Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Skylark 1
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	20 August 2018
Centre ID:	OSV-0004832
Fieldwork ID:	MON-0024674

About the designated centre

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

Skylark 1 comprises of three, two-storey houses on the outskirts of Limerick city. Two of the houses are within a short walking distance of each other. Each house has its own outdoor area and is located near many social and recreational amenities including local shops and services, and transport links. Each resident living in the centre has their own bedroom, some of which are en-suite. The centre provides a residential service to people aged over 35 years old, who have an intellectual disability.
Skylark 1 is open 365 days a year. When residents are attending day services, the centre is not staffed. It is stated in the statement of purpose for the centre that the purpose of Skylark 1 is to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person.

The following information outlines some additional data on this centre.

Current registration end date:	30/11/2018
Number of residents on the date of inspection:	7

How we inspect

To prepare for this inspection the inspector or 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
20 August 2018	09:30hrs to 16:00hrs	Mary Moore	Lead

Views of people who use the service

Seven residents live in this centre; many of the residents are very independent and attend their day service on a daily basis. Residents had just left for the day service as the inspector arrived. However, inspectors had spent time with all seven residents living in the centre on the previous inspection in May 2018.

Inspectors reviewed questionnaires completed by residents with staff support. Overall the feedback from residents was positive. Overall happiness was expressed with the centre, meals, and staffing support. The majority of residents were clear on who they would speak to if unhappy. Residents who had made complaints were happy with how these had been addressed.

There has been a reduction in the number of residents living in all houses that comprise the centre. Four of the questionnaires stated that residents were happy with the current situation in the centre and did not want anything to change.

Capacity and capability

The service was well governed and managed. A series of improvements had been made since the last inspection and this was reflected in a good level of compliance as observed on this inspection.

The last inspection had found evidence of good practice in the management and governance of service provision in the centre. However, it had also identified that improved oversight was required in a number of areas; these included risk management, fire precautions, medication management, restrictive practices, the complaints process, written service agreements, and guidance to staff regarding verbal reports made by one resident. This inspection established that while all matters were not fully resolved, action had been and was being taken by the provider to address the previous failings.

The management structure was clear as was individual responsibility, reporting relationships and individual accountability for the quality and safety of the service. The inspector discussed the previous inspection findings and found that the person in charge and persons participating in the management of the centre (PPIM) had a clear understanding of what good governance was, accepted responsibility for the failings previously identified and the requirement for improvement; improvement

was evidenced.

The person in charge and the area manager described how they regularly and consistently participated in the operation and oversight of the service; for example the person in charge worked shifts including weekends that corresponded to times when both residents and staff were in the houses. The area manager regularly called unannounced to each house again when residents and staff were present. There were regular meetings between staff and the person in charge, between the person in charge and the area manager and between the area manager and her line manger who was also a PPIM. It was confirmed that data collated from internal reviews, risk assessments and accidents and incidents would be standing agenda items at all senior management team meetings to ensure that any issues arising were adequately responded to and escalated if necessary.

The provider had also since the last HIQA inspection completed a review of the service as required by the regulations; the head of community services participated in this review. The review focused on both quality and safety and incorporated feedback from residents, staff and relatives. Overall the reviewers found satisfactory progress had been made; the reviewers followed up on areas identified as non-compliant by HIQA, for example they evaluated the adequacy of risk mitigating measures and reviewed restrictive practices.

The provider had improved the systems to receive and respond to residents' complaints.The person in charge described the actions taken since the last inspection to improve the recording of and the oversight of complaints. The inspector found that there was good understanding of the provider's complaints procedure; complaints management had been discussed with staff and explicit guidance on the completion of the complaints record was provided. The inspector reviewed one complaint recorded since the last inspection. It was evident that residents felt that they could raise a concern, that they were listened to and action was taken to resolve the matter. What was not recorded however was whether residents were satisfied that the matter was resolved to their satisfaction though staff reported that it was. This is an important feature of the complaints management and oversight process which is prescribed in the Regulations.

