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:	22 August 2018
Centre ID:	OSV-0003319
Fieldwork ID:	MON-0022517

About the designated centre

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

This is a organisation providing residential services to four male adults with autism and/or intellectual disabilities. The service is located in a rural location in Co. Kilkenny however, is in close proximity to the city and nearby towns. Transport is provided so as residents can access community based amenities such as gymnasiums, swimming pool, library, parks, shopping centre, cafes and restaurants. Residents also have access to a range of days service options where they engage in activities of their choosing and preference, such as art and pottery.
The service comprises of a large detached house and each resident has their own en-suite bedroom, decorated to their individual style and preference. Communal facilities include a spacious dining area, a well equipped kitchen, a sitting room and a sun room. There is also a private back garden area that residents can avail of for recreational purposes. The centre is staffed by a team of qualified social care workers, a social care leader and a social care manager. Staff provide support to the residents on a 24/7 basis so as to ensure their health and social care needs are provided for.

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:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
22 August 2018	11:00hrs to 16:00hrs	Raymond Lynch	Lead

Views of people who use the service

The inspector met, spoke with and had lunch with three of the residents that live in this centre. Residents appeared happy and content in the company of staff and said that they could speak with any staff member at any time about any issue or concern that they had. Two residents told the inspector that they did not like living in the centre and that they did not wish to continue living in the centre. At the time of this inspection plans were in place to support one of these residents to transition to a new house in the near future.

One resident appeared very happy in the centre, and appeared relaxed and comfortable around staff members. This resident communicated by means of facial expression and gestures and staff were observed to be knowledgeable and respectful of their communicative needs. A parent of a resident was also very complimentary about the service, saying their relative was very well looked after, was very happy in the centre and they saw it as a home away from home.

Capacity and capability

The governance and management arrangements in place were not effective to support and sustain a safe service and required urgent review. The arrangements in place for the person in charge and Social Care Manager to engage in the management and oversight of the centre also required review. This resulted in an urgent action being issued to the centre the day after the inspection. Within ten working days of issuing that urgent action the provider representative provided HIQA with written assurances that these issues had been satisfactorily addressed.

At the time of this inspection there was no person in charge present in the centre as they had been deployed to a different part of the service. It was also observed that the Social Care Manager (with managerial responsibility to the centre) had been delegated additional managerial duties in a different part of the service. This had resulted in inadequate and insufficient oversight, governance and management of the centre and some of the duties of the person in charge and senior management were not being completed in a timely manner. These new arrangement had not been reflected in the centres' statement of purpose and the impact of the new arrangements are detailed in both the findings from this section of the report and in the findings under quality and safety.

For example, the process of supervision of front line staff was not up-to-date, some areas of risk assessment required urgent review, there were gaps identified in staff training and some of the documentation kept in the centre informing practice required review and updating. It was also observed that information pertaining to

the transition of a resident was on file in the centre however, was not made available to the inspector to view on the day of the inspection. The concerns raised in this inspection with regard to the issues pertaining to risk management resulted in the provider representative being issued with an immediate urgent compliance plan.

However, of the staff spoken with, the inspector was assured that they had the experience and knowledge to support the residents in a caring and professional manner. The provider has ensured that staff were competent and skilled. Staff held third level qualifications and despite some gaps in staff training, the inspector observed from their interactions with residents that they knew and responded to their needs in a dignified and supportive way.

While the centre was being audited as required and there was an annual review of the quality and safety of care undertaken for 2017, there was an insufficient management presence in the centre to ensure that the actions arising from the audits were being addressed in a timely manner. For example, and as highlighted above, the process of staff supervision was not up to date and issues were found with regard to the upkeep of important documentation. For example, the centre could not evidence when a resident with epilepsy was last seen by a GP or had bloods taken, or provide evidence as to when another client who had specific oral care issues was last seen by a dentist/dental hygienist.

Overall, this inspection found that while front line staff were very supportive and attentive to the needs of the residents, there were significant issues with the arrangements in place for the oversight, governance and management of the centre. The person in charge worked away from the centre at the time of this inspection and the social care manager had been assigned additional managerial duties in a different part of the service. The process of staff supervision was not up-to-date, there were serious issues with regard to accessing critical information that informed practice (staff could not access aspects of residents healthcare documents as they were kept locked in an upstairs bedroom that staff could not access and staff had no access to the annual review for 2017) and the process of risk management required urgent review.

Regulation 21: Records

The process of record keeping in the centre required review. Some documentation (while kept in the centre) was not available for review on the day of inspection.

