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:	SLS
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 24
Type of inspection:	Announced
Date of inspection:	18 December 2018
Centre ID:	OSV-0003932
Fieldwork ID:	MON-0021842

About the designated centre

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

Supported Living Service provides residential accommodation, care, and support to people with intellectual disabilities. It comprises five apartments, located in the same apartment block in a busy South Dublin suburb. It is located near multiple public transport networks as well as a wide range of local amenities including shopping centres and restaurants. It can accommodate up to seven residents, who are supported by a team of social care workers.

The following information outlines some additional data on this centre.

Current registration end date:	19/05/2019
Number of residents on the date of inspection:	6

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
18 December 2018	09:40hrs to 17:00hrs	Amy McGrath	Lead

Views of people who use the service

The inspector met with three of the residents who live in the centre. One resident spoke with the inspector, and showed them around their home. They said they were happy living there, and that they liked the staff who worked with them. The inspector observed staff and residents interacting with each other over the course of the inspection, and found that residents appeared comfortable expressing their needs, and were directing the care and support they received. For example, residents made decisions about how they would spend their day, and when they would receive visitors. Staff spoke respectfully to residents, and residents appeared happy and content in their homes.

One resident spoken with told the inspector that they had no complaints about their care or support, but would speak with staff if they had concerns. It was also expressed by this resident that they felt they were listened to by staff.

Capacity and capability

There were governance and management arrangements in place to monitor the quality and safety of the service, however there was improvement required to ensure effective oversight of key areas, and that required actions were implemented. The provider carried out an annual review of the quality and safety of the care and support delivered to residents, and developed an improvement plan based on findings. The provider also conducted a six monthly unannounced visit and subsequent report, and a review of this report found that a number of issues had been identified and included in an improvement plan, however for a number of these issues no action had been taken. For example, the report acknowledged that the designated centre was not meeting the needs of one resident; this was an issue that was identified in a previous inspection, and the action in relation to this remained outstanding at the time of inspection. The provider had not effectively deployed resources to meet the needs of all residents.

There was a range of local audits and reviews carried out by the person in charge and the social care team leader, such as medication audits and personal plan reviews. A review of residents' finances was also conducted, however this required improvement, and is discussed later in the report. Although the provider demonstrated an understanding of the quality and safety risks present in the centre, they had failed to adequately respond to some key issues. In relation to safeguarding and protecting residents from potential harm, the provider was aware of a number of ongoing issues such as incompatibility of residents (which was identified at a previous inspection) and had not sufficiently acted on these concerns. The impact of this inaction resulted in residents being exposed to

potential harm as detailed in incident forms.

The provider had prepared a statement of purpose that was reviewed at regular intervals. The information required as per Schedule 1 of the regulations, was contained within the statement of purpose, however it did not describe the specific care and support needs that the designated centre intended to meet. It also did not contain information related to the facilities and arrangements for day services.

There were sufficient staff, who were appropriately qualified and skilled to meet the needs of residents. There was an actual and planned roster, both of which were well maintained, and accurately reflected the staff on shift. The person in charge had arrangements in place to ensure continuity of care for residents, and they were supported by a consistent team of social care workers.

There was a clearly defined management structure in place, with clear lines of accountability. The staff team reported directly to a social care leader, who in turn reported to the person in charge. The person in charge reported to a programme manger, who was supervised by a regional director. All staff had received mandatory training in areas such as adult safeguarding and fire safety, and there were arrangements in place to ensure that staff training needs were identified and addressed.

The provider had not ensured that all applications for admission to the centre had been determined on the basis of transparent criteria. One resident had been admitted on a temporary basis, outside of the emergency admissions process and standard admissions process set out in the statement of purpose. The provider had prepared a contract of care for each resident, however they did not contain clear information regarding the fees to be charged to residents. In some cases, residents were being charged different fees for the same service, with no rationale for the determination of these figures.

There was a complaints policy in place, and accessible versions of complaints procedures available to residents. The provider had nominated a number of complaints officers, who dealt with complaints made by or on behalf of residents. Although there were no complaints made during the period since the last inspection, residents expressed that they knew how to make a complaint if necessary.

There were a number of policies and procedures, required under Schedule 5 of the regulations, that had not been reviewed and updated within a three year period (the minimum review period outlined in the regulations). This had been acknowledged by the provider previously and there was a plan in place to ensure all policies were up to date. The provider had not prepared and implemented a policy on the prevention, detection and response to abuse, and relied on the national policy in lieu of an organisation specific policy. This did not effectively guide staff practice in relation to protecting residents from the risk of potential abuse.

