Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Ardnore
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	17 September 2020
Centre ID:	OSV-0003412
Fieldwork ID:	MON-0030412

About the designated centre

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

This centre comprises of three houses, and is home to eighteen residents. Each house is in close proximity to each other and accommodates six individuals. The houses that make up this centre are all close to local amenities and are on the outskirts of Kilkenny City. The centre provides community based living for adults with mild to moderate intellectual disability and is open seven days a week all year with no closures. This is a low support home with some residents assisted to access their community independently.
This centre aims to provide services that are person centered and that promote relationship building and social inclusion in the communities where the individuals live. The staff team for this centre comprises of a social care leader and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Thursday 17 September 2020	09:30hrs to 17:00hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This centre comprises of three houses in Kilkenny city, the inspector had the opportunity to visit one house on the day of inspection and meet with four of the six residents who lived there. This inspection took place during the COVID-19 pandemic and the inspector adhered to public health guidance at all times with respect to social distancing and the wearing of personal protective equipment.

The house visited by the inspector comprises of a number of separate communal living spaces internally and a number of private and more open external spaces where the residents can either sit together or on their own as they prefer. The inspector was greeted on arrival by a resident in the front of the house who was getting ready to go on a drive with a member of staff. They asked the inspector their name and why they were coming to the house and explained that it was time for their drive. The staff member outlined the importance of ensuring that activities that had been discussed were carried out as planned. Both the resident and the staff member were relaxed with each other and there was warm engagement observed.

Another resident was sitting in a chair by the front door of the house in the sunshine. They told the inspector that they had been relaxing and were really enjoying the peace outside and the sunny day. The resident explained that they had requested a banana sandwich and a staff member had gone into the kitchen to prepare this for them so they could remain outside.

The other two residents were inside the house one was seen being supported by staff to walk to a small individual sitting room and they explained to the inspector that they liked to relax in the peace and quiet there. They found it difficult to recognise staff with their masks on and so staff were seen to say their names when chatting to provide cues to the resident. The other resident was in the larger communal sitting room listening to music on an electronic tablet and had a favoured newspaper and some magazines open around them They explained that they really liked particular bands and singers and showed the inspector a CD of music that a member of their family had recorded stating it was their favourite.

Capacity and capability

Since it was last inspected, this centre has undergone a number of management changes with a new person in charge and new assistant director of services in place. They were supported by a team leader who worked across all three houses that make up this centre. Overall, these three managers were found to have a good understanding of the residents' individual care needs and of the structures, systems

and resources which were available to support those needs. The managers knew all residents by their name and it was clear from observation that residents were familiar with them and were comfortable engaging with them.

Prior to the inspection some incidents had occurred in the centre which the person in charge was keeping under review. Residents had found one of the recent incidents stressful and resulted in staff members using reactive and proactive measures to resolve it. Additionally, this incident had resulted in a temporary move of centre for one resident. A review of long term living arrangements in consultation with residents was in train on the day of inspection.

The provider had completed all reviews as required by the regulations and these were used to provide oversight in regards to delivery of care. However, in the annual review of the quality and safety of care there was limited evidence of residents views expressed and no evidence that family views had been sought. A number of audits were being carried out however, not all of these were comprehensive and a number of these did not identify actions arising and were simply overviews in the form of lists.

It was apparent from a review of the incidents recorded in the centre that the provider had been made aware of a frequency of low level incidents which were occurring in one particular house. It was highlighted to the inspector that the designated officer and senior management of the centre were keeping these incidents under close review. However for other incidents which were of significance, where for example, a resident was absent from the centre on a number of occasions without staff knowledge these had not been notified to the Chief Inspector of Social Services as required by regulation.

As mentioned earlier, staff who were supporting residents on the day of inspection appeared kind and considerate in their approach to care. Overall, residents appeared relaxed in their company and there were appropriate levels of staff in place to ensure that the residents could engaged in personal activities as required. From a review of staff personnel files, documents as required by Schedule 2 of the regulations, were for the most part in place for staff. However, in the files reviewed, one staff member did not have the required number of references in place and two staff had out of date identification in place. Staff members were in receipt of support and supervision by the team leader or person in charge however no clear system had as yet been put in place for the formal supervision of the redeployed or additional staff who had been in the centre since March 2020 when the COVID-19 pandemic began.

The provider also had a training programme in place which, while it had ensured that staff had received training which was appropriate to their role had not reviewed their refresher training requirements on an ongoing basis. In addition where extra staff had been brought into the centre to provide support to residents during the COVID-19 pandemic and were still in place on the day of inspection, the provider had not ensured they had been in receipt of refresher training in key areas such as safeguarding or fire safety with some not having had training since 2014 and 2015. This was highlighted to the provider on the day and following discussion the

provider stated they would submit assurances with respect to resolving this to the inspector following the inspection. It was clear from the observations of the inspector that staff members had a good rapport with residents and they were in-tune with each resident's individuality. This assisted in creating a warm and person centred atmosphere.