Judgment: Not compliant

Quality and safety

Residents were supported to have meaningful and active lives in the

community and staff were seen to be supportive and attentive to their needs. While the quality and safety of care provided to the residents was being monitored, significant issues were identified with regard to how some aspects of risk was being identified and managed and as already highlighted in this report, there was inadequate managerial oversight and governance arrangements in place for the centre.

The individual social care needs of residents were being supported and encouraged. From viewing a small sample of files, the inspector saw that residents were being supported to maintain links with their families and community. Residents also had a range of day service options to avail of where they engaged in a range of meaningful tasks, such as art and pottery. Residents were also members of a local gymnasium, attended regular swimming sessions and availed of community based facilities such as local hotels, restaurants, shops and shopping centres.

It was observed however, that one resident was due to be discharged and transition from the centre within four weeks of this inspection. Transition planning is an essential part of supporting the resident in a time of change and helps ensure more successful outcome for the resident. While the process of the discharge had commenced and actions taken regarding the residents transition had been documented, they were not made available to the inspector on the day of the inspection. This meant the inspector could not ascertain the effectiveness of the transition plan or the actions being taken to support the resident with their transition to a new living arrangement.

Residents were supported with their health care needs and experience best possible health. While it appeared that regular and as required access to a range of allied health care professionals formed part of the service provided, it was not possible to ascertain when one resident with epilepsy has last been reviewed by a GP, or when another resident with oral hygiene issues had last been reviewed by a dentist/dental hygienist. This was because there was no documentation made available on the day of the inspection to inform the inspector or the staff present.

However, residents were supported to enjoy best possible mental health and where required had access to a range of mental health professionals such as a behavioural support specialist and psychologist. It was also observed that most staff had training in positive behavioural support techniques so as they had the skills required to support residents in a professional and calm manner if or when required.

Any adverse incident occurring in the centre was being managed in a timely manner. Residents were also informed of their rights, knew how to make a complaint if they wished to. Staff had training in safeguarding of vulnerable adults and from speaking with two staff member, the inspector was assured that they had adequate training to ensure the safeguarding of the residents in their care. Where required, safeguarding plans were in place so as to further promote the residents' safety and well being.

The inspector observed that there were a high number of peer to peer incidents between two residents in the centre. However, there were plans in place to manage

this issue, and staff provided individual activities to both residents to reduce the amount of time they had to spend together.

One of these residents were still not fully satisfied with their current living arrangement. The resident spoke with the inspector for some time and stated that they would prefer to move to a new centre. While management and staff were aware of this issue and put a number of actions in place to support the resident, this complaint had not been fully resolved at the time of this inspection.

There were systems in place to manage and mitigate risk. For example, where a resident may be at risk in the community, 1:1 staffing support was provided. This ensured that the resident remained connected to their community and could engage in regular social activities in a safe and dignified manner such as swimming and going to the gymnasium. However, one resident who presented with a significant level of risk had only one risk assessments in place (relating to the use of psychotropic medication). This resulted in staff having insufficient documented strategies on how best to manage and mitigate the serious level of risk this resident could present with.

There were systems in place to ensure all fire fighting equipment was serviced annually. A sample of documentation informed the inspector that staff undertook as required checks on all fire fighting equipment and where required, reported any issues or faults. Fire equipment was also serviced by a fire consultant as required.

There were procedures in place for the safe ordering, storing, administration and disposal of medicines which met the requirements of the Regulations. Although there were gaps in training with regard to the safe administration of medication, only staff with this training were permitted to administer medication.

Overall this inspection found that the arrangements in place for the governance and management of the centre were inadequate which resulted in significant gaps with regard to the management of risk and the appropriate upkeep of important files such as residents healthcare plans required urgent attention

Regulation 25: Temporary absence, transition and discharge of residents

One resident was due to be discharged from the centre within four weeks of this inspection. While the process of the discharge had commenced and actions taken regarding the residents transition had been documented, they were not made available to the inspector on the day of the inspection. This meant the inspector could not ascertain the effectiveness of the plans for the transition on the day of this inspection.

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 21: Records	Not compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
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	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Leeside OSV-0003319

Inspection ID: MON-0022517

Date of inspection: 22/08/2018

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:

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: Director of Nursing returned to her post in a fulltime capacity on 03/09/2018, Social Care Manager with responsibility for the management of the centre returned to her post fulltime on 03/09/2018.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A new soft copy record of training has been developed, which will identify the dates of expiry on training in a more streamlined and user friendly manner. A training schedule is being developed to meet any current gaps in training. Person Centred Active Support Training (pre-cursor to Positive Behaviour Support and Medication Training along with Fire Safety Training all scheduled for 2018. Manual Handling, First Aid and any other trainings identified will be scheduled for January and February 2019.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A new archive system for documentation is being developed currently and will be completed by 31/12/2018.	

