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:	Dukesmeadows Respite Service
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	20 March 2019
Centre ID:	OSV-0005763
Fieldwork ID:	MON-0025145

About the designated centre

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

Dukesmeadows is a two storied detached house located within easy walking distance of a town. It is a residential respite service for four adults with intellectual disabilities. The property is managed by SOS (Special Occupation Scheme) Housing Association. The accommodation comprises of five bedrooms. One of these are en suite. One of the bedrooms upstairs is used as a staff bedroom and office. The communal area comprises of two sitting rooms, a kitchen come dining room, a utility and a downstairs toilet. There are small front and rear facing gardens.There is a service vehicle to support residents to access community based activities and attend appointments. The staff team consists of social care workers and care assistants. Dukesmeadows aims to develop services for residents that are individualised, rights based and empowering.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

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
20 March 2019	08:30hrs to 16:00hrs	Sinead Whitely	Lead

Views of people who use the service

The inspector had the opportunity to meet with one resident availing of respite on the day of inspection. Staff were supporting the resident to go about their daily routine and this appeared to be a person-centred and familiar experience. Staff spoken to appeared to be striving to provide a safe and quality service for residents availing of respite.

The provider was considering the compatibility of each resident together with each respite admission. This was in line with residents specific complex needs and appeared to be positive for the residents availing of the service.

There was a service vehicle available for residents to take part in individualised activities if they wished. No complaints were communicated with the inspector on the day of inspection.

Inspection findings indicated that some improvements were needed to ensure that supports in place maximised all residents' well-being and personal development when availing of respite in the designated centre.

Capacity and capability

Overall, some improvements were needed to ensure the provider was delivering a safe and effective service for the residents availing of respite. This was the centres first inspection since registration. Compatibility of residents availing of respite was at the forefront of the service, and this was positive for residents availing of respite secondary to residents' complex and individual needs.

The person in charge had the qualifications, skills and experience necessary to manage the designated centre. An arrangement was in place whereby a team leader reported any concerns to the person in charge. However, the person in charge had a shared post and was not ensuring effective governance of the designated centre at all times. The person in charge had not attended a team meeting. There was a handover system in place with the team leader, however this did not appear to be effective at times as oversight and knowledge of the designated centre and the residents availing of respite and their individual needs was poor at times. Specifically in relation to one resident's safeguarding concerns and safeguarding plan. The person in charge was not completing any supervision with staff working in the designated centre. This was discussed at opening and during the feedback session at the end of the inspection day.

The registered provider was ensuring that the qualifications and skill-mix of staff was appropriate to the assessed needs of the residents. The staffing team consisted of social care workers and care assistants. There was a planned and actual staff rota in place that reflected staff on duty. A sample of staff files was reviewed and all

required Schedule 2 documents were in place. These were maintained and reviewed by a human resource (HR) staff member to a high standard. However, staffing complements in place did not match the whole time equivalent outlined in the centre's statement of purpose. Furthermore, arrangements were not in place at all times to support times of staff illness. This meant that scheduled respite days needed to be cancelled at times due to short staffing.

The registered provider had ensured all staff had access to appropriate training, including refresher training as part of a continuous professional development. This included training in areas including fire safety, safeguarding, medication management, Childrens First, manual handling, and behaviour management. Staff supervisions were completed by the centre's team leader. However, one staff member did not have training to meet the specific healthcare needs of one resident. This posed a risk to the resident as a lone working system was in place.

A detailed and accessible complaints procedure was in place and the provider ensured that residents were aware of their right to make a complaint and the process to follow. Complaints were addressed in a serious and timely manner and investigations carried out were comprehensive. Complaints were escalated appropriately in stages in line with the service policy in place. There was a designated complaints officer in place, nominated to investigate complaints by or on behalf of residents. Residents had access to advocacy services if required. The complaints procedure was prominently displayed in the designated centre.

The inspector reviewed a sample of the centre's accident and incident records and a number of resident's progress reports. It was found that not all relevant incidents had been notified to the Office of the Chief Inspector. This was particularly in relation to notification at the end of each quarter of each calendar year reporting any occasion in which a restrictive procedure was used including physical and environmental restraints.

Regulation 14: Persons in charge

While the person in charge had the qualifications, skills and experience necessary to manage the designated centre, they were not ensuring effective governance of the designated centre and oversight of the designated centre was poor at times.

