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:	Ailesbury Park
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	09 May 2019
Centre ID:	OSV-0001992
Fieldwork ID:	MON-0024955

About the designated centre

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

This designated centre is a home to three male/female adults with an intellectual disability. The house is a bungalow is on the outskirts of a large town in Co. Kildare. The designated centre consists of four bedrooms, one bathroom (wet-room), a kitchen, a sitting room, a personal computer room, a toilet and a utility room. There is a small patio area out the back of the house and to the front a small garden area. A bus is made available to this centre in the evenings and during the day if required. The person in charge divides her time between this centre and one other. There are two social care leaders and four care assistants employed in this centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
09 May 2019	10:30hrs to 19:50hrs	Jacqueline Joynt	Lead
09 May 2019	10:30hrs to 19:50hrs	Andrew Mooney	Support

Views of people who use the service

The inspectors met with all three of the residents in the centre and spoke with one resident in detail in the afternoon. Where appropriate staff supported the residents communicate with the inspectors so that their views could be relayed. The inspectors observed elements of the residents' daily lives throughout different times of the day.

The inspectors spoke in detail with the operations manager and one staff member who advocated on behalf of the residents and provided a clear view of what it was like for residents to live in this centre.

One resident advised the inspectors that they were happy with their staff and named a few staff members that they particularly liked going on activities with. The resident advised the inspectors that they knew who they could talk to if they were not happy or wanted to make a complaint.

In conversation, one of the residents told the inspectors that they were not happy living in this centre as they would prefer to be living in their family home.
They informed the inspectors that they had talked to the person in charge and the person participating in management about how they felt. They also advised that they were not always happy with their interaction with another peer and that they had talked to staff about this also. Later in the day one of the inspectors observed the person participating in management arranging a meeting with the resident to talk more about the areas the resident was unhappy about. The resident appeared happy after this conversation.

Overall, the inspectors observed that there was an atmosphere of friendliness in the house and that staff were kind and respectful towards the residents through positive, mindful and caring interactions.

Capacity and capability

The inspectors found that overall, the governance and management systems in place ensured the delivery of a safe and quality service. The inspectors found that there was a comprehensive auditing system in place by the provider to evaluate and improve the provision of service and to achieve better outcomes for the residents.

Further to the annual and six monthly reviews the person in charge carried out

monthly audits to support them ensure the operational management and administration of centre resulted in safe and effective service delivery.

A notification had been sent to the office of the chief inspector to notify of the planned absence of the person in charge. The form advised of the appointment of a new person in charge during this period however, on the day of inspection it was found that there had been an error on the notification and that the person listed as the person in charge was not aware of their position. This oversight did not result in risk to residents living in this centre and the provider submitted an updated form the following day. The re-submitted notification provided the necessary assurances that the designated centre would continue to be properly managed when the person in charge was absent.

The staffing arrangements included enough staff to meet the needs of the resident and overall, were in line with the statement of purpose. However, improvements were required to the staff roster so that it clearly identified the person in charges' hours of work in this designated centre.

The inspectors found that there was a continuity of staffing so that attachments were not disrupted. The inspectors reviewed the staff roster and saw that where relief staff was required, either the current staff members were employed for extra hours or the same relief staff members that were familiar to the resident were employed.

The inspectors saw that the majority of staff training was up to date however, on the day of inspection, a training course specific to the needs of the residents had not been provided to all staff.

Staff who spoke with the inspector demonstrated a good understanding of residents' needs and wishes and were knowledgeable of policies and procedures which related to the general welfare and protection of residents.

Performance management meetings were taking place on a quarterly basis to support staff perform their duties to the best of their ability. Staff advised the inspector that they found these meetings to be beneficial to their practice.

The registered provider had established and implemented effective systems to address and resolve issues raised by residents or their representatives. Residents who spoke with the inspector advised that they knew who to make a complaint to. Furthermore there were systems in place, including an advocacy services, to ensure residents had access to information which would support and encourage them express any concerns they may have.

The registered provider had record keeping systems in place that included a mixture of electronic and paper based records. During the inspection, this led to delays in retrieving important information throughout the day. These difficulties were raised with the person in charge during the inspection.

