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:	Skylark 3
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	10 May 2021
Centre ID:	OSV-0007415
Fieldwork ID:	MON-0032801

About the designated centre

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

Skylark 3 provides a full time residential service to 4 males over the age of 18 with a primary diagnosis of Intellectual Disability.
The centre which is located in Limerick city is a 2 story detached house which provides single rooms for all residents. The house has a kitchen, dining area, bathroom and toilet facilities as well as areas for relaxation and socialisation. The house has an outdoor area with sitting area. All bedrooms are single and the ground floor bedroom has en suite WC. Residents have open access to a secure back garden.
The purpose of SKYLARK 3 is to make every effort to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person. To achieve the purpose of the Designated Centre a person centred approach is adopted by staff and management. The centre is managed by a person in charge and a team of social care workers and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 10 May 2021	10:00hrs to 17:00hrs	Cora McCarthy	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the residents in this centre were supported to enjoy a good quality of life and to have meaningful relationships in their local community. The inspector observed that the residents were consulted in the running of the centre and played an active role in decision-making within the centre.

On the day of inspection the inspector had the opportunity to meet and speak with all four residents. Conversations with residents took place from a 2-metre distance, wearing the appropriate personal protective equipment (PPE) and was time-limited in line with national guidance.

The inspector received a very warm welcome from the residents and was shown around the centre by one resident. The residents were very proud of their home and showed the inspector paintings and photographs they had decorated their home with. The residents were observed engaging in a video call to friends in other parts of the service. There was also a music zoom class that the residents were involved with on the day of inspection. The residents were very articulate and told the inspector clearly that they were happy and felt safe in their home. Residents are also supported to keep in contact with their family on a regular basis, and during the current health pandemic, this was primarily through video and telephone calls.

The inspector reviewed feedback that had been submitted by families as part of the annual report consultation process. These families said they were satisfied with the quality of care and support provided to their family member. One family member said they never saw their family member so happy since they moved to the new house.

Residents were observed cooking lunch with support from staff. The staff were noted to support the residents in a very respectful manner while maximising the residents independent living skills. The inspector spoke with one resident who discussed his upset at losing a parent. The resident was very upset and the staff member present was very caring and spoke to the resident about bereavement support that the resident had previously utilised. They advised that the resident could access the support again and that they would support them to do so. They also suggested a trip to visit the parents grave which the resident agreed to. It was obvious that the staff were very aware of the residents needs.

Residents were encouraged and supported around active decision-making and social inclusion. Residents participated in weekly residents' meetings where household tasks, activities and other matters were discussed and decisions made. Where appropriate, residents were encouraged to help out in household tasks. For example, a staff member advised the inspector that one resident enjoyed helping out with meal preparation.

The inspector observed that, overall, the residents' rights were being upheld in this

centre. The provider supported a self-advocacy group within the organisation and information about this group was on display in the house. Where appropriate, informed consent and decisions relating to the residents were made in consultation with the residents' family members. The inspector saw that satisfactory consent forms, and decision-making assessments were included in residents' personal plans.

The centre was a new building and was very modern, clean and comfortable. Each resident had their own bedroom and had decorated it to their taste, with personal belongings and photographs etc. The residents stated that they were happy and were very well supported and cared for by staff and loved their home.

In summary, the inspector found that each resident's well being and welfare was maintained to a good standard and that there was a visible person-centred culture within the designated centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The findings on the day of this inspection found that the designated centre was adequately monitored. There was a clearly defined management structure, which identified the lines of authority and accountability for all areas of service provision. The person in charge held the necessary skills and qualifications to carry out the role and the day-to-day management of the centre. The person in charge was appointed person in charge of more than one centre.

The provider had ensured that staff numbers and skill mix at the centre were in line with the assessed needs of the residents and with the statement of purpose. The inspector reviewed the actual and planned staff rota which indicated continuity of care from a core staff team. The staff members whom the inspector spoke with were very knowledgeable around the residents' assessed needs and their abilities.

The person in charge had a training matrix for review and the inspector noted that all staff had received mandatory training. It was noted that some mandatory training had been cancelled due to the COVID-19 pandemic, however, the person in charge had ensured that staff members were scheduled to access appropriate online trainings until face-to-face training could recommence. Discussions with staff demonstrated that staff were supported to access mandatory training in line with the provider's policies and procedures in areas such as safeguarding, medication management, fire safety and infection control.