Registration Regulation 5: Application for registration or renewal of registration

All documentation was submitted as required to the office of the chief inspector of social services by the provider for the application to renew the registration of the centre.

Judgment: Compliant

Regulation 15: Staffing

The inspector was satisfied that there were appropriate staff numbers and skill-mix in place to meet the assessed needs of residents. Staff who were supporting residents on the day of inspection appeared kind and considerate in their approach to care. From a review of a sample of personnel files on the day of inspection some of the documents that are required under Schedule 2 were not in place.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had been provided with relevant training to assist them in supporting residents however a substantial number had not received refresher training as required in key areas. In addition a number of staff had not been in receipt of supervision and support as outlined in the providers policy.

Judgment: Not compliant

Regulation 22: Insurance

The provider had ensured there was current and appropriate insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place with a person in charge supported by a team leader. However, the auditing process required review as an ongoing issue as outlined above where actions are not being adequately identified and addressed.

While the required reviews of the quality and safety of care and support were occurring they were not seen to adequately include the views of residents and their family/representative.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

While the provider and person in charge were aware of their remit to notify the chief inspector of social services of any adverse incident occurring in the centre as required by the regulations this had not happened consistently.

Judgment: Not compliant

Quality and safety

The inspector reviewed the quality and safety of the service being provided to the residents and found good practice in number of areas. The quality and safety of care provided to the residents was for the most part being comprehensively provided for. However, ongoing compatibility issues between residents had resulted in a number of safeguarding issues which were now being addressed. These issues were seen to have impacted adversely on residents quality of life.

Residents who lived in this centre required support in regards to some behaviours and a sample of behavioural support plans was reviewed on the day of inspection. In addition to these plans some residents had bespoke stress support plans and their own personal easy read set of house rules. The inspector reviewed recent

incidents and saw that staff members were skilled in responding to behaviours and their interventions resulted in de-escalation of incidents. A review of adverse events also indicated that there were events which occurred on a regular basis which a resident found difficult and which also impacted on other residents in the centre. The provider was aware of this issue and, as mentioned earlier, had begun review and an action plan had been established. There were a number of restrictive practices in place in the centre and these were reviewed regularly and there was evidence of reduction and removal of restrictions over time in some instances.

A resident in one of the houses of this centre had requested the opportunity to move and live in another centre run by the provider. The inspector reviewed the discussions and actions to date related to this move. The provider and person in charge had completed transfer documentation and there was evidence of meetings with the residents, their family or representatives in advance of the decision being made for transfer. The resident has been provided with opportunities to visit the other centre and a referral has been made for independent advocate support for the resident before making a final decision. This process was being prioritised following a requirement to support the resident with an emergency short term transition to another centre.

There were good systems for consultation with the residents' regarding their wishes, with both house meetings and individual key worker meetings to ensure the residents' voices were heard. In one of the houses the residents meetings were not happening as frequently as in the other two houses however this had been identified by the provider and had restarted. Additionally, an external advocate had met with some residents on a number of occasions, so as to ensure they were aware of their rights and how to use such supports if they needed them. Other residents had recently been referred to advocates and were waiting for meetings.

There were systems in place to prevent and respond to any incidents or allegations of abuse, with safeguarding plans implemented where this was necessary. A review of these plans however, demonstrated that they were not always being reviewed in line with the providers own policy and time lines. In some cases a number of interim safeguarding plans were open and waiting on other processes to conclude prior to moving safeguarding plans on. The inspector reviewed a recent adverse event and noted that while concerns relating to safeguarding residents within use of social media all areas of safeguarding concern had not been identified in this circumstance. In one instance where a concern had been identified by the provider in October 2019 a referral to the safeguarding team had not yet been made. Despite ongoing discussions in an attempt to achieve resolution, the issue for the resident remained outstanding and no safeguarding plan had been developed. Where residents required support with personal and intimate care there was detailed and up to date guidance for staff in place.

There were systems in place for the management of risk that were balanced and proportionate, allowing for residents to take appropriate risks with the support of staff. Each resident had pertinent risk management plans implemented for their identified individual risks, whether falls or smoking, or participating in leisure activities such as cycling without staff presence. There was evidence of the

development of new risk assessments following an event such as a change in fire evacuation practice. The centre risks however were incomplete and while those identified had been reviewed and there were robust control measures in place there was inconsistency across the houses and a number of risks had not been identified such as slips trips and falls or fire.

There were good fire safety management systems with evidence of servicing of the fire alarm, emergency lighting and extinguishers on an annual and quarterly basis as required. Additional in-house checks were carried out by staff and practice drills were also held with the residents at various times, using the various different exits. Areas identified as a concern at the previous inspection had all been attended to and the inspector was happy that the provider had systems in place to detect, contain and extinguish fires in the centre.

