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

Issued by the Chief Inspector

Name of designated centre:	Bird Hill
Name of provider:	St Catherine's Association Company Limited By Guarantee
Address of centre:	Wicklow
Type of inspection:	Short Notice Announced
Date of inspection:	05 November 2020
Centre ID:	OSV-0005660
Fieldwork ID:	MON-0023881

About the designated centre

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

Birdhill designated centre is operated by St. Catherine's Association. This designated centre is a bespoke property located in a rural part of County Wicklow but within a short driving distance from local amenities and towns. The property provides residents with scenic views of the local countryside, it is modern and comfortable throughout. The centre has a capacity for two residents and provides services to adults with intellectual disabilities and autism. The centre is managed by a person in charge who also has a remit for two other designated centres that are located within a short distance from each other. A staff team of social care workers support residents in this centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Thursday 5 November 2020	09:30hrs to 15:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

In line with infection prevention and control guidelines the inspector carried out the inspection mostly from one space in the centre.

The inspector ensured physical distancing measures were implemented during interactions with residents and staff and in the centre during the course of the inspection. The inspector respected resident's choice to engage with them or not during the course of the inspection at all times.

As part of the inspection, the inspector briefly met with one of the two residents living in the centre. There was a sensory room adjacent to the main house which was the preferred sitting room area of the resident. They were observed listening to music and watching programmes on their electronic handheld device or the television in this area. From time-to-time staff checked in on the resident to ask them if they needed anything and to inform them their meals were ready, for example. When asked if they liked their home the resident said 'yes'.

The inspector also spoke to the resident's parent over the phone during the course of the inspection to gather their feedback about the service. They were very positive about the centre. They told the inspector they felt they could voice any concerns or issues that they had and knew they would be listened to. They told the inspector that they thought the service was very good and they were very happy that visiting arrangements were back in place since the lessening of restrictions.

Capacity and capability

The findings from this inspection demonstrated the provider had the capacity and capability to provide a good quality service to meet the needs of residents. Some improvements were required to ensure the provider's governance oversight arrangements continued to meet with the requirements of the regulations. The provider was also required to review the current staffing resources for the centre to ensure they were in line with those as set out in the statement of purpose for the centre.

It was demonstrated the provider had addressed the non-compliances from the previous inspection. For example, the provider had carried out a significant review of policies and procedures within the organisation addressing the findings from the previous inspection. Each resident had an agreed contract of service provision in place.

The provider had completed a 2019 annual report for the centre as required by the

regulations. The provider had completed one six-monthly provider-led audits of the the centre in February 2020. This was found to be of a good quality and reviewed specific regulations in detail, providing a quality action plan for any areas that required improvement. A second provider-led audit was scheduled shortly after the inspection date, the provider submitted evidence of it's completion to the inspector after the inspection to verify it had taken place.

Audits and quality checks were carried out by the person in charge within the centre and formed part of the ongoing quality oversight arrangements for the centre.

The provider had ensured staffing contingency measures were in place to manage staff absences due to a COVID-19 outbreak in their designated centres. The inspector noted there was a planned and actual roster in place. However, it was not demonstrated that staffing levels had been maintained as per the whole-time-equivalent numbers as set out in the statement of purpose for the centre. For example, the whole-time-equivalent staffing ratio for the centre was 11. However, from a review of the rosters, it was demonstrated by the person in charge that there was a shortfall of 1.3 whole-time-equivalent staff for the centre. The provider was required to ensure there were appropriate staffing resources and skill-mix to meet the assessed needs of residents.

The person in charge was responsible for this designated centre and two other designated centres within a close distance. The provider had put systems in place to ensure a deputy manager was in place to supervise and manage the centre on a day-to-day basis as part of the overall governance arrangements for the centre. The post for deputy manager was vacant with interviews occurring at the time of inspection to fill the vacancy.

The person in charge was found to meet the requirements of regulation 14 and associated sub-regulations. The provider had met their regulatory requirements to notify the chief inspector of any absence for the person in charge greater than 28 days.

The provider had ensured a full and complete application to renew registration of the centre within the appropriate time-frame.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete application to register within the appropriate time-line.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge met the requirements of regulation 14.

Judgment: Compliant

Regulation 15: Staffing

The provider was required to address any staffing resource shortfalls to ensure the centre was operating with the staffing whole-time-equivalent numbers as set out in the statement of purpose.

