Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cairdeas Services Kilkenny
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	03 February 2020
Centre ID:	OSV-0005054
Fieldwork ID:	MON-0025022

About the designated centre

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

Cairdeas Services Kilkenny provides long-term residential care to 8 adults, both male and female. These residents present with a high level of intellectual disability, and require nursing interventions and have additional care needs and behavioural needs. The centre comprises of two bungalows located in rural towns in Co.Kilkenny. The staff team consists of staff nurses and care assistants and the centre is staffed 24/7 tp provide the care and support required by residents. The centre has good access to local services and amenities. Residents also have access to a number of service multi-disciplinary services. There are a number of day services attached to the centre, which offer a variety of programmes suitable for the residents who are provided with attend individualised activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Monday 3 February 2020	09:30hrs to 17:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all eight residents living in the designated centre on the day of of inspection. Residents used both verbal and non verbal methods to communicate at times. The inspector gauged the resident thoughts and views through observation, speaking with residents, speaking with the staff providing support and reviewing residents documentation. Overall, it appeared residents were content living in the designated centre and had choice in their daily lives.

The inspector observed two residents sitting together in the sitting room waiting to head out to day services together on the morning of the inspection. Both residents appeared happy sitting together and chatting amongst themselves and with staff. One resident when spoken with, reported that they liked having a sleep-in on the weekends and finds it hard to get up early on a Monday. Staff were supporting the resident to have a lie-in at weekends. One resident proudly told the inspector what county they were from and it was then communicated that the house was named after a towns land in this county. The resident appeared very happy with this. Both residents appeared comfortable in their space and each others company. The inspector could hear residents and some staff singing and laughing together on the morning of the inspection.

Some residents were attending day services on a daily basis and others were receiving individualised support during the day and attending various activities. Some residents were refusing to attend day services at times and this preference was respected. One resident liked to relax in their room with their DVD player and their radio. This resident also liked read the daily paper and to discuss different stories and political issues with staff members. One resident loved music and had a goal in place to invite a singer they liked to visit the centre. The inspector observed some residents sitting down together for their evening meal. This appeared to be a relaxed experience with staff supporting residents with feeding when needed. Residents were using some non verbal methods to communicate with each other and were laughing together. Some residents were registered to vote and had received polling cards and were being supported to vote in the upcoming general election. There were no complaints communicated with the inspector regarding the service that was provided.

Capacity and capability

This inspection was unannounced and its purpose was to monitor the centres ongoing compliance with regulations. Overall, the inspector found that residents were happy and appropriately supported living in the designated centre. Both

actions from the centres most previous inspection had been addressed. However, there were some improvements needed to ensure a higher level of compliance at times.

There was a clear management structure in place. There was a full time person in charge (PIC) who divided their time between the two premises. The person in charge was also supported by a nurse in charge in one of the houses who supported the PIC with administration duties. The PIC had allocated protected time, but was also part of the staff numbers at times. Regular audits and reviews of the service being provided were taking place. An annual review of the care and support provided had been completed by the person in charge and appropriate actions had been devised and addressed from this. Persons in charge from the providers other designated centres, also completed six monthly unannounced visits on behalf of the provider. These were used as shared learning amongst PIC's in the service. Satisfaction questionnaires were issued to residents and their representatives annually and these were considered when completing reviews of the support and care provided.

There were appropriate staffing numbers and skill mixes in place to meet the assessed needs of the residents living in the designated centre. The staff team comprised of a mix of care assistants and staff nurses. There was an internal relief system in place to cover staff sickness and leave. There was a clear staff rota in place that accurately reflected staff on duty. Staff spoken with were familiar with their role in the designated centre and were familiar with the reporting systems and who was in charge. The centre also had a student nurse present on the day of inspection. An appropriate orientation program was in place for them, and safeguarding training was completed before commencing their placement in the centre. The inspector did not have the opportunity to review staff files as these were located off site on the day of inspection.

All staff had access to appropriate training, including refresher training, as part of a continuous professional development program. Training was provided and completed by staff in areas including medication management, fire safety, manual handling, first aid, safeguarding, behaviour management and the service code of practice. Training was also provided in the safe administration of emergency epilepsy medication. Staff were appropriately supervised by line managers and a schedule was in place for one to one staff supervisions to take place. Following a review of training records, the inspector found that three staff members were due refresher training in fire safety. Furthermore, four staff members were due refresher training in safeguarding and three were outstanding in refresher training in management of challenging behaviours. The PIC was aware of this and training dates had been planned for these staff members.

