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: | College Green Designated Centre |
| Name of provider: | S O S Kilkenny Company Limited by Guarantee |
| Address of centre: | Kilkenny |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 26 August 2020 |
| Centre ID: | OSV-0005872 |
| Fieldwork ID: | MON-0030279 |

## About the designated centre

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

College Green comprises of two bungalows both of which are close to the centre of Kilkenny City. Both houses aim to provide community based living in a homely environment for adults with intellectual disability and additional complex medical conditions. They are both high support homes with a requirement for three staff in the day and two staff overnight. Each house sits on it's own site with ample parking and enclosed gardens. One house is home to five individuals, each having their own bedroom, and with three of these en-suite. There is a large sitting room, and a kitchen dining room, with a smaller quiet sitting room and a working or cooking kitchen separate to the kitchen/dining room. The other house is recently refurbished and is home to six individuals currently. It has six bedrooms, three of which are en-suite, a large sitting room, a kitchen, and a dining room.
This centre aims to develop services that are individualised and person centred, promoting inclusion and relationship building in and of the communities in which the residents live. Residents are supported by a staff team comprising of a combination of qualified Staff Nurses, Social Care Leaders and Social Care Workers and Care Assistants. In addition a household cook is also employed Monday – Friday within each home.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 10 |

## 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 |
|---|---|---|---|
| Wednesday 26 August 2020 | 09:30hrs to 16:30hrs | Tanya Brady | Lead |

## What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and as such the inspector visited only one house within the centre and adhered to national guidance at all times. The inspector met with five residents and had an opportunity to engage with them all over the course of the visit.

On arrival two residents were relaxing in the living room and the television was on with a radio channel selected to play preferred music. Another resident had been told that the inspector was on their way and had been waiting at the window watching out for their arrival. This resident then brought the resident through the centre to introduce them to staff and their peers.

A resident explained to the inspector that they had been to have a haircut and had just returned home. They communicated this via non verbal methods including gesture. They indicated that the cut hair was making them itchy under their collar and staff engaged to try and alleviate this and to explain that this would be dealt with. The resident was later noted to be supported to go to the kitchen for a cup of tea.

One resident was sitting in a room by the kitchen with music playing on their electronic tablet and this location ensured that as staff passed frequently, they were observed to pause and engage with the resident. The inspector had earlier read in documentation that residents had been occupied in projects in their garden over the COVID-19 lock down period and asked if residents would show them the garden. A resident explained they had gathered and painted stones which were seen to surround a tree and decorate flowerbeds. One resident explained that their stones had cars on them. The staff pointed out areas which had been created to allow for residents to relax and enjoy peace and quiet if they wished. In addition the garden walls had been painted with bright murals by residents.

All residents were seen to be comfortable in their home and were warmly engaged with staff in a number of activities.

## Capacity and capability

As found on the previous inspection, College Green was a service where the registered provider provided effective and safe services to residents, resulting in a good quality of life for the resident. Individual needs were catered for in line with the resident's interests and hobbies. However it was noted that some actions from

the last inspection had not been addressed such as maintenance of premises which is referred to later in the report.

The person in charge was newly appointed by the provider to this centre. The inspector spent time formally with them and found that they were experienced in the provision of residential care and demonstrated the necessary skills, knowledge and enthusiasm to fulfil their governance role. This person reported directly to the assistant director of service who had been appointed as the person participating in management for this centre.

While it was seen that effective operational management systems were mostly in place, some areas were identified for improvement. The provider had completed an annual review of the quality and safety of care in the centre. Six monthly unannounced visits as required by regulation had been facilitated by the provider only once in May 2020 since the centre had become operational. While an action plan had arisen from this report there was no one individual named with responsibility for completion of the action and no timelines set other than for one point. At centre level, the person in charge had begun reviewing systems that needed to be in place to ensure the ongoing review of service provision within the centre. Regular auditing of some supports was implemented including financial and medication audits. Other areas however required review in a manner that allowed for identification of areas that needed to be addressed and acted upon, such as the review of incidents and accidents which was a numerical record.

