Office of the Chief Inspector

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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Ardnacrusha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Brothers of Charity Services Ireland</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Clare</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>30 April 2019</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0004817</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0026553</td>
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</tbody>
</table>
About the designated centre

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

Ardnacrusha is a centre run by Brothers of Charity Services Ireland. The centre is located on the outskirts of a village in Co. Clare and provides residential care for up to four residents over the age of 18 years, who present with a mild to moderate intellectual disability. The centre comprises of one bungalow dwelling with residents having their own bedroom, along with access to communal bathrooms, utility room, kitchen and dining area, sitting room and large garden area. Staff are on duty both day and night to support residents who avail of this service.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>09/10/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 April 2019</td>
<td>09:30hrs to 13:30hrs</td>
<td>Anne Marie Byrne</td>
<td>Lead</td>
</tr>
</tbody>
</table>
## Views of people who use the service

The inspector met with one resident who lives at this centre and she spoke positively about the improved quality of service she receives now that additional staffing resources are available to her.

This resident told the inspector that she requires the use of a wheelchair when accessing the community and of how the availability of consistent staffing resources has enabled her to receive the staff support she requires to regularly engage in activities of her choice. The resident also stated that the provider had consulted with her and her peers in relation to how they wished to allocate the additional social care hours each week. She told the inspector that she were very happy with having access to these regular support hours, which allowed her to plan in advance how she wished to spend her time. She told the inspector that she was also very happy with the selection of activities available to her and her peers and she now looked forward to planning for and taking part in mid-week evening activities.

This resident also spoke positively about regular consultation between residents and staff at the centre.

## Capacity and capability

This was a follow-up inspection to identify if the provider had improved the staffing arrangements at this centre, following the findings of the centre's last inspection in February 2019. Overall, the inspector found the provider had made significant improvements to the staffing arrangements at this centre, which had a positive impact on the quality of social care now delivered to residents who lived there. However, some improvements were still required to the governance and management and risk management systems at this centre.

Additional social care hours were now provided each Saturday, Sunday and on one mid-week evening. The inspector reviewed a sample of rosters which demonstrated consistency in the allocation of these additional staffing resources and continuity of care for residents, with familiar staff members allocated each week to support them with their social care needs. The person in charge told the inspector that since these hours were allocated to the service in March 2019, residents had not experienced any disruption to their social plans and also spoke of the positive impact these additional support hours had made to the overall quality of service now delivered to residents. The provider had also reviewed the staff roster since the last inspection, ensuring it now clearly identified the names and start and finish times worked by
staff at the centre.

In response to the findings of the previous inspection in February 2019, the provider revised the governance and management systems in place, which had a positive impact on overseeing and addressing issues relating to inadequate staffing resources at the centre. Improved communication systems were put in place, which ensured local and senior management regularly communicated about the progress made towards addressing this issue. However, the inspector found that these systems required further improvement to ensure relevant operational issues and areas of concern within the service, were robustly overseen, discussed and reviewed by the management team to ensure clear oversight of any improvements required. For example, although additional social care hours were provided to the service, the provider had also sought and was refused funding for one additional support hour in the morning at the request of a resident. It was unclear from the records available, if the outcome to this business case was since reviewed by the management team to review the impact on the service delivered to this resident in the absence of this additional staff support or if a plan was put in place as to what actions were required to address this issue.

**Regulation 15: Staffing**

The provider had put additional staff supports in place to ensure residents' social care needs were met. The provider had also reviewed the roster to ensure it clearly identified the names, start and finish times of worked by staff at the centre.

Judgment: Compliant

**Regulation 23: Governance and management**

Since the last inspection, the provider had improved the governance and management arrangements, which supported the oversight of additional staffing resources to the centre. However, the inspector found that further improvements were required to ensure these governance and management systems were robust in regularly monitoring and reviewing operational issues arising within the service.

Judgment: Substantially compliant

**Regulation 34: Complaints procedure**

The provider had a system in place for the recording and response to complaints. At the time of this inspection, the provider was in the process of reviewing residents'
satisfaction levels to the outcome of the management of a previous complaint made by residents in relation to staffing resources.

