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:	Leeside
Name of provider:	Health Service Executive
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	12 March 2019
Centre ID:	OSV-0003319
Fieldwork ID:	MON-0026022

About the designated centre

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

The service is a secure unit or four adult males with intellectual disability and severely challenging behaviours. It is staffed by qualified social care staff.
The premises is a two story building with each resident having their own individual bedroom with en suite. It is located in a rural site but with easy access to all local and community facilities. There is a commitment to the process of maximising the health and social well being of each service user, where individual choice and community participation are encouraged with staff supports.

The following information outlines some additional data on this centre.

Current registration end date:	27/10/2019
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
12 March 2019	09:30hrs to 18:00hrs	Noelene Dowling	Lead

Views of people who use the service

The inspector met and spoke with two of the three residents. One resident communicated in their own preferred manner and stating they were looking forward to their planned activities. The resident was observed going out with staff to cycle to the nearby town.

Another resident showed the inspector their own accommodation, and said that they were happy with their life in the centre, and enjoyed taking part in all of the activities. However, the resident also described how some of the incidents which had occurred in the centre had disturbed and disrupted him but that staff tried to make sure they were OK.

The resident outlined plans being made to provide more independence from the main unit but that stated they would still like access to the centre for meals and social occasions and wanted the support of staff.

Capacity and capability

Management systems were not fully effective to ensure the service was safe and suitable for all the residents. This inspection was undertaken in order to ascertain the provider's actions following an unannounced inspection in August 2018. At that time, significant issues emerged regarding the governance arrangements in the centre which had negatively impacted on resident's health and welfare.

On this inspection, the person in charge was on extended leave, and there were no suitable arrangements found to be in place regarding the management of the centre. The inspection was also informed by information received by HIQA prior to this inspection which indicated that systems for responding to, and acknowledging, concerns raised on behalf of residents required improvement.The provider was requested to submit a detailed assurance report to HIQA. This matter was found to be resolved on this inspection. The director of services was appointed as person in charge on an interim basis for this inspection.

The inspector found many issues identified on the previous inspection had been addressed.There was evidence of systems being implemented to provide better oversight of practice. These included residents having appropriate access to healthcare reviews, staff training and supervision had improved as had overall support provided to the residents.

However, further more proactive approaches to the management of the complex needs of the residents was found to be necessary. This would help to ensure that

the residents achieved the best quality of life despite the complexities of their care needs. This is confirmed by the findings on safeguarding, risk management and behaviour supports detailed in the quality and safety section of this report.

There was a very high staff ratio available to support the residents. When speaking with and observing staff, they demonstrated a commitment to and were very familiar with the residents' needs. They were suitably qualified for their posts and had demonstrated resilience in managing some very complex situations. However, they advised that further clinical review and guidance in supporting the residents' complex behaviours was needed.

The inspector reviewed the accident and incidents records and noted that there was insufficient review of the significant incidents to demonstrate appropriate learning and avoid re-occurrences. While audits were undertaken, there was no substantive analysis of accidents and incidents occurring, to support learning and robust risk management.

The provider had undertaken one unannounced inspection in 2018 and there was an annual report completed for 2018. Both of these reviews identified issues of compatibility of residents living in the same environment, reviews of the significant restrictive practices being necessary, and the poor level of incident review. It was apparent therefore that these issues were known to the provider. While there were tentative plans outlined to address them, such as reconfiguring the centre, to provide greater separation of accommodation. These measures had not yet been formalised or implemented.

It was of concern that a number of incident reports viewed by the inspector indicated that the threshold for negative peer to peer interactions were not recognised, managed and subsequently reported to HIQA as safeguarding concerns.

Regulation 14: Persons in charge

The person in charge arrangements in place were not found to be satisfactory.

Judgment: Not compliant

Regulation 15: Staffing

There was a very high staff ratio available to support the residents and staff were found to be committed to and very familiar with the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were suitably qualified for their posts and all additional mandatory training was provided.

Judgment: Compliant

Regulation 23: Governance and management

There were gaps identified in both the governance arrangements and the systems used to ensure the service is safe and suitable to meet the needs of the residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose accurately reflects the service and care being provided in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge failed to notify HIQA of a number of relevant safeguarding incidents.

Judgment: Not compliant

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

The provider failed to notify the Chief Inspector of the planned absence of the person in charge for a period longer then 28 days.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents were aware of how to complain and who to complain to. Issues raised were seen to be managed satisfactorily at the time of the inspection.

Judgment: Compliant

Quality and safety

The residents were supported by staff to have active and meaningful lives. Their social care needs and preferences were clearly identified and were being supported by staff on a day-to-day basis. The residents had 1:1 staffing for all day time activities. Most activities, routines and day services were undertaken individually and tailored to the individual residents. Access to the community was well supported under strict supervision. They participated in numerous individual activities outside of the centre. They went cycling, swimming, attended art and drama which they said they enjoyed. They knew how to make complaints and where necessary staff used social stories and pictures to help them communicate. They were observed to be comfortable with the staff and busy with their various activities.