The registered provider had ensured the allocation of adequate staff to meet the assessed needs of the resident.There appeared to be effective recruitment and selection arrangements in place for staff. In a selection of staff files reviewed by the inspector for members of staff, all of the documents as required by schedule 2 of the regulations were in place. The rota in place on the day of inspection was reviewed and seen to accurately reflect the position in the houses on the day. Staff spoken with voiced awareness of the individual needs of the resident and recognised their role as a advocate for the person they supported. The person in charge had begun to review and implement effective systems in place for the supervision of staff. Formal staff supervision was not being implemented in line with local policy on the day of inspection.

Staff who worked in this centre were supported by the registered provider to ensure they were competent to carry out their roles.A training programme was in place which was coordinated by the providers training department. Training records however, showed that while staff had received mandatory training requirements a small number of staff required refresher training. Refresher training was for example due in the area of fire safety and manual handling. In addition where the provider had recommended refresher training for staff as an outcome from an investigation into an incident it was noted that this had also not taken place.

A statement of purpose is a key governance document which describes the service to be provided. The provider had ensured that a statement of purpose was in place and had been subjected to review, most recently to describe the change to the service as provided during the COVID-19 pandemic. The inspector was not

however satisfied that the statement of purpose accurately reflected the day to day operation of the centre and this was discussed with the person in charge and the person participating in management on the day. As a result the statement of purpose was amended on the day of inspection to reflect the change of person in charge and the accurate staffing compliment in place. Another important document that required review on the day of inspection was the directory of residents as this had not been amended to reflect the current residents in the centre.

A complaints log was present within each of the houses in the centre with a record maintained of any complaints, comments or compliments maintained. There was documented evidence that all complains were dealt with in a timely effective manner. A complaints policy was in place which gave clear guidance for staff in how to deal accordingly with a complaint being submitted.

## Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

## Regulation 15: Staffing

The full complement of staff were in place and considered to have the required skills and competencies to meet the needs of the residents living in the centre.A sample of staff files reviewed for members of staff were found to contain all of the information as required by schedule 2 of the regulations.

Judgment: Compliant

## Regulation 16: Training and staff development

While training had been provided for staff to improve outcomes for residents a number of staff required refresher training in line with the providers policy.

Staff were not in receipt of supervision as outlined in the providers policy to support

them to perform their duties to the best of their abilities.

Judgment: Not compliant

## Regulation 19: Directory of residents

The directory of residents was amended on the day of inspection to ensure it was an accurate record of residents who lived in the designated centre. The inspector was satisfied it was complete and up to date by the end of the inspection day.

Judgment: Compliant

## Regulation 23: Governance and management

The governance and management systems in place required review to ensure delivery of a quality and safe service to residents. Only one six monthly unannounced report had been completed in the year since the centre had been in operation and the action plan in place did not have identified time frames for completion not allocated individuals to carry out the work. In addition audits in place were not consistently identifying actions required.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The centre had an available statement of purpose, dated August 2019 with a COVID-19 addendum dated March 2020, that did not accurately and clearly described the services provided. This was discussed and amended on the day of inspection and the inspector was satisfied that a version dated August 2020 was in place prior to their departure.

Judgment: Compliant

## Regulation 34: Complaints procedure

A complaints log was maintained with evidence of complaints being dealt with in a timely effective manner. The provider had ensured that there was accessible information available to residents on how to make a complaint and the inspector

saw that staff advocated on behalf of residents when making a complaint.

Judgment: Compliant

## Quality and safety

The inspector was satisfied that the residents' quality of life and overall safety was prioritised and managed in a person-centred manner with emphasis on facilitating and promoting the residents' autonomy, choices and preferences. The residents' social care needs were actively supported and encouraged and the residents accessed numerous external activities such as walking, photography, and gardening.