Judgment: Not compliant

Regulation 15: Staffing

Staffing complements in place did not match the whole time equivalent outlined in the centre statement of purpose. Arrangements were not in place at all times to support times of staff illness.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider had ensured all staff had access to appropriate training, including refresher trainnig as part of a continuous professional development. This included training in areas including fire safety, safeguarding, medication managment, childrens first, manual handling, and behaviour managment. Staff supervisions were completed by the centre's team leader. However, one staff member did not have training to meet the specific healthcare needs of one resident. This posed a risk to the resident as a lone working system was in place.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose in place was not an adequate description of the service being provided on the day of the inspection. Arrangements were not in place for the staffing levels outlined.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all incidents of restrictive practices in use in the designated centre were notified under the quarterly notifications submitted to the Office of the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were addressed in a serious and timely manner. There was a designated officer in place.The complaints procedure was displayed prominently in the designated centre. No complaints were communicated with the inspector on the day of inspection

Judgment: Compliant

Quality and safety

Overall the registered provider was striving to ensure the designated centre was resourced sufficiently for the effective delivery of care and support to the residents availing of respite. This was a newly registered designated centre and this was the centres first inspection to date. Some area's in need of improvement were identified, specifically in relation to fire safety, risk managements, safeguarding and positive behavioural support.

Overall, the registered provider had ensured that the premises was designed and laid out to meet the needs of the residents. The premises was of sound construction and was in a good state of repair externally and internally. The premises consisted of a two-storey house. The accommodation comprises of five bedrooms. All bedrooms were single occupancy. One of these is an en suite. One of the bedrooms upstairs is used as a staff bedroom and office. The communal areas comprise of two sitting rooms, a kitchen come dining room, a utility and a downstairs toilet. There are small front and rear facing gardens. Cooking facilities and laundry facilities were in place. Adequate storage space was provided and communal living areas were a suitable size to meet the needs of the residents. There were no outstanding premises repair issues identified on the day of inspection.

Overall, the registered provider was ensuring that the designated centre was suitable for the purpose of meeting the needs of the residents. All residents had personal plans in place that were subject to review. However, some review dates for these personal plans had passed on the day of inspection. The person in charge had not ensured that a comprehensive pre-admission assessment was carried out that assessed the resident's health, personal and social care needs. One resident had a personal plan that outlined arrangements in place from a previous care facility. These arrangements were not longer in place in the respite service and was not guiding the care being provided.

There was a risk management policy in place that appeared to guide staff practice. There were systems in place for hazard identification and for the assessment, management and review of risk. Risk control measures in place were proportional to risks identified. Risk assessments in place were subject to review. There was a service vehicle that was suitably road-worthy and insured. Staff were suitably licensed to drive this and it was available for residents to use as transport to and from daily activities. However, some risks identified on the day of inspection had not been assessed. Furthermore, risk assessments in place were generic at times and were not individual to the designated centre and the residents availing of the respite service.

Systems were in place for detecting, containing and extinguishing fires. All staff had received training on fire safety in the designated centre. Emergency lighting and detection systems were in place around the designated centre where appropriate.

Testing and servicing of equipment was carried out at regular intervals and staff were completing regular safety checks on lighting, exits and fire doors. Staff spoken to appeared to have good knowledge regarding fire safety precautions and procedures. Regular fire drills were being completed by staff and residents. However, an up-to-date personal emergency evacuation plan (PEEP) was not in place for two residents availing of respite and arrangements outlined in one PEEP reviewed by the inspector, were not in place in the designated centre. Furthermore, a risk measure was in place secondary to the risk of absconsion whereby all doors in the designated centre were locked at all times. However, there were no arrangements for the residents to access a key or for exits to open so that residents could safely evacuate in the event of a fire.

Arrangements were in place for positive behavioural support. An up-to-date positive behavioural support plan was in place for residents with behavioural support needs that effectively guided staff to deliver care using a person-centred approach. Residents had access to support from a behavioural support therapist and all staff were trained in behaviour management. Regular positive behavioural support meetings were held with allied healthcare professionals to discuss residents ongoing support needs. There was evidence of therapeutic interventions being used by staff to support residents at times. However, all alternative measures did not appear to be considered before a restrictive practice was utilised. Restrictive practices in place were not always recognised by staff and were not always reviewed on a regular basis. Particularly in relation to environmental and physical restraints.

All staff had received training in the safeguarding and protection of vulnerable adults. Staff spoken with appeared knowledgeable regarding national policy and procedures necessary to safeguard residents. There was a designated person in place to review safeguarding concerns and the provider had ensured that any safeguarding concerns were investigated in line with national policy and were notified to the Office of the Chief Inspector. However, the person in charge of the designated centre had poor oversight of safeguarding concerns for one resident at the opening of the inspection and staff did not have knowledge of safeguarding measures in place for one resident availing of respite. This posed a risk to the resident concerned as measures in place to prevent the incident happening again were not robust. Intimate care plans were in place, however some of these were in need of review.

In general, practice relating to the ordering and administration of medicines was appropriate and safe. Administration of medication was carried out by suitably trained and qualified staff. The residents' medication prescriptions' was clear, regularly reviewed and accurately guided the administration of prescribed medication. Protocols were in place for the administration of emergency medication or medication to be administered as required (PRN medicines).

