that actions previously identified in audits and annual reviews were completed. Furthermore, vacancies in the provider's management structure impacted on the oversight arrangements for the centre such as the absence of ongoing support and supervision for the centre's person in charge.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose that described the service being provided to residents and met most of the requirements of the regulations. However, it did not clearly state some of the information required by Schedule 1 of the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incidents recorded for residents in this centre over the previous year. Incidents that required notification had been submitted in all instances.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had not ensured that all policies required under the regulations were available to staff in the centre. In addition where policies were available to staff, not all had been subject to a review in-line with regulatory time frames to ensure they reflected up-to-date development in health and social care.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints register was maintained at the centre, however not complaints had been received to date.

Judgment: Compliant

Quality and safety

Overall, the provider had ensured the service provided to residents was safe, met their health care needs and provided them with opportunities to engage in activities

in-line with their assessed needs.

Person centred planning had ensured that residents were supported to achieve their personal goals. Furthermore, where residents' required assistance with their health care needs, an associated support plan was in place which incorporated allied health professionals' recommendations. However, annual reviews into the effectiveness of personal plans had not occurred for all residents at the centre.

Where residents presented with behaviours that challenge, behaviour support planning was in place. Positive behaviour support plan identified specific triggers which may elicit behaviours that challenge and identified de-escalation techniques and strategies to manage those situations. Staff knowledge on the management of behaviours that challenge was also assisted by their relationships with residents, who they had supported for many years.

There were no safeguarding concerns reported in this centre at the time of the inspection. Safeguarding arrangements ensured that residents were protected from possible abuse in-line with the provider's policy. In addition, a designated safeguarding officer was assigned to the centre, which ensured a timely response and investigation of any safeguarding concerns should they occur.

The provider had also ensured that effective risk management arrangements were in place at the centre, with risk management policy for Shalom keeping residents protected from harm and meeting the the requirements of Regulation 26. Appropriate fire safety precautions and measures were in place at the centre with their effectiveness being assessed regularly through fire drills and checks of fire fighting equipment. Furthermore, staff knowledge on what to do in the event of a fire was kept up-to-date through regular access to fire safety training.

Regulation 10: Communication

Residents living in this centre were able to communicate verbally and staff said they liked to use assistive technology as a method of communication. However, access to the Internet in the centre was poor and this impacted on the residents ability to use assisted technology to support their needs. In addition; staff's access to technology was also limited which impacted on their ability to support the residents in achieving their personal goals.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents were supported with their personal possessions, including access to their own money. Capacity assessments had been completed with residents since the last

inspection and clearly described the supports they required to manage their money.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the premises met the aims and objectives of the service and residents' assessed needs. Furthermore, the premises was of sound construction and in a good state of repair.

Judgment: Compliant

Regulation 26: Risk management procedures

Robust and effective risk management arrangements were in place, with an up-to-date risk register maintained in the centre. Risk were identified, analysed and control measures implemented to reduce any possible harm to residents.

Judgment: Compliant

Regulation 28: Fire precautions

Appropriate fire safety measures and equipment was in place at the centre, which were assessed regularly to ensure their effectiveness in evacuating residents in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had received a health care assessment and where needs were identified an associated support plan was in place. Residents' personal plans also incorporated allied health professional reviews; however, not all residents' support plans had been reviewed on an annual basis.

The inspector was shown evidence that the residents had active lives and were supported to achieve a lot of their social goals throughout the year. However, where annual reviews had taken place it was not clearly documented if residents or their

representatives had been invited to the meeting, or had been involved in choosing activities and social goals for the coming year.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' health care was managed to a good standard in this centre.They had access to allied health professionals and there was a nurse appointed to support their assessed needs on a part-time basis at the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required behaviour support , plans were in place which followed positive behaviour support guidelines and principles. These plans had been reviewed recently by an allied health professional and there was also evidence that supports were in place and available to residents as and when they required them.

There was no restrictive practices in place in this centre.

Judgment: Compliant

Regulation 8: Protection

The provider's safeguarding of vulnerable adults policy and procedures ensured that residents were protected from the risk of abuse. Furthermore, staff knowledge was kept up-to-date through regular safeguarding training opportunities. The person in charge advised the inspector that there were no safeguarding concerns reported at the centre.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Shalom OSV-0002619

Inspection ID: MON-0023341

Date of inspection: 06/02/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 23(1) (c) The register provider shall ensure that the actions identified on the 6 monthly, annual review and audits are reflected and monitored through the service Quality Improvement Plan (QIP) the QIP will be monitored on a weekly basis until the service is satisfied that all actions have been completed. 23(2)(a) The register provider shall ensure to carry out an unannounced visit at least every 6 months and shell prepare a written report on the safety and quality of care and support provided in the centre. 23 (3)(a) The register provider shall ensure that effective measures are in place to support develop and performance all members of the workforce.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: 3(2). The registered provider shall review the statement of purpose (SOP) of intervals of not less that year. This SOP shall reflect the information set out in the certificate of registration.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: 4(3) the register provider shall ensure that all Policies and Procedure as set out in	

Schedule 5 are reviewed and available to staff to ensure they reflect up to date development in health and social care. This Schedule 5 folder will continue to be subject to Audit Quarterly as part of the services Self-Assessment Judgement Framework.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Internet in the centre was poor and this impacted on the residents ability to use assisted technology to support their needs.
10(3)(a) The register provider shall ensure that residents have access to Internet through the local Library.

10. the register provider shall ensure that Internet access will be made available to staff to support them to access their HSE emails and support residents to explore and achieve their goals.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
5(1)(b) the person in charge shall ensure that an annual review is carries out annually and that it is clearly documented that residents and their representative had been invited to the meeting or had been involved in choosing activities and social goals for the coming year. Reviews already in place shall be retrospectively reviewed to reflect this outcome.

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 10(3)(a)	The registered provider shall ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.	Substantially Compliant	Yellow	31/05/2019
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	12/02/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit	Not Compliant	Orange	18/02/2019

	to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	20/02/2019
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	20/02/2019
Regulation 04(3)	The registered provider shall review the policies and procedures	Not Compliant	Orange	20/02/2019

	referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	20/02/2019