There was a clear and effective complaints procedure in place. Any complaints were responded to in a serious and timely manner. The complaints procedure was prominently displayed in the designated centre and residents were aware of how to make a complaints. There was a designated person in place to manage any complaints that were received. Residents and their representatives were regularly consulted regarding their feedback on the service that was provided. There were no

complaints communicated with the inspector on the day of inspection.

Regulation 15: Staffing

There were appropriate staffing numbers and levels in place to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Training was being provided in line with residents needs. However, some staff members were out of date on refresher mandatory training.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in place and regular oversight and monitoring of the care and support provided.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place that was an accurate description of the service being provided and contained all items set out in Schedule 1.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an appropriate procedure in place to make a complaint. Complaints were treated in a serious and timely manner.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider, management team and person in charge were endeavouring to provide a safe and effective service for the residents living in the designated centre. Residents appeared to enjoy living in the centre and the level of support provided.

Each resident had a comprehensive assessment and personal plan in place that was guiding the care and support provided. Some residents presented with healthcare needs and there was an appropriate plans of care in place for these residents. Pictorial versions of residents care plans were also in place. Each resident had an allocated key worker who was responsible for maintaining their personal plans and reviewing social goals. The person in charge completed regular checks of personal plans and highlighted any outstanding pieces to staff and key workers. Residents had an annual review meeting and this was used as a forum to discuss the residents goals and aspirations for the year ahead. One resident had goals in place to invite a singer to come to the house and to go out for a meal with a friend. Some residents had goals in place to support them to develop independent living skills. These included gardening, baking, going to get their hair cut and going out to mass. One resident had an ongoing goal in place to go on a weekend holiday away in Ireland. Staff were researching a premises best suited to meet their needs. Goals observed, were in line with residents preferences and disabilities.

The centre comprised of two bungalows located some distance from each other in rural towns in Co.Kilkenny. Each resident had their own bedroom and these were decorated in line with residents preferences. Bathroom facilities in place had been adapted to suit the mobility needs of the residents and residents had appropriate access to communal kitchen and living areas. The provider had ensured the provision of all items set out in Schedule 6. However, chipped and worn paintwork was noted around both buildings. Furthermore, aspects of the centres large garden in one premises was not wheelchair accessible. Three of the residents living in this premises were wheelchair users. Following discussion with staff and a review of records, it was clear that some residents who were wheelchair users, enjoyed gardening and would have liked to access the garden.

The provider and person in charge had identified any actual or potential risks in the designated centre. These risks were assessed and mitigated when possible. Residents had individualised risk assessments in place secondary to identified risks. These included the use of any restrictive practices. A general house risk register was in place and this was reviewed annually. Residents who used bed rails due to a safety risk had a safety checklist in place for their use. Plans and procedures were in place for in the event of an emergency. There was a service vehicle available to the residents on a full-time basis. Evidence that this vehicle was appropriately insured

and road worthy was observed.

In general, the inspector found that residents were supported to manage their behaviours appropriately. Residents had access to a range of multi-disciplinary supports to help them manage their behaviours. Some environmental restrictions were in place to support residents to mitigate and manage potential risks. These were discussed and reviewed and approved at a service human rights committee and then reviewed annually following initial approval. Individualised risk assessments were in place to evidence the potential risks and the rationale for implementing a restriction. Residents had comprehensive positive behavioural support plans in place that guided staff to implement proactive and reactive behaviour management strategies these were devised and reviewed by behavioural specialists. One resident had a behavioural strategy in place around their evening meal time, the inspector observed that this strategy was appropriately implemented on the day of inspection and appropriate staffing levels were in place to follow this plan. However, following a review of residents progress notes, it appeared that at times some behavioural support plans were not followed. For example one resident had a protocol in place for the use of a psychotropic medication as needed (PRN). The protocol in place advised staff to monitor the resident for the presentation of three of six identified behaviours before administering this PRN. Progress notes suggested that at times, the resident only presented with one or two of these behaviours when staff had adminstered the PRN. Progress notes did not reflect the use of the numerous therapeutic interventions recommended in the residents positive behavioural support plan before the use of a PRN. Another resident used an all in one suit due to an identified risk. The positive behavioural support plan advised staff to use re-direction techniques at least three times before the use of this suit. Residents records and progress notes did not evidence that this was implemented by staff before the use of the all in one suit.