The residents had good access to allied healthcare assessment and interventions. Staff were seen to support and encourage them to manage their primary and healthcare needs very well.

The residents all had detailed support plans which detailed their heath, personal and psychosocial care needs and these had been reviewed.

However, despite this, the inspector found that there was a lack of comprehensive review of their care needs, risk and incident management, and insufficient access to psychological, psychiatry and other specialist clinicians given the complexity of the resident's needs and the purpose of the centre.

This is demonstrated by the following:

The centre is fully secure externally and internally with significant restrictions in place (in order to promote the resident safety).

There were a significant number of peer to peer incidents and behaviours which had serious consequences. For example, on a number of occasions the master keys used by staff were taken.This impacted on the safety of other residents and staff.

On occasions, other residents were threatened and intimidated to leave certain areas of the centre. Residents were being negatively impacted upon and this had

not been acknowledged as a safeguarding concern, except in the most serious of incidents. It is acknowledged that staff made every effort to mitigate the impact of the incidents. The provider had, however, acted in a responsible manner and taken appropriate action when other safeguarding concerns were reported.

There were detailed behaviour support plans available to staff. However, in one instance the inspector noted that in 2017, the treating psychiatrist had requested that a detailed psychological and environmental assessment be undertaken. This was necessary so that a full multidisciplinary review could be undertaken, given the increasing needs emerging. This was scheduled for March 2019.This delay did not demonstrate adequate recognition of the urgency of the situation.

Risk management processes were not consistent. Some risks are being managed very well by the 1:1 staffing and the level of supervision for the residents, both internally and externally. However, bedroom door censors had been installed for specific safeguarding purposes. These had not worked for some time and had not been fixed or replaced. In other instances, there was no management oversight or the incident reports for a number of weeks after an incident and no changes made to address the risks presented. This provided no guidance or support to staff.

The inspector was advised that plans were being made to provide individual and self-contained accommodation within the centre. This option would provide a more suitable environment and serve to protect residents while also meeting all needs. These had not been progressed sufficiently however, at the time of this inspection.

A number of different restrictions were in place. While a number were very pertinent for safety reasons, there was no complete record of the restrictions which would have assisted in reviewing them. This would also help to identify the impact on residents who may not require them within the centre.

Fire safety management systems were satisfactory however, with the required equipment and fire containment systems in place and serviced as required. Residents participated in evacuation drills.

Regulation 26: Risk management procedures

Risk management processes were not consistently satisfactorily with insufficient review of incidents and actions taken to address identified risks and learn from untoward events.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety management systems were satisfactory with the required equipment and fire containment systems in place and serviced as required. Residents participated in evacuation drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Systems for the management of medicines were satisfactory.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The residents' social care needs and preferences were clearly identified and they had access to a range of social, recreational and training activities of their choosing. However, their care reviews, while undertaken regularly were not sufficiently informed by clinical assessment to ensure the care provided and the environment was suitable to their needs.

Judgment: Substantially compliant

Regulation 6: Health care

The residents had good access to allied healthcare assessment and interventions.

Judgment: Compliant

Regulation 7: Positive behavioural support

While there were detailed behaviour support plans available to staff, additional clinical advise and support was not sufficiently available to ensure the causes of the behaviours were identified and where possible could be alleviated.

Restrictive practices were not sufficiently assessed and reviewed.

Judgment: Not compliant

Regulation 8: Protection

On occasions, residents were threatened, intimidated and significantly disrupted by behaviours that challenged.This experience was not recognised as abusive and no adequate safeguarding systems were implemented to protect them, despite the efforts of staff.

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 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not 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 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	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	Not compliant

Compliance Plan for Leeside OSV-0003319

Inspection ID: MON-0026022

Date of inspection: 12/03/2019

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A recruitment campaign is underway to recruit a permanent Social Care Manager/ Person in Charge (PIC) with interviews will be held in May. Since this inspection, an interim arrangement has been put in place. This is as follows: The Director of Nursing for the service been appointed as the Person in Charge (PIC) to cover Social Care Manager's leave or until the permanent appointee is in place whichever is sooner.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: As per above: A Person in Charge has been appointed for the centre. A recruitment campaign is underway to fill the Social Care Manager position. A Social Care Leader works full time in the centre to support the Person in Charge. On the 14.2.19 the roles/ responsibilities and duties of each person in relation to management and governance of the centre were discussed and agreed by the local management team. These have also been circulated to the staff team for their information and clarity. Monthly staff meetings and local managers meetings are scheduled for the year. The agenda, minute template and actions template used are from the HSE's Quality Improvement Division. The CHO5 Disability Practice Development Coordinator is supporting the audit cycle for the centre to ensure staff have the capacity and capability to undertake these audits on their own from June 2019. The practice development co-ordinator in conjunction with the PIC will be testing the system to provide assurance that all follow up actions are implemented and reviewed for effectiveness.	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The staff member on duty will report all incidents to the PIC or the SCL in person or by phone if they are not present in the house.
• The staff member on duty will complete an incident form.
• All incidents are screened at the time they are reported for any safeguarding concerns as per the HSE National Safeguarding Policy.
• The SCL or PIC receiving the report will notify all relevant incidents within the required timeframes.
• A service level report on the incident is developed if the incident reaches the threshold for further reporting.
• The is PIC available to the SCL at any time for any support with regard to screening the incident or ensuring that all incidents requiring notification are sent to all relevant statutory agencies and personnel