Not all adverse incidents that require notification to the Office of the Chief Inspector had been notified. For example, some incidents that were recorded as potential peer to peer abuse (such as aggressive behaviour towards a resident) had not been

notified as such.

Regulation 15: Staffing

There were sufficient staff, who were suitably qualified and experienced to meet the needs of residents. The provider had obtained the information required in respect of staff under Schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received all mandatory training, and there was a schedule of refresher training in place. The person in charge ensured that staff were appropriately supervised.

Judgment: Compliant

Regulation 23: Governance and management

While the governance and management systems in place identified gaps in the quality and safety of care delivered to residents these concerns were not appropriately responded to. Issues that had been identified by the provider, or during previous inspections, had not been addressed. Furthermore, the provider had not ensured that the centre had efficiently and effectively deployed resources, such as accommodation and facilities, to effectively deliver care and support in accordance with the statement of purpose.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had not ensured that applications for admission to the centre had been determined on the basis of transparent criteria in accordance with the statement of purpose. There were contracts of care in place for residents, however they did not include detail of the fees to be charged to residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose available that was updated regularly. It contained most of the information required by Schedule 1 of the regulations; however it did not clearly set out the specific care and support needs that the centre is intended to meet, and further detail was required in relation to the provision of day services.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all adverse incidents were notified to the Office of the Chief Inspector, as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy and associated procedures in place, and there were accessible versions of each made available to residents.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had not prepared in writing, adopted, and implemented a policy on the prevention, detection and response to abuse.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that although residents were safe, and appeared happy with the care and support they received, some of the arrangements in the centre required strengthening to ensure that key areas were being well monitored; such as assessment of need and personal planning, and safeguarding. For the most part, the provider was managing risk well, with a good knowledge of the local risks in the centre. Improvement was required in relation to medicines, personal possessions and premises.

The person in charge had not ensured that there was a comprehensive assessment of the health, personal and social care needs of each resident carried out prior to admission, and subsequently as required. While there had been some needs identified, these were primarily emerging healthcare needs, and there was insufficient information to effectively guide plans for personal or social care goals. This was identified in the previous inspection of the centre, in March 2017, and in the providers most recent six monthly report on the quality and safety of care and support, and remained an outstanding issue. In the absence of a clear and comprehensive assessment of need, it was not possible for the provider to ascertain if the arrangements were in place to meet the needs of residents, and if the centre was suitable for meeting their support needs.

While some personal plans were developed with the participation of residents, this was not the case for all plans. Furthermore, personal plans were not reviewed to take into account the preference of residents. For example, one plan had a number of goals identified in January 2018, which were reviewed on a regular basis with notes that the resident was not interested; despite this these goals remained active in the resident's plans for more than twelve months.

Staff had up to date knowledge and skills to respond to residents' behaviour support needs. Residents had a positive behaviour support plan in place where it was identified they had support needs in this area. These plans contained comprehensive guidance and information to enable staff to provide the appropriate support. There were some restrictive procedures in use and these were assessed for effectiveness and subject to regular review.

Safeguarding mechanisms were not robust and inspectors found that the arrangements did not support the person in charge to carry out their responsibilities under this regulation. Not all incidents of a potential safeguarding nature were appropriately screened, and where a concern was screened by a nominated person within the organisation, the subsequent safeguarding plan was not made available to the staff team for implementation. A sample of safeguarding screenings reviewed found that there was no confirmation that the relevant safeguarding and protection team had reviewed the concern, and safeguarding plans had not been subject to oversight and review as per national policy.

The inspector requested to review the organisations policies and procedures in relation to safeguarding adults, and found that the provider used the national safeguarding policy in lieu of their own organisation specific policy. This did not clearly guide staff on the procedures they were to follow, and the roles and

responsibilities of staff was not clearly outlined.

In general, there were effective risk management arrangements in place, and local risks were identified and responded to in a timely manner. Residents were supported to take measured, positive risks, and personal development and autonomy was considered throughout the risk management process. For example, residents had support measures in place to minimise risks associated with socialising in the community, so they could continue to access their local community in a safe manner.

The person in charge had not ensured that each resident was encouraged to take responsibility for their medicines, following an assessment of capacity and risk assessment. Some residents were being supported to manage their own medication in accordance with their ability and preference, and the inspector reviewed a detailed assessment of capacity in relation to one resident, however the person in charge had not ensured that this was subject to a risk assessment. In this instance, a medicine was being stored outside of its original packaging, against manufacturers advice, to support the resident in self administration; this was not identified as a risk, and therefore not subject to appropriate control measures.

