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:	St. John of God Kildare Service DC 11
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	29 July 2019
Centre ID:	OSV-0004137
Fieldwork ID:	MON-0022569

About the designated centre

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

DC 11 is a residential service operated by St. John of God Services and is located in a large town in Co. Kildare. The designated centre is comprised of two detached houses in a housing estate, next door to each other. Both properties are a two storey building, building one has capacity for three residents and building two has capacity for five residents. Building one has been adapted to meet the accessibility needs of residents. DC 11 supports eight male residents with an intellectual disability by a team of; social care workers, a social care leader and a person in charge. Staffing levels are based on the needs at each location. Some residents have the support of staff sleeping over; while other residents have the support of staff dropping in to their home to provide specific supports like assistance with cooking/sorting out domestic bills/support with safety checks. Residents have access through a referral system for the following multi-disciplinary supports; psychology, psychiatry, social work. All other clinical supports are accessed through community based primary care with a referral from the individuals G.P. as the need arises. There is also an accessible vehicle for residents use in accessing the community along with well serviced public transport.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
29 July 2019	11:30hrs to 19:30hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The inspector of social services met with residents as they independently came and left the centre throughout the course of the day to go to work, day programmes and leisure activities. The inspector had the opportunity to meet with five residents and three of these residents spoke directly with the inspector about the care and support they receive. All of the residents stated clearly that they were very happy living in the the centre and were satisfied with the care and support provided by staff. These residents told the inspectors of how they are supported by staff to spend time alone in the centre, to independently access the community and of their understanding and awareness of contacting staff if they needed additional support.

Three residents showed the inspector their bedrooms and pictures of their achievements and items of importance. Residents spoke of their many interests, roles, skills and talents. It was apparent that residents were aware of and consulted with regarding their healthcare, personal goals and participated in the organisation of their home.

The inspector observed staff and residents interacting with each other over the course of the inspection, and found that residents appeared comfortable expressing their needs, and were directing the care and support they received. For example, residents made decisions about how they would spend their day and what they would like to eat. Staff spoke respectfully to residents, and residents appeared happy and content in their homes.

Prior to the inspection, eight residents completed questionnaires. Each questionnaire identified positive experiences for residents living in the centre. Overall, areas that required improvement most often referred to the provision of additional resources. Two residents voiced their opinion in the questionnaire that they would like extra staff to facilitate outings in the evenings and weekends and this was discussed at feedback.

Capacity and capability

The governance and management arrangements in this designated centre ensured that residents received a good quality of care and support in accordance with their assessed needs. There were very clear examples of both person-centred and resident-led practices on the day of inspection. The inspector found that further development was required in the notification of incidents, provision of supervision and staffing arrangements.

The person in charge, who commenced their role in January 2019, was not based in the centre on a full time basis as they were also responsible for three other designated centres. The inspector reviewed the governance and monitoring systems in place to ensure there was adequate oversight of the centre from the person in charge due to their large geographical remit. These were found to be effective at the time of the inspection. A social care leader, employed full time, deputised in the absence of the person in charge and was responsible for the day to day management of the centre. The person in charge and social care leader had formal and informal meetings on a daily / weekly and monthly basis. There was documented evidence that the person in charge visited the centre on a regular basis. Audits and reports generated in the centre were sent to the person in charge on a monthly basis for review.

A record of all incidents that had occurred in the designated centre was maintained in the centre and reviewed by the inspector. All adverse events requiring three days' notice of notification to the Chief Inspector of Social Services had been submitted; however there was an unexplained gap in the quarterly notifications requirements from October 2017 to January 2019.

The provider had conducted all required reviews and audits as stated in the regulations. A quality improvement plan was devised based on these mandatory reviews and other internal audits. The inspector found that information gathered from these audits and reviews was used to improve the quality of life for residents and also to ensure that consistency of care was provided in the centre. The quality plan was updated on a monthly basis to track improvement and to sign off on completed actions, for example updating of personal plans, health action plans and maintenance requests. There was evidence of shared learning in monthly management meetings chaired by the programme manager (person participating in management) for all persons in charge and social care leaders within her region. This shared knowledge was based on previous inspections, internal audits and review of accidents and incidents.

A full complement of staff were employed as per the centres statement of purpose at the time of inspection. However due to a long term absence there was a gap of cover two afternoons a week for the designated 'social shift', whereby residents could request one to one outings with staff. This impacted upon one of the houses where the residents had high levels of independence and only required drop in staff support. While a regular relief staff team covered the majority of hours while a staff member remained out sick, these social shifts were only covered on only a few occasions on review of rosters since January 2019.

The provider had measures in place to ensure that staff were competent to carry out their roles. Staff had received training relevant to their work, in addition to mandatory training in fire safety, manual handling, safeguarding and behaviour management. There was a training schedule in place to ensure that training was delivered as required. It was identified that while staff were receiving formal and informal supervisor it was not aligned to organisational policy and required review.