In addition to this process:
• The HSE Safeguarding Team and newly appointed Quality and Patient Safety (QPS) Advisor for Disability Services in SECH are also available to the managers and the service for advice and guidance.
• The QPS advisor will also meet the staff team on April 30th to advice on reporting of incidents by staff members.

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 appropriate notification form has been sent to HIQA by the Providers Representative (PR) and the responsibilities in relation to this are acknowledged by the PIC and PR.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The following process has been put in place:
• A process map for the services in relation to incident reporting and review has been developed to assist all staff in ensure that appropriate review and follow up is adhered to as follows:
• The PIC will review incidents on a weekly basis.
• All incidents will be reported to either the PIC or Social Care Leader by phone if they are not present on site at the time that they occur
• The manager on call is identified to staff each week. This will allow for the timely review of an incident and to provide the necessary supports and required interventions to staff in a timely manner.

• As necessary an emergency Interdisciplinary Meeting will be held to review an incident within 5 working days.
This process will be tested for effectiveness by the practice development co-ordinator over the coming months

A Quality and Patient Safety Advisor for Disability Services in SECH has been appointed and has met with the Director of Nursing to identify the needs within the services.
They will support the services to put structures on the incident management processes and will also attend the Local Managers Meetings and Team Meetings as necessary to discuss incidents and support the documentation of learning from incidents and analysis of the incidents and all trends on a quarterly basis.
The QPS advisor will also provide staff training.

Incident review is on the agenda of team meetings and management meetings in Leeside.

The PIC is attending training on Risk Management in Healthcare on 17.04.19 to support improvement in this area.

Maintenance requests are on the agenda for review at Team Meetings to ensure appropriate follow up on requests and that actions are completed

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:
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Consultation will take place at a team meeting on 30th April with the Clinical Psychologist, CNS Behaviour Support and Managers and Staff team in relation to maximising access and availability of clinical support and guidance to the staff team. The Practice Development Coordinator will also develop a personal plan policy and audit tool with the service. Samples will be available to discuss with the team at this meeting.

Ongoing monthly meetings with the staff team will be used to complete psychological and environmental assessments. The assessment for one person is completed pending validation by the staff team at these meetings. Longitudinal information gathering and data collection will be commenced in May for the completion of the next assessment.

A review of each person's Adaptive Behaviour will be undertaken in the next few weeks by the Clinical Psychologist and completed by 30th September 2019. Further funding will be sought for an Occupational Therapist to carry out an environmental assessment in addition to this.

Consultant Psychiatry support is available following a period of unavailability on a

Consultant Liaison basis and a MDT meeting is scheduled to take place with the Consultant Psychiatrist at their earliest availability for 1 particular resident, June 20th in Leeside. That person has a review meeting with the Psychiatrist on May 3rd and the Psychiatrist has also held a review meeting with another resident since her return from leave.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Functional Assessments to identify, where possible, the causes of a person's behaviour will commence under the guidance of the CNS – Behaviour Support on April 25th and May 3rd with one person's key workers with the aim of enhancing the current behaviour support plans to identify proactive strategies in an effort to alleviate incidents occurring. This will be an ongoing process for different behaviours with each person.

Review of Restrictive Practices is ongoing with Key workers, managers, CNS Behaviour Support and Clinical Psychologist input. Restrictive Practices used will be identified, indexed and a protocol for their use completed by the 30th June 2019.

A policy on Restrictive Practices is in place.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The service has received the drawing form estates in relation to the separation of the building.
These are currently been costed and once fully determined a business proposal will be submitted to the Chief Officer for approval. Including the tendering timeframe and completion of works a timeframe of 16weeks for completion of works has been advised.
Safeguarding plans are in place for each person. Safeguarding actions include supervision from staff and individualized activity/daily plans for each person.
The service is currently reviewing the status of all the residents in the service to ensure that the HSE are compliant with its statutory obligations.

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 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Yellow	28/03/2019
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.	Not Compliant	Orange	23/09/2019
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.	Not Compliant	Orange	17/05/2019
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	12/03/2019
Regulation 32(1)	Where the person in charge proposes to be absent from the designated centre for a continuous period of 28	Not Compliant	Orange	28/03/2019

	days or more, the registered provider shall give notice in writing to the chief inspector of the proposed absence.			
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.	Substantially Compliant	Yellow	31/12/2019
Regulation 05(6)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	30/04/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/06/2019
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	25/04/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	23/08/2019