As seen on previous inspections the premises visited by the inspector was clean, homely and spacious and met the needs of the residents. A sixth resident had moved into this house since the last inspection and all bedrooms were now occupied. One area in the house, that of an en-suite bathroom required maintenance and repair and these works are outstanding from the last inspection where the provider had given a commitment to have completed these works.

The residents had regular multidisciplinary reviews according to their needs and also regular review meetings. These meetings informed plans and goals for the year. Goals set by the residents were meaningful and encompassed the providers targets of best health, access to the community and contact with friends and family. Unfortunately due to the COVID-19 pandemic some of these goals had been put on hold. However, staff had identified innovative ways of trying to work within the confines of the pandemic in achieving success. For one resident who had wanted to participate in sporting events as a spectator, the staff had installed a basketball net in the garden and had been playing 'golf' with residents also in the garden. For another resident who enjoyed playing bingo, the staff had arranged for this to continue via an online live video forum.

There were systems in place to protect the residents from abuse and the person in charge and the staff team provided effective supports to the residents. Where an incident had occurred the provider and person in charge had investigated and put safeguarding plans in place however they had not been reviewed in line with the providers guidelines and some remained in an interim format. In one instance where a formal review by the provider had been completed with actions set, follow through of these actions required had not been implemented and reviewed accordingly.

As required each resident had a positive behaviour support plan in place. Plans reviewed by the inspector did reflect the changing needs of residents for example, the change due to COVID-19 and the requirement to isolate. The use of restrictive practices was done so to ensure the safety of residents. A restrictive practice log was in place and maintained by the person in charge however it did not contain details of all restrictions in place in the centre. In addition, where a restrictive practice had been identified, these were not consistently recorded on the

corresponding risk assessments, for some residents the use of lap belts on wheelchairs was noted as restrictive practice and for others it was not recorded as such. In addition where a restriction such as 'lack of access to the community due to COVID-19' had been assessed for and recorded as being in place for one resident this had not been duplicated to reflect all residents.

There were risk management policies and procedures in place, and whilst operational risks were well identified and assessed, improvements were required to ensure that risks to residents were assessed, control measures identified, and included on the centres risk register. Risks that had been identified in one house were not automatically applied to the other house and in the case of some individual risks reviews were not occurring as outlined by the provider.

There were fire safety management systems in place, however, as previously mentioned in this report not all staff had received the appropriate refresher training in fire safety. There were adequate arrangements in place for the detection, containment and extinguishing of fires, and equipment was regularly serviced. In one of the houses it was noted that evacuation times were particularly long in particular at night. The provider and person in charge had identified this as an area of concern and had identified actions to target this concern.

The inspector found the centre to be visibly clean. Additional measures had been implemented for infection prevention and control due to the COVID-19 pandemic. This had been of importance in this centre where there had been a number of confirmed cases for both residents and staff. The provider had demonstrated learning from each case and there was evidence that change had been made to improve management of an outbreak of infection and audits in place outlined areas for improvement and learning. Regular temperature checks were being completed by staff. Staffing teams had been reviewed and adjusted to reduce contacts in the houses. The centre had ample supplies of personal protective equipment (PPE) and hand washing facilities and alcohol gels were available throughout the centre for staff and residents to use. The inspector found the use of face masks was adhering to national guidance. All staff were wearing face masks when providing care and support with residents within two metre parameters.

## Regulation 17: Premises

While the inspection found that overall the premises was clean and homely with adequate private and communal space an area identified in two previous inspections as requiring maintenance and repair remained outstanding.