The provider had ensured that a statement of purpose, which is a key governance

document for the centre, was in place and was reflective of the service provided. The inspector was satisfied that the statement of purpose reflected the day-to-day operation of the centre and accurately described the model of care and support provided. There was a written contract in place for all residents for the provision of services that was signed by either the resident or their representative. This accurately reflected the service being provided and any fees that would be chargeable to the resident.

Registration Regulation 5: Application for registration or renewal of registration

A full and complete renewal application was received from the provider in line with renewal requirements.

Judgment: Compliant

Regulation 14: Persons in charge

The inspector found that the person in charge met the requirements of this regulation with regard to her qualifications, knowledge and experience. Additionally, it was noted that there were clear systems in operation to facilitate the person in charge's current regulatory responsibilities for four designated centres.

Judgment: Compliant

Regulation 15: Staffing

The inspector was informed that the overall staffing levels for the designated centre had decreased by 0.5 full-time equivalent over a prolonged period of time. There was no time bound plan in place to address this deficit or re-implement the evening social shifts after ten months, which allowed some residents to engage with staff on one to one outings. While there was evidence that regular relief staff were providing cover in the centre, this did not include the above shifts.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector found evidence that all staff had received mandatory training including safeguarding, medication management, manual handing, behaviour support and fire safety. Improvements were required in relation to formal staff supervision to ensure that these were implemented in line with organisational policy.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had a contract of insurance against injury to residents and other risks in the designated centre, including loss or damage to property.

Judgment: Compliant

Regulation 23: Governance and management

There were governance, leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to residents. There was a clear management structure, and there were systems in place, such as audits and management meetings, to ensure that the service provided to residents was safe. Six-monthly audits of the service were carried out by representatives of the provider, and an annual review, which included the views of residents and their representatives, had been completed and supplied to the provider.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

A sample of the contracts of care were reviewed by the inspector, there was a written agreement in place which clearly outlined the fees that they would be charged and any additional charges which they may incur. These agreements were signed by the resident or their representative, and also by a nominated person from the registered provider of the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The inspector reviewed the centre's statement of purpose and found that it contained the majority of information as outlined in Schedule 1 of the regulations. Some minor adjustments were required and the provider completed it on the day of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider and person in charge had not ensured that quarterly returns had been submitted to the Chief Inspector as required by the regulations.

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 all areas inspected against. There was evidence that residents received a person-centred service and experienced a good quality of life in the centre. Overall a high level of compliance was found but some improvement was required in relation to risk management and medicines.

The lived experience of individuals availing of the services of the designated centre was overall one of respect and value. There was evidence available to demonstrate that the service was resident led and person centred. The inspector found that residents had been supported to develop and maintain personal relationships and links with the wider community. The residents were supported to spend their day in a manner that was meaningful and purposeful for them. This included availing of local day services, work placements, paid employment and many community participation opportunities. Also the residents' right to remain at home was also respected and supported.

The inspector reviewed a sample of documentation relating to residents, including assessments and personal plans. There was evidence of regular review of these plans including multidisciplinary professionals. This ensured that plans reflected the residents' current needs and that staff were provided with clear guidance on how to provide appropriate support. Each resident had developed their own goals that were meaningful to them that they wished to achieve. Examples of these goals included; completing a first aid course, driving lessons, sporting classes and

going on holidays. Through review of residents' personal plans, conversations with residents and staff, the inspector were assured that resident participation was encouraged and supported in all aspects of service provision in the centre.

Arrangements were in place to support residents on an individual basis to receive services to enjoy best possible health. Residents had access to a GP, and other allied health care professionals as required. Residents were educated and informed of any healthcare issues that pertained to them and strategies of best practice in managing in these healthcare concerns. Healthy lifestyles and choices were well promoted and regular reviews of residents weights and physical health and well-being were evident. Healthcare plans reviewed were of a good standard and residents had continuous access to allied health professionals in line with their needs. Residents with increased healthcare needs were provided for in terms of regular reviews and care planning updates. Residents were also facilitated to avail of any National Screening Programmes.

There were no safeguarding plans required in this centre but the provider had measures in place to ensure that residents were safeguarded from potential abuse. There was a safeguarding policy in place and all staff had received safeguarding training. This ensured that they had the knowledge and skills to treat each resident with respect and dignity and to recognise the signs of abuse. Residents themselves could inform the resident what they would do and who they would contact if they had concerns. The person in had ensured that residents retained control of their of finances and that residents received support with managing finances, where required. Financial support plans in place clearly demonstrated the level of support required. The providers own recording and auditing systems effectively recorded and monitored the support provided to residents in relation to their banking transactions.

The inspector completed a walk around of both houses, guided by residents that lived in each house. The designated centre, consisting of two buildings were found to meet the needs of residents both in terms of space, accessibility and facilities available. Each house that comprised the centre was clean, warm and decorated in a homely manner. An adequate number of bathroom facilities were provided along the other regulatory requirements such as suitable storage, a separate kitchen area and communal space The inspector also spoke with the person in charge and the social care leader regarding any premises issues that arose. Residents had highlighted some maintenance requirements that they would like completed in their bedroom and outside area. These had already been noted by the maintenance team who had visited the property recently for an environmental assessment and a time bound plan was implemented into the centres quality improvement plan to address the residents requests.