Social Care Manager implemented a number of changes to the existing filing system in the unit to ensure the system is more streamlines. Following this the Social Care Manager completed an audit on the files and developed an action plan for keyworkers, the completion date for actions on the audit is 31/10/2018.

The filing system will be subject to regular monitoring from the Social Care Manage along with the 6monthly and annual HIQA audit completed by the provider or a nominated person.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Director of Nursing and Social Care Manager returned to their post on 03/09/2018 in a full time capacity and were relieved of all additional duties.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

Statement of Purpose reviewed by Social Care Manager and management structure in the unit are now in line with the Statement of Purpose following the return of Director of Nursing and Social Care Manager to their posts.

The Social Care Manager will review the Statement of Purpose on a regular basis and ensure that any changes are updated.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

A new complaints log has been implemented in October 2018 to provide more structure to the handling and resolution of complaints. Complaints will also be a recurring agenda item on staff team minutes and also at the Local Managers Meetings.

A resident has complained about living in the centre and highlighted that they would like to move to another house. A care plan was developed on 18/05/2018 relating to the residents complaint. This was discussed in detail with the resident and their family at their annual review and the resident identified that they like living in Leeside and enjoy spending time with staff and other residents. The resident identified that they would like remain living in Leeside but would like more space to themselves such as having a sitting room area for their own use and also a separate entrance to their living area away from

other residents. Resident also highlighted that they would like to continue to eat their meals as part of the group with the main house. It was agreed that social care manager would follow up. Social care manager has met with Estates department on two occasions 11/10/2018 and 06/11/2018 and estates are currently working on drawings regarding alterations to the centre to ensure the residents are happy with their living conditions.
Social Care Manager and Estates will work together to create an appropriate living setting for all residents and ensure their wishes and preferences are being met.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:

Transition Plan has been devised and updated for a resident that is moving from the centre in the coming months. The transition plan is updated on a regular basis and all actions are noted. However the organisation that will be providing the service to the resident in the future has not provided a date for the transition as of yet. A meeting with stakeholders took place on 30.08.2018 regarding transition, the focus was new service provider phasing in to manage day service. Another meeting is schedule for 14.11.2018 to discuss status of the transition and ensure full disclosure relating to the resident. It is hoped the new service provider will be in a position to provide a date for the resident to move and then the transition plan can be reviewed and developed accordingly.

Director of Nursing has escalated the risk associated with the uncertainly around dates and the impact it is having on the resident to the Disability Manager as the uncertainly in causing an increase in anxiety for the resident.

Keyworkers review and update the care plans on a regular basis. A Person Centred Plan review is scheduled to ensure the residents wishes and preferences are heard and documented in relation to the transition. Staff record in daily progress notes the residents feelings and views relating to the transition. Resident has one to one staffing levels providing a person available every day that can support them to highlight and explore what their preferences for their future is.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Keyworkers ensured that all risk assessments required under legislation were in place for each of the residents by 28/08/2018.

Social Care Manager reviewed and updated risk assessments on 24/10/2018 and updated the risk register in line with risk assessments in place.

Risk Assessments have been sent to IDT team for review at next scheduled meeting on 21/11/2018. IDT will also identify any other risk assessments that are required and this will be actioned by the Social Care Manager.

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:

Social Care Manager introduced a number of changes to the existing filing system in place in the unit to ensure it is operating on a more streamlined basis. Following this Social Care Manager completed an audit of files and developed an action plan for keyworkers with a completion date of 31/10/2018 on all actions.

Files, Care Plans, PCPs etc. will be subject to regular monitoring and review by Social Care manager.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Resident had a GP visit on 27/09/2018 and full bloods on 06/10/2018. Another resident had a dental appointment on 24/08/2018 and 21/09/2018. Keyworkers will action any follow up appointments required.

Keyworkers have begun to keep a record of all appointments attended including healthcare on the inside cover of the daily progress notes for ease of access to review and ensure that healthcare needs are being met in a timely fashion.

Communication diary also has a record of appointments attended and keyworkers input any future appointments in this book, this is reviewed as part of handover daily and ensures that all appointments are attended.

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	Orange	03/09/2018
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	20/03/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/11/2018
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are	Not Compliant	Orange	31/10/2018

	available for inspection by the chief inspector.			
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	Red	05/09/2018
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Red	05/09/2018
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Not Compliant	Orange	14/11/2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of	Not Compliant	Red	05/09/2018

	Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	19/10/2018
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	26/10/2018
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.	Substantially Compliant	Yellow	30/11/2018
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider	Substantially Compliant	Yellow	06/10/2018

	or by arrangement with the Executive.			