Judgment: Compliant

**Quality and safety**

The inspector found improved arrangements were in place to ensure residents experienced an improved quality of life, with adequate staffing resources now in place to meet their social care needs. Residents now had consistent access to social care hours each Saturday and Sunday and on one mid-week evening each week, which facilitated each resident to plan in advance their activities of choice and social engagements. Residents with mobility needs also experienced an increased variety in the activities they could chose from due to the consistent availability of staff support. In addition, the introduction of increased staff support had a positive impact on supporting residents to choose to engage in activities independent of their peers, if they wished to do so. Records reviewed by the inspector demonstrated residents often visited local attractions, went for meals out, went shopping and regularly attended social evenings. One resident who spoke with the inspector, said they were much happier with the service they received as they now had regular access to the staff support they required to access the community.

Effective and regular consultation was occurring between staff and residents, with weekly recorded meetings held with residents to discuss and plan what activities they wished to participate in at weekends and mid-week. The person in charge also held a separate monthly meeting with residents, which informed residents on any changes happening within the organisation. Various records reviewed by the inspector demonstrated that the provider had met with residents on a regular basis to discuss the progress made towards the allocation of additional social care hours to the centre and that prior to the allocation of these additional support hours, the provider had also consulted with residents as to which mid-week evening they wished to have these hours scheduled for. One resident who met with the inspector, spoke positively of how they valued this regular consultation brought about from regular meetings with staff and the person in charge.

Although the provider had made improvements to the risk management system in place since the last inspection, further improvements were required to ensure this system supported the on-going monitoring and evaluation of the effectiveness of the measures put in place by the provider in response to the risk identified to the centre's staffing arrangement. For example, although the provider had put additional staffing resources in place, it was unclear from the records available, what impact these measures had made on reducing the risk to staffing at the centre. It was also unclear what system was in place to support the on-going monitoring and review of the current controls measures put in place by the provider in response to the staffing risk. Furthermore, it was unclear if the outcome of a recent business
case submitted by the provider seeking an additional support hour in the morning, was reviewed to assess the level of risk this outcome posed to the overall quality of service received by residents.

### Regulation 13: General welfare and development

Residents' had opportunities for recreation, social engagement and to take part in activities of their choice and appropriate to their developmental needs.

Judgment: Compliant

### Regulation 26: Risk management procedures

Although the provider had a system in place for the assessment, response and management of identified risk, some improvements were required to ensure clear systems were in place for the monitoring of risks at the centre, for example, adequate staffing levels.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

The provider had ensured that adequate staffing arrangements were now in place to meet the assessed needs of residents, in accordance with their individual assessments and personal plans.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents' rights were well-promoted at the centre, with adequate staffing arrangements now in place to ensure residents' choice and preferences for social care were at all times met.

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:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Views of people who use the service</strong></td>
<td></td>
</tr>
<tr>
<td>Capacity and capability</td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 13: General welfare and development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
</tr>
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</table>
Compliance Plan for Ardnacrusha OSV-0004817

Inspection ID: MON-0026553

Date of inspection: 30/04/2019

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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time 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:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- Going forward the Person in Charge and the Area Manager will meet on a monthly basis to discuss operational issues within the service. Issues such as risk assessments, complaints and outstanding business cases will be monitored and reviewed. Issues that are outside the remit of the Person in Charge and the Area Manager will be escalated to Senior Management. The minutes of the monthly meetings will clearly illustrate the actions that are required following the meeting and who is responsible for oversight of the proposed actions.

| Regulation 26: Risk management procedures  | Substantially Compliant    |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
- A risk assessment in relation to adequate staffing levels was conducted. The risk assessment illustrates the controls that are in place to ensure staffing levels within the service are adequate and consistent. The risk assessment will be monitored and reviewed on a quarterly basis.
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 23(1)(c)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>04/06/2019</td>
</tr>
<tr>
<td>Regulation 26(2)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>04/06/2019</td>
</tr>
</tbody>
</table>