There was some good practices with regard to risk management, positive risk taking was actively promoted which assisted in developing and maintaining residents' independence. A risk register was present within the centre and individual risk assessments developed for each resident to take into account the varying hazards and level of risk identified. These risk assessments required review to ensure that all risks being managed in the centre were reflected. For example there was clear

control measures in place for the management of diabetes, epilepsy, home alone and being in the community independently; however corresponding risk management plans were not developed for these risks to ensure staff had up to date and accurate information, that all control measures were effectively implemented and were effective.

The person in charge had ensured that each resident was encouraged to take responsibility for their medicines, following appropriate capacity assessment. Some residents were being supported to manage their own medication in accordance with their ability and preference, and the inspector reviewed a detailed assessment of capacity in relation to residents that promoted the independence of residents to self-administer their own medication. Staff who administered medicines to residents were trained in its safe administration and demonstrated a clear understanding of the systems in place for the ordering, receipt, prescribing, storage, disposal and administration of medicines. The inspector noted that while medicines were appropriately stored in a locked unit, the refrigerator in the staff office to store insulin did not have a locking mechanism and required review.

The centre had a robust fire management system in place. The house had appropriate fire precautions in place and staff were conducting regular checks of emergency lighting, exits, fire doors, fire extinguishers and the fire alarm panel. Fire exits were observed to be unobstructed on the day of inspection. The provider had ensured that all fire precautions were serviced as required and emergency procedures were on display. Regular fire drills were occurring in the centre, both day and night time simulated drills, which indicated that the residents could be evacuated in a prompt manner.

Regulation 13: General welfare and development

The care provided to residents was appropriate to the nature and extent of residents assessed needs. Great effort was made to ensure residents had access to occupation and recreation that interested them and utilised their skills.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs.The centre was homely, accessible and promoted the privacy, dignity and safety of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

While some good practice was noted regarding the management of risk, improvements were required in the documentation of risk management plans to ensure staff had up to date and accurate information. Not all identified risks had an associated management plan to ensure that all control measures were effectively implemented and managed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had ensured that effective measures were in place to protect residents and staff from the risk of fire. These included up-to-date servicing of fire safety equipment, fire containment doors, internal fire safety checks by staff, fire safety training for all staff, completion of fire evacuation drills, and individualised emergency evacuation plans for all residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Overall, the centre had a comprehensive medicines management system to support the residents' needs. Records were kept to account for the management of medicines including their administration. Resident interest and capacity to participate in the management of their medicines had been established. Segregated storage had been implemented for medicines that were unused or no longer required. Records verified by the pharmacy were maintained of medicines returned to the pharmacy. The refrigeration used to store insulin was not securely locked.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The residents had comprehensive assessment and plans in place to support the their needs. The personal plan reflected the needs of the resident as assessed

by allied health professionals. The personal plan indicated a person centred approach to the care the resident received and maximised the participation of the resident.

Judgment: Compliant

Regulation 6: Health care

The person in charge had ensured that residents' healthcare needs were assessed on a regular basis and guidance was available to support staff in caring for the healthcare needs of these residents. Residents also had access to a wide variety of healthcare professionals, as required.

Judgment: Compliant

Regulation 8: Protection

There were systems and measures present to ensure that the resident was protected from possible abuse. Staff were facilitated with training in the safeguarding of vulnerable persons and were found to be knowledgeable in safeguarding matters.

Judgment: 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for St. John of God Kildare Service DC 11 OSV-0004137

Inspection ID: MON-0022569

Date of inspection: 29/07/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • 15(3) Recruitment occurred on the 25th of July for 0.5 post this post has been filled prior to stage one report.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • 16(1)(b) Local Operational procedures in relation to supervision of staff will be reviewed in line with St. John of God Human Resource Policies.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • 31(4) The PIC will ensure that where there are no incidents which require to be notified under section (1) (2) or (3) have taken place. The registered provider shall notify chief inspector of this fact on a six monthly basis by NF40 Nil return.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • 26 (1) (e) A risk assessment will be completed to ensure the identified health risk for a resident will have control measures to address when the resident is alone in the community or alone in their home. Control measures will be proportional to the risk identified; along with the impact such measures might have on the resident's quality of life and independence.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • 29(4)(a) the PIC will ensure a lockable medication fridge is ordered and used to store insulin in the Designated Centre.	

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	09/09/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2019
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	Substantially Compliant	Yellow	30/09/2019

	responding to emergencies.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	31/08/2019
Regulation 31(4)	Where no incidents which require to be notified under (1), (2) or (3) have taken place, the registered provider shall notify the chief inspector of this fact on a six monthly basis.	Not Compliant	Orange	31/01/2020