Judgment: Substantially compliant

Regulation 23: Governance and management

Appropriate governance and management arrangements were in place to monitor the quality and safety of care and support for residents living in the centre.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had an agreed contract of care in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was found to meet the regulatory requirements of Schedule 1.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had met their regulatory requirement to notify the Chief Inspector of any absences of the person in charge for greater than 28 days.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had addressed the actions from the previous inspection in relation to policies and procedures.

In addition, the provider had created a suite of COVID-19 policies and procedures for the organisation.

Judgment: Compliant

Quality and safety

Residents living in the centre were in receipt of a good quality service. A good level of compliance was found on this inspection. A parent of a resident, the inspector spoke with, said they were very happy with the service provided. They felt they could raise any issue or concern and knew it would be listened to or acted on. Some improvements were required in relation to the creation of support plans for some identified support needs for residents and ensuring risks presenting in the centre were captured in the centre's risk register.

The provider had ensured an up-to-date risk management policy was in place and evidence of the implementation of this policy was found on inspection for the most part. A risk register was maintained and where required further personal risk assessments for residents were documented, reviewed and maintained in residents' personal plans.

While the risk register captured some of the risks managed in the centre, it did not capture all risks. For example, some infection control management procedures, not associated with COVID-19, were implemented in the centre, these related to procedures for the management of soiled linen. It was not demonstrated that this risk had been assessed or captured in the centre's risk register.

Personal risk assessments had been created and maintained in residents' personal plans. However, some of those risks were also not captured in the centre's risk register. For example, some personal risks identified included the management of aggression associated with behaviours that challenge and had been assessed as a high risk but were not reflected as a centre based risk in the risk register. Therefore, improvement was required to ensure the provider's framework for oversight of risk

was effectively implemented in the centre.

There was evidence of the provider's implementation of both National and local safeguarding vulnerable adults policies and procedures. Staff had received up-to-date training and refresher training in safeguarding vulnerable adults was available if and when required. Intimate care planning was also in place for residents as required, these plans focused on skill teaching and supports to help residents increase their personal care skills and independence.

Residents living in the centre required positive behaviour support and it was noted behaviour support planning arrangements were in place to meet those needs. Where required, some behaviour support plans had received a review in response to an increase in incidents earlier in the year. Behaviour support planning followed a positive behaviour support framework and outlined a number of proactive strategies and de-escalation techniques which could help to mitigate and manage incidents of behaviours that challenge. Staff had received training in behaviour support and the implementation of breakaway techniques.

Where restrictive practices were in place, they had been referred to the provider's Human Rights Committee for review. Logs and details of restrictive practices implemented were maintained locally. Where an increase of restrictive practices had occurred it was noted a behaviour support review had taken place with further healthcare reviews occurring in an effort to reduce any causes or triggers that may make the behaviours more likely to occur.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required. The provider had created a suite of COVID-19 related policies and procedures for the organisation. Personal protective equipment was available for staff and hand washing facilities were adequate in the centre with a good supply of hand soap and alcohol hand gels in place also. Each staff member and resident had their temperature checked daily as a further precaution.

The inspector reviewed the centre's COVID-19 staffing contingency and isolation planning with the person in charge. Some discussion and review between the inspector and person in charge identified where revisions to isolation planning for residents and staff contingency response planning could be further enhanced. The person in charge undertook to review these plans during the course of the inspection.

Each resident had received a comprehensive assessment of need which had been completed for 2020. Residents' assessed needs were identified and for the most part support planning was in place to provide guidance for staff in how to support the resident's assessed need in relation to management of behaviours that challenge or medication supports for example.

However, some improvement was required to ensure a support plan was in place for each identified assessed need for residents and outlined all the various support

interventions and measures in place in one specific support plan document. For example, where a resident's assessed health care need required daily recording notes, medication management and regular reviews by a clinician it was evidenced that a separate system and record was maintained for each of those aspects. However, a overarching support plan which identified each process in place, guidance for staff in how to implement them, how often they occurred and criteria for when they should be updated and reviewed was not in place.

Regulation 26: Risk management procedures

Not all risks managed in the centre had an associated risk assessment in place. Not all risks managed in the centre were captured in the centre's risk register.

Judgment: Substantially compliant

Regulation 27: Protection against infection

It was demonstrated that appropriate infection control procedures were in place and in adherence with public health guidance. Some further improvement of staff contingency planning and resident isolation planning was carried out by the person in charge during the course of the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Some improvement was required in relation to support planning for some of the assessed needs for residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Staff had received training in the management of behaviours that challenge. Behaviour support planning was in place and had been reviewed following an increase of incidents earlier in the year.