The inspector noted the house visited was visibly clean. All cleaning schedules were seen to be comprehensive and completed by staff on duty as required. Hand washing facilities, alcohol gels and personal protective equipment (PPE) was readily available in the house. Emergency contingency plans had been developed in light of the recent COVID-19 pandemic. Guidance on infection prevention and control was available to staff and residents. Guidance was in place for staff on the use of face masks in line with national guidance. Staff members were observed wearing face masks appropriately on the day of inspection.

Regulation 20: Information for residents

All residents had personalised folders with a suite of easy read and symbol supported material. This included policy documents and information on accessing training opportunities and the residents tenancy agreements and details with respect to their contributions to the centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

A significant incident resulted in an emergency transition of a resident to another centre for a number of nights. The inspector was not assured that the resident was included in the decision making for this move and provided with information to support them in making a decision to transfer. However, the resident had requested transfer to another centre and this has resulted in clear transition planning involving both the resident, their family/representative and referral to an independent

advocate to support the resident.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had not ensured that effective systems were in place for the ongoing review and identification of risk within the centre. However individual risks had been assessed and had effective control measures in place. There was evidence of review following an incident and evidence of positive risk taking in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The person in charge, provider representative and director of care and support had taken steps in relation to infection control in preparation for a possible outbreak of COVID-19. The infection control policy had been updated to include up to date guidance on how to prevent and manage an outbreak of COVID-19 in the centre.

The person in charge ensured regular cleaning of the premises, sufficient personal protective equipment was available at all times and staff had adequate access to hand-washing facilities and or hand sanitising gels. Mechanisms were in place to monitor staff and residents for any signs of infection

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured effective systems for the prevention, detection and containment of fire. Fire systems were in place as required and fire equipment was serviced quarterly. Regular fire drills were occurring and there was evidence of learning from these. Areas for improvement identified in the previous inspection had been concluded.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents where required had comprehensive behaviour support plans in place. Staff practice on review was seen to be in line with the recommendations in these plans. Restrictive practices in place were reviewed and monitored and had been implemented in line with the providers policy.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to prevent and respond to any incidents or allegations of abuse, with safeguarding plans implemented where this was necessary. A review of these plans however, demonstrated that they were not always being reviewed in line with the providers own policy and time lines. Where the provider had identified a safeguarding concern referral to the safeguarding team had not occurred in a timely manner. Additionally following review of a recent adverse incident only one area of concern was included in the safeguarding plan which was the use of social media, where it was clear there were other areas of concern.

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
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ardnore OSV-0003412

Inspection ID: MON-0030412

Date of inspection: 17/09/2020

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: All personnel files under schedule 2 are been reviewed and any outstanding documentation will be updated	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: SOS Kilkenny CLG has employed a new Staff Training Officer who commenced in his role on 21st September 2020. The Staff Training Officer is currently reviewing all training records to identify areas of non-compliance. Following completion, • Reports will be sent to each Manager on a monthly basis. • Additional training sessions will be added to address outstanding non-compliances. • Staff will be given time and support throughout the day to complete online training. • Training will be addressed in all quality conversations. Managers and staff will be checking training records and booking training as part of the quality conversation. A training matrix is been set up on DMS which will allow staff to access, monitor and book their own training. Managers will be sending monthly reports to the Operations Managers which will include staff training numbers for the previous month. The Staff Training Officer will monitor and review numbers of staff completing training and will report findings to Managers and Operations managers. SOS Kilkenny CLG aim to have all outstanding training up to date within six to eight months.	

A supervision schedule has been updated and all staff will received supervision in line with the quality conversation policy.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: A Quality assurance officer has been appointed and a schedule has been put in place to ensure that the six monthly and annual registered provider audits are completed. The quality assurance officer will continue to carry out comprehensive audits which will include residents and family views. Following each audit, the Quality assurance officer will meet with the Residential Manager to complete an action plan. The Residential manager will be responsible for allocating individuals to carry out identified actions and will review these actions to ensure they are completed.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Protocols have been reviewed and all incidents will be notified in line with regulation 31.

Regulation 25: Temporary absence, transition and discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents: The incident of temporary emergency transition for a resident has been fully reviewed and learnings discussed to ensure that all moving forward,residents will have full input in the event of any future incident of this nature.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A risk management committee is being set up to review and identify risk trends and learning across the organization.

The current process around the center risk assessments will be reviewed to ensure that all risks are captured across each designated center.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding processes has been updated and all notifications are now been completed on DMS which allows for a more comprehensive governance of notifications.
A safeguarding committee is been set up which will allow for in depth review of all safeguarding plans to ensure that they are reviewed in line with policy and timelines. This committee will also review plans to ensure that they capture all areas of concern.

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/12/2020
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.	Not Compliant	Orange	31/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/10/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/12/2020

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	14/03/2020
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Substantially Compliant	Yellow	30/11/2020
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	31/12/2020
Regulation 31(1)(e)	The person in charge shall give	Not Compliant	Orange	31/10/2020

	the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any unexplained absence of a resident from the designated centre.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	16/10/2020