Judgment: Not compliant

## Regulation 26: Risk management procedures

Whilst operational risks were well identified and assessed, improvements were required to ensure that risks to residents were assessed, control measures identified, and included on the centres risk register. For example the risk identified in ensuring there was 24 hour cover of staff on duty qualified to administer medication had not been reviewed as set out by the provider.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

Judgment: Compliant

## Regulation 28: Fire precautions

There were fire safety management systems in place, and the provider had ensured there were appropriate arrangements for detecting, containing and extinguishing fires. Residents regularly took part in fire drills, while records of such demonstrated difficulties in evacuation from one house the provider had a plan in place to mitigate the risk of this.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. The person in charge and staff team had worked hard to establish specific and measurable social goals for residents even during the COVID-19 pandemic.

Judgment: Compliant

## Regulation 7: Positive behavioural support

There were support plans in place for residents who required support in this area.

There were some restrictive practices in place that were inconsistently reviewed and monitored and there were discrepancies in the recording of the same restrictive practice for a number of residents.

Judgment: Substantially compliant

## Regulation 8: Protection

There was evidence that safeguarding concerns were actively addressed in a timely manner however progression of the resulting plans was not always occurring as set out by the provider. In addition where following an investigation specific actions were named as being required, follow through of these had not been implemented and reviewed accordingly.

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 |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for College Green Designated Centre OSV-0005872

## Inspection ID: MON-0030279

## Date of inspection: 26/08/2020

**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 | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>SOS Kilkenny CLG has employed a new Staff Training Officer who commenced in his role on 21st September 2020.<br>The Staff Training Officer is currently reviewing all training records to identify areas of non-compliance. Following completion,<br>• Reports will be sent to each Manager on a monthly basis.<br>• Additional training sessions will be added to address outstanding non-compliances.<br>• Staff will be given time and support throughout the day to complete online training.<br>• Training will be addressed in all quality conversations. Managers and staff will be checking training records and booking training as part of the quality conversation.<br>A training matrix is been set up on DMS which will allow staff to access, monitor and book their own training. Managers will be sending monthly reports to the Operations Managers which will include staff training numbers for the previous month. The Staff Training Officer will monitor and review numbers of staff completing training and will report findings to Managers and Operations managers.<br>SOS Kilkenny CLG aim to have all outstanding training up to date within six to eight months.<br>A supervision schedule has been updated and all staff will received supervision in line with the quality conversation policy. | |
| Regulation 23: Governance and management | Not Compliant |

| |
|---|
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A Quality assurance officer has been appointed and a schedule has been put in place to ensure that the six monthly and annual registered provider audits are completed.<br><br>The Quality assurance officer will meet with the Residential Manager following each audit to complete an action plan. The Residential manager will be responsible for allocating individuals to carry out identified actions and will review these actions to ensure they are completed. |

| | |
|---|---|
| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>All costings for the identified works have been submitted and funding has been secured, Works will be carried out once the current Covid-19 restrictions are lifted and it is deemed safe to commence. | |
| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>Risk registers have been reviewed by the Residential Manager, and any improvement required have been assessed, control measure have been identified and included in the centre risk registers.<br>A risk management committee is being set up to review and identify risk trends and learning across the organization. | |
| Regulation 7: Positive behavioural support | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>The restrictive practice committee and residential manager have reviewed all restrictive | |

practices in place; these practices have been recorded in the restrictive practice protocol. All restrictive practices will be reviewed by the committee every 3 months in line with the policy.

| Regulation 8: Protection | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 8: Protection:
All safeguarding plans have now been reviewed and long term plans put in place.

The recommendations identified following the investigation mentioned will be completed by 31st Dec 2020.

## 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. | Not Compliant | Orange | 31/12/2020 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Yellow | 31/10/2020 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Not Compliant | Orange | 31/01/2021 |
| Regulation 23(1)(c) | The registered provider shall ensure that management | Not Compliant | Orange | 31/12/2020 |

| | | | | |
|---|---|---|---|---|
| | systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | Not Compliant | Orange | 31/12/2020 |
| Regulation 26(2) | 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. | Substantially Compliant | Yellow | 31/12/2020 |

| | | | | |
|---|---|---|---|---|
| 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 | 31/10/2020 |
| 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 | 31/12/2020 |