While in general, the premises were well maintained and in a state of good repair, there was some furniture that required repairing, such as damaged kitchen counters. The premises were each decorated to residents' preferred style, and were well equipped. However, for one resident, the size and layout of the premises was not appropriate to meet their needs; there was insufficient space to provide support to this resident overnight, which impacted on the residents access to their home. This had been identified in a previous inspection in March 2017, and was an outstanding action from the providers action plan. Subsequent to this inspection, the provider was required to submit a provider assurance report which outlined a clear time-frame for implementation of this action.

The provider had ensured that residents retained control of their personal property; residents had their own items in their homes and these were recorded in a log of personal possessions. Residents received support with managing finances, where required, however financial support plans were not clear in relation to the level of support required, and the consent of residents to have money belonging to them paid into a financial institution.

The providers own recording and auditing systems did not effectively record or monitor the support provided to residents in relation to their banking transactions. For example, staff regularly withdrew large sums of money from a residents' bank account, and paid it into a separate savings account (each in the name of the resident). A review of records found that it was not recorded which staff member withdrew or paid money into accounts on behalf of the resident, and while a sample of checks found that sums withdrawn were deposited appropriately, this information was not easily accessible. While the person in charge conducted effective audits and reviews of cash expenditure, the auditing system needed to be widened to include banking transactions to ensure that residents had provided consent, and to protect

them from the risk of financial abuse.

The inspector reviewed the actions required from the previous inspection in relation to fire safety. The provider had clear arrangements in place in relation to the maintenance of fire equipment and containment measures. Improvements were required to ensure that evacuation plans were updated to reflect learning from fire drills; not all personal evacuation plans had been reviewed following fire drills where issues were identified. While the learning from the evacuation drills reviewed by the inspector did not represent a high risk to residents, improvements were necessary to ensure that residents' changing needs were included in evacuation plans, so as to support safe evacuation.

Regulation 12: Personal possessions

The person in charge had ensured that residents retained control of their personal property and possessions. Improvement was required to ensure that the provider had obtained the consent of residents prior to paying money into an account held in a financial institution.

Judgment: Substantially compliant

Regulation 17: Premises

In general, the premises were maintained well and in a good state of repair. However, for one resident, the premises was not suitable to meet their assessed needs. This was an outstanding issue from the previous inspection.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were arrangements in place to manage risk, including a risk management policy and associated procedures. Risks to residents were identified and managed, to promote the safety and autonomy of residents.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector reviewed outstanding actions from the previous inspection, including arrangements to evacuate residents in an emergency, and found that suitable arrangements were in place, although the implementation of learning from fire drills could be improved.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had ensured that there were appropriate practices in place in relation to the administration of medicines. While there was a capacity assessment conducted, and support plan developed for one resident, this had not been carried out for all residents. Additionally, risk assessments had not been carried out in relation to self management of medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Although the provider had carried out various assessments in relation to residents needs, there was no comprehensive assessment of need conducted and reviewed on an annual basis. Not all personal plans were developed with the maximum participation of residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Staff had received appropriate training in the provision of positive behaviour support. There were comprehensive positive behaviour support plans in place for residents who required support in that area.

Judgment: Compliant

Regulation 8: Protection

The person in charge had not initiated and carried out an investigation in relation to

all incidents, allegations or suspicions of abuse. The arrangements for responding to safeguarding incidents did not facilitate the person in charge to fulfil their responsibilities under this regulations.

The providers failure to act on safeguarding concerns, which they were aware of, exposed residents to potential incidents of harm.

Judgment: Not 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for SLS OSV-0003932

Inspection ID: MON-0021842

Date of inspection: 18/12/2018

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:

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

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 12(4)(a)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the consent of the person has been obtained.	Substantially Compliant	Yellow	14/03/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	24/05/2019
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff	Substantially Compliant	Yellow	30/04/2019

	shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	24/05/2019
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	24/05/2019
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on	Not Compliant	Orange	28/02/2019

	the basis of transparent criteria in accordance with the statement of purpose.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	30/03/2019
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.	Substantially Compliant	Yellow	14/03/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or	Not Compliant	Orange	04/02/2019

	her disability.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	04/02/2019
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	04/02/2019
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/08/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/08/2019
Regulation 05(1)(a)	The person in charge shall	Not Compliant	Orange	30/04/2019

	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.			
Regulation 05(1)(b)	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 subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/04/2019
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	30/04/2019
Regulation 08(3)	The person in	Not Compliant		04/02/2019

	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.			