Regulation 15: Staffing

Overall, the staff roster was in line with the statement of purpose and was maintained satisfactorily however, the staff roster did not clearly identify the person in charges' hours of work in this designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Overall, staff were provided with training that enabled them carry out their duties to the best of their abilities however, on the day of inspection the inspectors found that all staff had not received training on dysphagia.

Judgment: Substantially compliant

Regulation 21: Records

Records were maintained, however they were not easily retrievable during the course of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

An annual review had been completed in the centre and an unannounced six-monthly visit had been carried out as required by the regulations.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was in line with the service being delivered and was made available to the residents and their families.

Judgment: Compliant

Regulation 31: Notification of incidents

Overall, notification of incidents were submitted as per regulation requirements however, on the day of inspection the inspectors found that the required quarterly notification NF39D regarding, any injuries other than those notified under NF03, had not been submitted for quarter one.

Judgment: Not compliant

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

On the day of inspection the inspectors were informed by management that a section of the notification form had been completed incorrectly. This resulted in the misinformation of who the current person in charge was of the designated centre and the arrangements in place for the running of the centre while the person in charge was absent.

The inspector found that this notification had not been sent to the office of the chief inspector within the required 28 days.

Furthermore, the notification had not been signed off by the appropriate approved person.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a photo of the complaint's officer and accessible information on how to make a complaint in a communal area in the designated centre. Furthermore, there was an advocacy service in place for residents should they want to talk to someone other than the complaint's officer.

Judgment: Compliant

Quality and safety

Overall, inspectors observed a safe service being delivered to residents. However, fire precautions systems required improvement and there were gaps in some documentation which negatively impacted the quality of service delivered.

The centre had appropriate fire-fighting equipment, fire alarm, emergency lighting and fire safety checks in place. The centre carried out regular fire drills and followed up on any learning identified from these drills. However, during the inspection the inspectors observed that some high risk areas did not have suitable fire doors in place. For instance the kitchen door did not have a automatic fire closing mechanism. Additionally, inspectors observed that not all parts of the emergency lighting was working correctly. This was raised with the provider and remedial actions were undertaken to resolve the issue. Furthermore, while staff had received appropriate fire safety training not all staff who worked in the centre had participated in a fire drill.

Each resident had a comprehensive assessment of need and an appropriate personal plan. Families and friends were welcomed by the service and they participated in and were regularly involved in residents lives. However, the arrangements to ensure assessments of need were regularly updated and reviewed required improvement. For example a resident that was identified as requiring regular speech and language assessment due to a risk of choking had not been assessed as required. Residents exercised choice and control in their daily lives and were supported to maintain personal relationships and links with the community. Personal plans outlined the supports required to maximise residents' personal development. However the system for reviewing personal plans required improvement. On review of a sample of personal plans and discussions with staff, it was evident that some information recorded within a residents' personal plan was inconsistent with the practice within the centre and this may have led to conflicting care.

There was a lack of appropriate positive behaviour support plans in place to guide staff when supporting residents with their assessed needs. Some environmental restrictions were implemented to protect residents. However, these were inconsistently applied and it was unclear if they were the least restrictive option for the shortest duration possible. For example, inspectors were told that all exits were locked to support a resident with their assessed needs. However, inspectors observed an exit door from a room used by this resident, unlocked. Staff spoken with confirmed that this door was always left open. It was therefore unclear why all other exit doors would be locked. Furthermore, reviews of restrictive interventions did not clearly identify what alternative measures were considered prior to the implementation restrictive practices. For instance there was a practice in place to lock certain internal doors at night, however it was unclear what alternatives

were considered prior to the implementation of this restriction.

Risk was generally managed appropriately and there were policies and procedures in place to support this. The provider had initiated reasonable measures to prevent accidents. When adverse incidents did occur, there was an electronic system for recording adverse incidents and this escalated risk appropriately. Inspectors observed a sample of adverse incidents and noted reasonable responses to them. However, not all identified risks were reviewed in a timely manner.