The previous failure to submit prescribed notifications to HIQA had been addressed. The inspector was advised that staff had consolidated their knowledge of what had to be notified, for example any injury that required medical intervention, as this had contributed to the previous failing. The area manager committed to ensuring that all notifications would be submitted in the absence of the person in charge. Previous notification deficits had been addressed.

The provider had put better systems in place to ensure residents were informed about the service to be provided and the fees involved. The inspector saw recent correspondence in an accessible format issued to residents that explained what the fee for living in the centre was and what was provided to the resident for that fee. Work on individual service agreements was ongoing. The provider confirmed that it was in the process of redrafting the individual service agreement and shared a copy of the draft with the inspector; once the final draft was agreed each resident was

to receive a new contract that would be discussed, agreed and signed by the resident or their representative if appropriate.

Over the course of this inspection it was discussed how the governance structure could be further strengthened to prevent a reoccurrence of poor regulatory compliance and to maintain the current good practices. This included ensuring that all governance meetings were recorded with an action plan that could be monitored, the inclusion of the review of narrative notes as a tool to monitor the consistency and adequacy of the support provided on a daily basis to residents and the transfer of learning between centres from internal reviews and HIQA inspection findings.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The centre was effectively and consistently governed so as to ensure and assure the delivery of safe, quality supports and services to residents. The provider had systems of review and utilized the findings of reviews to inform and improve the safety and quality of the service. Areas were discussed during the inspection that could be developed to further strengthen and support good governance and prevent a recurrence of regulatory non-compliance. The provider had and was in the process of addressing previous failings so as to ensure and assure the quality and safety of the service.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed a small sample of written service agreements; the fee to be charged was included but the agreement was not signed as discussed and agreed between the provider and the resident. The inspector observed that the provider

had written to the residents about this matter and work was ongoing to finalise signed service agreements for each resident.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider reviewed, amended and submitted a revised statement of purpose. The record contained all of the required information and was an accurate reflection of the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

There were effective arrangements and adequate staff knowledge for ensuring that the prescribed notifications would be submitted to HIQA. At the time of this inspection previous omissions had been rectified.

Judgment: Compliant

Regulation 34: Complaints procedure

While there was evidence that complaints were welcomed and action was taken on foot of the complaint, oversight was required to ensure that complainant satisfaction or otherwise was consistently recorded.

Judgment: Substantially compliant

Quality and safety

For the most part arrangements were in place to support residents to receive a service that was safe and experience a good quality of life. The last inspection found that residents received a person centred service and experienced a good quality of life but improvements were required in some areas including risk identification and management, fire safety procedures and medicines management to ensure resident safety was promoted and protected at all times. This inspector

again found that the service provided was tailored to individual resident needs and the provider had taken action to address the previous failings. However, there were outstanding fire safety works and further clarity was required in relation to the management of behaviours of concern so as to assure consistency in practice.

There was a good understanding of each resident, their needs, choices and required supports. This was based on staff knowledge, formal assessments of resident's needs and regular review by the multi-disciplinary team of the effectiveness of the support provided to each resident. The person centred nature of the service was reflected in the providers' decision to reduce the occupancy of the centre in response to resident's needs and choices and in the measures taken to ensure that residents could continue to safely live in their home for as long as possible despite increasing needs.

However, a review of narrative notes by the inspector did not provide assurance that the support plan adequately addressed all resident's needs so as to provide sufficient guidance for staff particularly from a healthcare perspective although improvement was noted on the last inspection findings. For example, there was an outstanding referral for a review by the clinical nurse specialist, the findings of which would help to inform the completion of evidenced based guidance for staff.

The inspector did find that staff supported residents in times of illness and sought medical review and advice.

There were initiatives to help residents to be more independent. The person in charge had spoken with each resident since the last HIQA inspection to establish their interest and capacity to participate in the management of their own medicines. One resident was still considering this option but the remaining residents had chosen that staff continue to provide them with support; this discussion and decision was recorded.

The review carried out by the person in charge and the provider review, completed in June 2018, had both assessed the adequacy of risk identification and management processes. Risk assessments had been completed on hazards identified at the time of the last HIQA inspection. The inspector found that the risk register was centre and resident specific and that the risk posed was managed and reduced following the implementation of control measures.