Where restrictive practices were in place, they had been reviewed by the provider's

Human Rights Committee.

Judgment: Compliant

Regulation 8: Protection

Staff had received training in safeguarding vulnerable adults. Localised policies and procedures in place were reflective of national safeguarding vulnerable adults policies and procedures. Intimate care planning focused on promoting and encouraging residents' self-help skills and independence.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bird Hill OSV-0005660

Inspection ID: MON-0023881

Date of inspection: 05/11/2020

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 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. St Catherine's Association routinely complete a full review of the designated centre staffing requirements based on multiple criteria, including;
a. the ever evolving assessed need(s) of individual residing in the centre,
b. their individual support needs requirement during specific activities, and
c. a complete review of the delivery of safe and effective service over the previous 12 month period with due consideration given to tracking / trending of presenting incidents of concern and associated consequence of these adverse events.
An outcome of this review process is that St Catherine's Association agree core hours between the Senior Management Team and the Person-In-Charge based on analysis of the available information. Review meetings are usually scheduled for the beginning of each year, and analysis from the previous 12 months is considered.
Core hours run rate of 372 hours was agreed for 2020 as suitable to provide safe and effective service in Bird Hill based on a thorough examination of available data from the previous 12 months. Unfortunately the agree WTE's for 2020 was not reflected accurately in the locations Statement of Purpose, therefore St. Catherine's Association will revise and update the relevant section of the centres' Statement of Purpose effective immediate, and submit to the Regulator.
2. Due to COVID-19, St Catherine's annual review of staffing requirements in 2021 for Bird Hill will be larger conducted remotely as St Catherine's Association seeks to curtail face-to-face appointments. Following the thorough review process, as detailed above, St Catherine's Association will agree core hours for the coming year. If this figure differs from the 2020 core hour run rate, a further review of the location's Statement of Purpose will be conducted and submitted to Regulator if necessary.
3. St. Catherine's Association is actively engaged in an on-going recruitment process to identify and recruit suitable social care workers, as and when required.

Time-scale;

1. 18th December 2021
2. 31st March 2021

3. As necessary	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. A full Health and Safety review of the designated centre to be scheduled and conducted by the organisational Environmental, Health and Safety Officer. The process will include;
a. A full review of all current risk assessments and associated/supporting documentation; incl. individual risk assessments, individual risk profiles, individual risk registers, locational risk assessments, locational risk register, supporting trend analysis in delivery of evidence-based assessments, etc.
b. The identification of new / previously not considered risks, and production of appropriate risk assessment where necessary,
c. And full Health and Safety report focused on Risk Management; plus action plan for identified deficits.
2. Following inspection, a review of the relevant risk assessments identified an over-scoring of individual risk assessment relating specifically to Physical Aggression. A review of trend analysis identified that likelihood ratings were not in line with frequency of incidents occurring in the location. Improvements in organisational oversight are therefore required to address the discrepancy as current bi-monthly reporting would appear not to be sufficiently robust. As of Q1 2021, all centre's will be required to make risk management assessments and registers available to the Quality & Compliance department for continuous spot-check and review.

Time-scales;

1. 31st January 2021
2. 31st January 2021

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. A full review of individual assessed needs to be conducted by the relevant key-worker(s) to ensure all relevant associated support plans are in place to guide staff work

practice. The Person-In-Charge / designate will review the key-worker individual assessed need report and put a corrective action plan in place to address any identified deficit(s).
2. Assessed Need review forms an integral part of future key-worker meetings [i.e. agenda item] ensuring support plans remain accurate, up-to-date, and that continual improvements are achieved in supporting an individual's assessed need(s).
3. St Catherine's Association will create a supplementary, overarching support plan document that ties together existing associated documentation for an assessed need. The support document will clearly identify each process in place for the associated assessed need and will provide appropriate direction and guidance to staff on implementation of same. The document will include a version history for relevant supporting documentation, and review criteria to ensure that information is accurate, up-to-date, and provides sufficient organisational oversight through provider-led inspections.

Time-scale;

1. 28th February 2021
2. As required
3. 31st March 2021

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/03/2021
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	31/01/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days	Substantially Compliant	Yellow	31/03/2021

	after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			