The centre design and the layout was as described in the statement of purpose. Residents bedrooms were decorated in accordance with their preferences and this led to the centre feeling welcoming and homely. However, inspectors observed some maintenance issues within the centre that had not been identified or resolved within a timely manner. This included a a broken light switch and some small areas that required painting. The main bathroom had a very strong unpleasant smell and this was discussed with staff during the inspection, they outlined that this may have been a problem with the roof and that the maintenance department were investigating the issue. However, on further review it was identified that this issue had not been formally logged on the centres maintenance request list.

Regulation 17: Premises

The design and layout of the centre was in line with the statement of purpose. However, some areas of the centre required decorating and some maintenance issue had not been responded to appropriately.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was a system in place for the assessment and management of risk but reviews were not ongoing. For example not all risk assessments had been reviewed in a timely manner.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The building was not adequately subdivided with appropriate fire containment measures. There was no fire closing mechanism on the kitchen door and there was no fire door installed on the utility room. Additionally, not all emergency lighting

within the centre was operating as intended on the day of inspection. Not all staff had completed a fire drill within the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Not all residents comprehensive assessments of need had been reviewed annually. Additionally, some information recorded in a residents' personal plan was inconsistent and could have led to conflicting care.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was insufficient guidance for staff in relation to supporting a resident with their assessed needs. Some environmental restrictions were not consistently applied and others were not reviewed appropriately to ensure they were the least restrictive option for the shortest duration.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Ailesbury Park OSV-0001992

Inspection ID: MON-0024955

Date of inspection: 09/05/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider has amended the staff roster to identify the specific hours the PIC is working in the designated centre. This was completed on 24/5/2019	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Registered Provider has reviewed staff training records to satisfy themselves that all staff in the Designated Centre have completed Dementia Awareness Training, this was completed on 25/5/2019 The Person in Charge will ensure that all staff complete training in Dysphagia by 30/6/2019	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Registered Provider will have all residents' records stored and accessible through a single Electronic Client Record System by 30/9/2019	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The Registered Provider has updated its procedure to facilitate notification of non-serious injuries to HIQA into the future and has submitted the non-serious injury through an NF39D notification on 9/5/2019	
Regulation 32: Notification of periods when the person in charge is absent	Not Compliant
Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent: The Registered Provider has reviewed the procedure for notifying HIQA of planned absence of Person in Charge for 28 days or more, to ensure timely and accurate submission of NF30Bs. This was completed by 20/5/2019	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider has replaced the broken light switch and will address the decoration and maintenance issues by 30/6/2019	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

The Registered Provider will have an electronic system in place to support the timely review of individual risk assessments by 31/9/2019 The Person in charge will update the individual's risk assessment and ensure the controls are appropriately reflected in the House Risk Register by 30/6/2019

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Registered Provider had the Emergency Light repaired on 10/5/2019 The Registered Provider will install a fire closing mechanism on the Kitchen door by 30/7/2019 The Register Provider will install a Fire Door in the Utility room. This will be completed by 30/7/2019 All staff members have participated in a Fire Drill, this action was completed on 30/5/2019	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The Registered Provider has satisfied itself that residents' Assessment of Needs have been updated annually and a system in place to ensure they reviewed annually. This was completed by 29/5/2019 The Person in Charge will ensure the resident's Individual Support Plans reflect their current support need. This will be completed by 30/6/2019	
Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Person in Charge will consult with relevant others to review all Restraint/Restrictive Practices Assessments and Plans to ensure alternative measures are considered and the least restrictive practice in in place and that all staff are fully aware of these plans. This action will be completed by 30/7/2019

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	24/05/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2019
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.	Substantially Compliant	Yellow	30/06/2019
Regulation 21(1)(b)	The registered provider shall ensure that records	Substantially Compliant	Yellow	30/09/2019

	in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.			
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	30/09/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	10/05/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/07/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/05/2019
Regulation 31(3)(d)	The person in charge shall ensure	Not Compliant	Orange	09/05/2019

	that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.	Not Compliant	Orange	20/05/2019
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	25/05/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is	Not Compliant	Orange	30/06/2019

	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 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/07/2019
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/07/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/07/2019