In general, there were appropriate fire safety management systems in place in the designated centre. Appropriate fire fighting equipment was in place around the designated centre and this was regularly checked and serviced by a fire specialist. Arrangements were in place for detecting and extinguishing fires and emergency lighting was in place all around the designated centre to illuminate exit routes in the event of a fire. Regular fire evacuation drills were completed three monthly and night time conditions were simulated during some of these drills. All residents had personal emergency evacuation plans in place. One resident regularly refused to evacuate the centre during simulated drills. This was reviewed and alternative safety measures were outlined in the residents evacuation plan, should they refuse to evacuate in the event of a fire. However, following a walk around the centre, the inspector noted that while there were some containment measures in place, these were inadequate at times and would not prevent a fire spreading in the designated centre. This area required further review by the provider.

The person in charge had ensured that the designated centre had appropriate and suitable practices in place relating to the prescription, ordering, storage and administration of medicines. Residents had their own shelf in the centres medication storage unit and this was labelled with the residents photograph. Staff had received training on the safe administration of medication and staff had also received training

in the safe administration of emergency epilepsy medication as some residents required this. The residents pharmacist audited medication and prescriptions annually and recommendations made by the pharmacist were then reviewed and implemented. The inspector reviewed a number of resident's prescriptions and found that these safely and accurately guided the administration of resident's medication. Protocols were in place for the administration of medication taken as required (PRN). Staff completed weekly medication stock checks on medications administered as required (PRN) and these were recorded appropriately.

There were no safeguarding concerns identified on the day of inspection. All staff had received training in the safeguarding and protection of vulnerable adults and staff had also received specific training on intimate care. Safeguarding plans were in place where appropriate and ongoing safeguarding measures in place were discussed with staff on a daily basis and in staff meetings. Staff spoken with were familiar with safeguarding measures in place and knew the reporting systems should a safeguarding concern arise. The person in charge was regularly part of the staff numbers and supervised the care and support provided.

Regulation 17: Premises

The premises was designed and laid out to meet the assessed needs of the residents. However, some outstanding paintwork was noted around the building. Furthermore, aspects the centres large garden was not wheelchair accessible. Some residents using wheelchairs liked gardening.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider and person in charge had identified an actual or potential risks in the designated centre. These risks were assessed and mitigated when possible.

Judgment: Compliant

Regulation 28: Fire precautions

In gerneral, appropriate systems were in place for the prevention of fire and the protection against fire. However, the inspector noted there were inadequate containment measures in parts of the designated centre.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Safe practices were in place in relation to the management of medicines in the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment and personal plan in place that was guiding the care and support provided.

Judgment: Compliant

Regulation 7: Positive behavioural support

In general, the inspector found that residents were supported to manage their behaviours appropriately. However, at times records were not reflecting that the use of restrictive practices were in line with residents positive behavioural support plans.

Judgment: Not compliant

Regulation 8: Protection

There were no safeguarding concerns identified on the day of inspection. Staff had received training in the safeguarding and protection of vulnerable adults and ko

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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cairdeas Services Kilkenny OSV-0005054

Inspection ID: MON-0025022

Date of inspection: 03/02/2020

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff will be booked in to all out of date mandatory refresher training.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Paintwork will be carried out in both houses. Covered outdoor area in garden will be enhanced to enable residents to participate in gardening activities.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Update emergency plan for the designated centre. Bedroom doors to be closed at all times when staff have finished supporting residents. Self-closing devise to be fitted on one bedroom door. Any fire doors that have an extended part to allow clear entry and exit of wheelchairs	

must be bolted close after the wheelchair has passed so as not to render the self-closing devise ineffective.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Records will now reflect the use of restrictive practices as per behaviour support plans.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/10/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/05/2020
Regulation	The person in	Not Compliant	Orange	30/03/2020

07(5)(b)	charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			