Clear management structures were in place. The provider had also undertaken unannounced inspections of the service and an annual review of the quality and

safety of service was carried out for 2020. This annual review included a review of information gained from consultation with families/representatives and residents, notifications, complaints, quality and safety and safeguarding. However some issues were not identified in the audit for example incidents of a safeguarding nature had not been identified and reviewed. Incidents which were written up in the daily notes and described as incidents had not been recorded on the providers internal incident recording system. This was not in line with the providers own policy for reviewing incidents. The inspector found four such incidents of of a safeguarding nature between residents. These incidents were discussed at multi disciplinary meetings but not recorded as such and were not notified to the designated officer for review. Therefore these incidents were not notified to the chief inspector in line with regulatory requirements.

The registered provider had a written statement of purpose in place for the centre, which contained all information required under Schedule 1 of the regulations.

The provider had an effective and accessible complaints process in place. There were no active complaints at the time of inspection

Regulation 14: Persons in charge

The person in charge demonstrated the relevant experience in management.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the number of staff was appropriate to the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had a training matrix for review and the inspector noted that all staff received mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the centre was effectively monitored. Some issues in the designated centre were not identified in the annual review audit. For example, incidents of a safeguarding nature had not been identified as such and reviewed. Incidents which were written up in the daily notes and described as incidents had not been recorded on the providers internal incident recording system.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had a written statement of purpose in place for the centre, which contained all information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents of a safeguarding nature were notified to HIQA.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured there was a effective complaints system in place.

Judgment: Compliant

Quality and safety

The inspector reviewed the quality and safety of care received by the the residents in the centre and found it to be of a good standard. The inspector noted that the provider had implemented the necessary protocols and guidelines in relation to good infection prevention and control to ensure the safety of all residents during the

COVID-19 pandemic. These guidelines were in line with the national public health guidelines and were reviewed regularly with information and protocols updated as necessary. For example, when staff were coming into the centre they had to adhere to COVID-19 protocols such as temperature checks, a COVID-19 questionnaire and wear appropriate personal protective equipment (PPE).

The assessment of need in some areas was positive. For example the provider had ensured that there was a comprehensive mental health support plan in place for one resident which clearly outlined the supports the resident required to maintain good mental health. This plan was developed by the keyworker and a clinical nurse specialist. Staff with whom the inspector spoke were very knowledgeable about these needs.

However where behaviours that challenge were recorded in the daily notes for one resident, there was no behaviour support plan identifying the function of the behaviour or the therapeutic interventions necessary to support and manage these behaviours. There was no evidence of psychology, psychiatry or behaviour therapy input for this resident in relation their challenging behaviour. Staff had no guidance in how to manage behavioural incidents that this resident engaged in. However there was an effective behaviour support plan in place for another resident. In relation to the above mentioned resident who had no behaviour support plan the provider had not ensured every effort was made to identify and alleviate the cause of the residents challenging behaviour as per regulation 7.

Staff demonstrated a good knowledge of the residents' health care needs and how to support them. For example staff members with whom the inspector spoke were knowledgeable about the residents needs and were aware of one residents diagnosis and supports around haemachromatosis. The residents had access to a GP and other health care professionals.

While a person centred planning meeting had being arranged for a number of residents, these overdue. Residents' goals were not set but carried forward from the previous year. There was no evidence of goal achievement in the previous year.

Appropriate user friendly information with visuals was provided to the residents to support their understanding of COVID-19 and the restrictions in place. Other visuals in place included how to make a complaint or report alleged abuse.

The provider ensured that each resident received appropriate care and support, having regard to the nature and extent of the residents' disability, assessed needs and their wishes. There was evidence of access to facilities for occupation and recreation prior to COVID-19. Prior to the COVID-19 restrictions the residents were noted to have been active in their community and were regulars in the local cafes and restaurants. The residents were out for a walk on the day of inspection.

The premises was maintained to a very good standard and was appropriate to residents needs. The centre was a new building and was very modern, clean and comfortable. Each resident had their own bedroom and had decorated it to their taste, with personal belongings and photographs.