Regulation 17: Premises

Overall, the registered provider had ensured that the premises was designed and laid out to meet the needs of the residents. The premises was of sound construction

and was in a good state of repair externally and internally and met all requirements outlined in Schedule 6.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for hazard identification and for the assessment, management and ongoing review of risk. However, some risks identified on the day of inspection had not been assessed. Furthermore, risk assessments in place were generic at times and were not individual to the residents availing of the respite service.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Arrangements were in place for detecting, containing and extinguishing fires. All staff had received training on fire safety in the designated centre. Emergency lighting and detection systems were in place around the designated centre where appropriate. Testing and servicing of equipment was carried out at regular intervals.

However, an up-to-date personal emergency evacuation plan (PEEP) was not in place for two residents availing of respite and arrangements outlined in one PEEP reviewed by the inspector, were not in place in the designated centre. Furthermore, a risk measure was in place secondary to the risk of absconsion, whereby all doors in the designated centre were locked at all times. However, there were no arrangements for the residents to access a key or for exits to open so that residents could safely evacuate in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

In general, practice relating to the ordering and administration of medicines was appropriate and safe. Administration of medication was carried out by suitably trained and qualified staff.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents had personal plans in place that were subject to review. However, the person in charge had not ensured that a comprehensive pre-admission assessment was carried out that assessed the resident's health, personal and social care needs. Furthermore, some residents had no social goals in place.

Judgment: Not compliant

Regulation 7: Positive behavioural support

An up-to-date positive behavioural support plan was in place for residents with behavioural support needs that effectively guided staff to deliver care using a person centred approach. Residents had access to support from a behavioural support therapist and all staff were trained in behaviour management.

However, all alternative measures did not appear to be considered before a restrictive practice was utilised. Restrictive practices in place were not always recognised by staff and were not always reviewed on a regular basis. Particularly in relation to environmental and physical restraints.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had received training in the safeguarding and protection of vulnerable adults. However, the person in charge had poor oversight of safeguarding concerns for one resident. Staff did not have knowledge of safeguarding measures in place for one resident. Some intimate care plans were in need of review.

Judgment: Substantially 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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Dukesmeadows Respite Service OSV-0005763

Inspection ID: MON-0025145

Date of inspection: 20/03/2019

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Monthly meetings with The Person in Charge, Person Participating in Management and The Team Leader to commence from 28/6/19 to ensure effective oversight of the designated centre. The planning and accountability from these meetings will ensure the effective governance, operational management and administration of the designated centre.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Sufficient relief staff are now available to cover respite to ensure residents receive continuity of care and support. The staffing complement now matches the whole time equivalent as outlined in the statement of purpose.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have access to appropriate training, including refresher training as part of a continuous professional development programme. All staff are fully compliant with the training required for the designated centre. Gap in staff training highlighted was completed on 4/4/19.	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of	

purpose: The Statement of Purpose has been reviewed and sent to authority on 20.06.19.

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: An audit of all restrictive practices including physical, chemical or environmental restraint was carried out to ensure all were identified and are being reported to the authority through quarterly notifications.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All risk assessments have been reviewed and reflect the needs of the residents availing of the respite service. They will be updated to reflect the level of risk for each individual being supported on respite These risk assessments will be reviewed quarterly as per organisation policy or more frequently if required. A "lone worker" risk assessment has been carried out with staff team and on location in the designated centre.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A PEEPS is now in place for each person who avails of respite in the designated centre. Fire safety mechanism to be installed on front door in the designated centre by 15/7/19 to ensure adequate arrangements for evacuating that will automatically release when fire alarm is engaged.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Comprehensive pre-admission assessment updated to ensure all residents health, personal and social care needs are assessed, completed 20.06.19. Social goals in place and documented for all residents availing of the respite service, 20.06.19.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:	

Restrictive practices recognised, reviewed and all other measures considered before a restrictive practice is utilised. The registered provider will ensure that where restrictive procedures including physical, chemical or environmental restraints are used, such procedures are applied in accordance with organisation and national policy and evidence based practice. Staff training in organisation's restrictive practice policy to be carried out by 26.07.19 to ensure awareness and understanding of restrictive practices.

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Person in Charge, Person Participating in Management and The Team Leader are aware of current safeguarding plan in place and the team leader informs staff of safeguarding plans to ensure compliance. The Person in Charge, Person Participating in Management and The Team Leader will continue to review all safeguarding notifications/ plans at monthly meetings scheduled. Further Safeguarding training scheduled for The Person in Charge and The Team Leader scheduled on the 11/7/19.	

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	28/06/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/05/2019
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	04/04/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management	Substantially Compliant	Yellow	30/04/2019

	and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	15/07/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	20/06/2019
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	30/04/2019
Regulation 05(1)(a)	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 prior to admission to the designated centre.	Not Compliant	Orange	20/06/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines	Not Compliant	Orange	20/06/2019

	the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/04/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	11/07/2019