Residents did at times present with behaviours of concern and risk. There was a clear co-relation between behaviours, complaints and safeguarding that was reflected in the last HIQA inspection findings. The inspector reviewed the behaviour support plan and saw that it clearly outlined the behaviours, their origin and the purpose of them. There was guidance in the plan as to how staff should respond, record and report specific behaviours. A supporting risk assessment had also been completed. Narrative notes seen also indicated that staff referenced the associated incident report. However, as highlighted at the previous inspection, review of the resident, their needs and the plan was required to ensure that there was no ambiguity for staff as to the most appropriate procedures to follow. That is, complaints procedures, safeguarding procedures or behaviour management

procedures in response to specific behaviours. This clarity was required to ensure that deficits did not arise in safeguarding reporting procedures. The inspector was advised that the review was scheduled by the provider and was imminent. Further to this review oversight was required to ensure that staff adhered to the appropriate procedures.

A restraint free environment was promoted. There were two identified environmental restrictive practices; these were required to ensure resident safety and were implemented in line with the providers restrictive practices policy and procedures.

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised. The approach to risk management was dynamic, individualised and supported responsible risk taking as a means of enhancing quality of life while keeping residents safe from harm.

Judgment: Compliant

Regulation 28: Fire precautions

Since the last inspection the installation of integrated fire detection systems and emergency lighting had been completed in all of the three houses. The person in charge confirmed that staff and residents had been familiarised with the operation of the system. Certificates of installation, commissioning and of the servicing of fire fighting equipment were all made available to the inspector. However, there were no fire resistant doors in any of the three houses and consequently there were inadequate arrangements for the containment of fire and the protection of fire escape routes

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had medication management policies and procedures in place that complied with legislative and regulatory requirements. Records were kept to account for the management of medicines including their administration. Resident interest

and capacity to participate in the management of their medicines had been established. Segregated storage had been implemented for medicines that were unused or no longer required. Records verified by the pharmacy were maintained of medicines returned to the pharmacy.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Documentation in the centre did not adequately reflect all of the residents' assessed needs and did not always provide sufficient guidance for staff, for example in relation to healthcare needs. There was an outstanding referral for a review by the clinical nurse specialist.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The behaviour support plan required review to ensure that there was no ambiguity for staff as to the most appropriate procedures to follow in response to specific behaviours, that is, complaints procedures, safeguarding procedures or behaviour management procedures. Oversight was then required to ensure that staff adhered to the appropriate procedures.

Judgment: Substantially compliant

Regulation 8: Protection

There were policies and supporting procedures for ensuring that residents were protected from all forms of abuse. In the context of specific resident requirements clarity was required as described above in Regulation 7 to ensure that there was no ambiguity in practice between complaint's and a safeguarding concern. Management clearly understood this and what was required. The inspector did not identify any safeguarding concerns that had not been responded to as such.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Skylark 1 OSV-0004832

Inspection ID: MON-0024674

Date of inspection: 20/08/2018

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Written and verbal guidance has been given to staff with regard to recording complaints appropriately as per policy. This includes ensuring that resolved issues are recorded for the individual and if the issue is not resolved that it is escalated as per policy and that the escalation is recorded and the individual is informed of any outcome. • Written and verbal guidance have been given to staff with regard to writing care notes. PIC and Area Manager review care notes on an ongoing basis.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • L1 fire panel and emergency lighting has been installed • Phase 2 will be rolled out in line with fire inspection reports subject to securing funding from our funders. This continues to be discussed as part of Service Arrangement.	
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:	

- Care Plans have been put in place for all individuals who require same. Age Related Nurse Specialist will continue to support this process.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- Grievance log has been developed by Behavioural Therapist following consultation with Designated Officer and MDT team. This log will offer guidance to staff in relation to recording complaints, grievances for one individual and ensuring Safeguarding concerns are responded to appropriately. Behavioural Support Plan will be updated to reflect the above.

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 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	Phase 1 18/06/2018 Phase 2 - 31/12/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	05/09/2018
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended	Substantially Compliant	Yellow	14/09/2018

	following a review carried out pursuant to paragraph (6).			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/11/2018