The provider had a risk management policy in place and all identified risks had a risk management plan in place including the risks attached to COVID-19. The provider ensured that there was a system in place in the centre for responding to emergencies.The provider had ensured that residents who may be at risk of an infection such as COVID-19 were protected by adopting procedures consistent with the standards for infection prevention and control. The person in charge had ensured that the residents were still able to engage in activities such as walks and drives. Staff were observed to wear masks and practice appropriate hand hygiene during the inspection. There was adequate supply of personal protective equipment in the centre and hand sanitizer while all staff were trained in infection prevention and control.

The person in charge had ensured that all fire equipment was maintained and that there was emergency lighting and an L1 fire alarm system in place. The inspector reviewed evacuation drills which were carried out quarterly and found that they indicated that all residents could be safely evacuated in 30 seconds. Personal egress plans were in place for the residents. Fire doors were in place and the automatic magnetic closers were placed on doors.

The inspector observed that there were systems and measures in operation in the centre to protect the residents from possible abuse. Staff were facilitated with training in the safeguarding of vulnerable persons. The inspector spoke with one staff member regarding safeguarding of residents. The staff member was able to clearly outline the process of recording and reporting safeguarding concerns.

The provider had ensured that the residents had the freedom to exercise choice and control in their daily life and consent was sought from the residents for example for the COVID - 19 and flu vaccine.

Regulation 10: Communication

Residents were supported to communicate and had access to the Internet for video calling friends and family.

Judgment: Compliant

Regulation 13: General welfare and development

The provider ensured that each resident received appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and their wishes.

Judgment: Compliant

Regulation 17: Premises

The premises were laid out to meet the needs of the residents.

Judgment: Compliant

Regulation 18: Food and nutrition

The residents were supported to prepare and cook their own meals and there was adequate choice of healthy food.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place and all identified risks had a risk management plan in place including the risks attached to COVID-19. The provider ensured that there was a system in place in the centre for responding to emergencies.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that residents who may be at risk of an infection such as COVID-19 were protected by adopting procedures consistent with the standards for infection prevention and control.

Judgment: Compliant

Regulation 28: Fire precautions

The registered Provider had an effective fire management system in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a assessment of the residents needs had been completed. However residents goals were not set but carried forward from the previous year.

Judgment: Substantially compliant

Regulation 6: Health care

The person in charge had ensured each resident received appropriate health care.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured every effort was made to identify the function of behaviours that challenge and supports were provided where necessary.

Judgment: Not compliant

Regulation 8: Protection

The provider had ensured there were systems in place to protect residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had ensured that the residents had the freedom to exercise choice and

control in their lives.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Skylark 3 OSV-0007415

Inspection ID: MON-0032801

Date of inspection: 10/05/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Governance group (to include PIC and all PPIM's) of the designated centre will meet on an annual basis to review 6 monthly unannounced reports, annual review and latest HIQA inspection. • Management training in Safeguarding has taken place on June 16th and 23rd. Same attended by full governance group of the designated centre. • Clear direction will be issued re the requirement to review AIRS reports on a monthly basis to monitor trends following the safeguarding training for managers. Where a trend is identified in the monthly review of AIRS that indicates that an individual may be at risk of abuse due to frequency of incidents of a particular kind (e.g. vocalisation) and the impact of same then a CP1 and NF06 will be completed retrospectively.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Review of AIRS currently underway. Retrospective notifications will be submitted if required at the end of the review process. • Clear direction will be issued re the requirement to review AIRS reports on a monthly basis to monitor trends following the safeguarding training for managers. Where a trend is identified in the monthly review of AIRS that indicates that an individual may be at risk of abuse due to frequency of incidents of a particular kind (e.g. vocalisation) and the impact of same then a CP1 and NF06 will be completed retrospectively.	

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: • 2021 Information gathering for the Person Centred Plans has been adapted to reflect changes & goal achievements that have occurred in the lives of the people supported during 2020. Planning meetings for Person Centred Plans will be held by 30/07/2021.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Behaviour support plan created by the CNS Behaviour Support following consultation with Staff, PIC, Area Manager and MDT. Information sharing sessions will be held for staff on the behavior support plan. MDT meetings will be held for the resident in relation to supporting & managing challenging behavior with input from staff, PIC, behavior support, psychology & psychiatry. The MDT meetings will be quarterly and at other times when required.	

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/06/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days	Substantially Compliant	Yellow	01/08/2021

	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.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	01/08/2021