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)

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| Name of designated centre: | Parkside Residential Services Kilmeaden |
| Name of provider: | Brothers of Charity Services Ireland |
| Address of centre: | Waterford |
| Type of inspection: | Announced |
| Date of inspection: | 27 February 2019 |
| Centre ID: | OSV-0005106 |
| Fieldwork ID: | MON-0022608 |

## About the designated centre

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

Parkside Residential Services Kilmeaden is a five bedroom two–storey detached house located in a rural area. The centre provides residential care for three men with mild to moderate intellectual disability ranging in age from 28 to 54 but has a maximum capacity for four residents. It is open 365 days of the year on a 24 hour basis. Each resident has their own bedroom and other facilities throughout the centre include a kitchen, a dining room, two living rooms, bathroom facilities and garden areas. Staff support is provided by social care workers and care assistants.

**The following information outlines some additional data on this centre.**

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| Current registration end date: | 04/08/2019 |
| Number of residents on the date of inspection: | 3 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

### 1. Capacity and capability of the service:

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

### 2. Quality and safety of the service:

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| 27 February 2019 | 09:15hrs to 17:30hrs | Conor Dennehy | Lead |
| 27 February 2019 | 09:15hrs to 17:30hrs | Liam Strahan | Support |

## Views of people who use the service

Two of the three residents who lived in the centre completed pre inspection questionnaires independently, while the third resident also completed one with the assistance of a staff member. These questionnaires described these residents' views of the centre and all contained positive views regarding the centre. A high level of satisfaction with many aspects of life in the centre such as activities, bedrooms and meals provided was indicated.

Inspectors met all three residents on the day of inspection who used a mixture of verbal and non-verbal communication. Inspectors had an opportunity to speak with two of the residents with one of them indicating that they liked living in the centre. This resident was observed to be comfortable in the presence of a staff member who engaged appropriately with the resident.

The other resident who spoke to inspectors indicated that they were unhappy living in the centre and were particularly unhappy with a recent decision which had impacted on how the resident spent their days. This resident did indicate though that they were supported by staff members while they were living in the centre.

The third resident living in the centre was met briefly by inspectors who did not have an opportunity to meaningful engage with this resident or observe them in their environment.

## Capacity and capability

The provider had ensured that structures and supports were available to residents to provide a high standard service. This was shown by the improved arrangements for the person in charge and the consistent staffing that were in place in the designated centre. It was also noted that the provider's oversight arrangements for the centre had improved since the previous inspection although some further improvement was required in this area.

This designated centre had previously been inspected in March 2018 where it was found that the governance systems in place and the remit of the person in charge required review to ensure the quality and safety of the service provided to residents would be maintained. However, the shortcomings in the governance arrangements identified were compensated by the consistent and knowledgeable staff team that was in place in the centre at that time.

The present inspection found that an experienced and suitably qualified person in

charge remained in place and the provider had made changes to ensure that the person in charge had increased oversight of the centre. During the March 2018 inspection it was found that person in charge was responsible for five designated centres in total and did not visit this designated centre. Since then the remit of the person in charge had been reduced to four centres while from talking to staff members and reviewing records it was clear that the person in charge was now a presence in the designated centre.

Since the March 2018 inspection, the provider had ensured that two unannounced visits were carried out. Reports of such visits were maintained along with an action plan to address any areas identified for improvement. Where areas for improvement were highlighted by these, evidence was seen on inspection that such matters had been addressed by the provider. Unannounced visits by the provider are a requirement of the regulations and are important in reviewing the quality and safety of care and support that is provided to residents.

However some aspects of the unannounced visits carried out by the provider required improvement. For example, it was noted during this inspection that the person in charge had prior knowledge of such unannounced visits and was also involved in conducting the unannounced visits. Given that these unannounced visits reviewed various aspects of the service provided, which were the responsibility of the person in charge, this undermined the purpose of such visits. When reading copies of visit reports it was also noted that they contained a lack of information in describing the quality and safety of care and support provided to residents.

Overall inspectors were satisfied that oversight arrangements had improved in the centre as it was now observed that the provider had been carrying out unannounced visits at six monthly intervals as required while most areas for improvement, as identified during the March 2018 inspection, had been acted upon. In addition, regular audits were carried out in areas such as medicines and health and safety. The provider had also ensured that an annual review, another regulatory requirement, had been carried out for 2018. This was noted to cover a broad range of areas but, while it included feedback from residents' families, it did not fully reflect the views of the residents themselves.

However, it was seen that the provider had systems in place to obtain residents' feedback. This included the complaints process that was in place. Residents were given information on the complaints procedure during regular resident meetings while information on how to make complaints was on display in the designated centre. One resident spoken to indicated an awareness of the complaints procedure in operation while access to advocacy services was also facilitated where necessary. As required by the regulations a log of any complaints made was also maintained.

The arrangements for complaints in the centre where also outlined in the designated centre's statement of purpose. This is an important governance document in the setting out the services that are to be provided to residents. Based on the overall findings of this inspection, the statement of purpose reflected the day-to-day operations of the designated centre and contained all of the required information such as details of the organisational structure and the staffing compliment that were

in place in the centre.

The designated centre's staffing compliment had been maintained since the previous inspection. Staff members spoken to were able to accurately describe the residents' needs and the supports required to provide for these while a wide range of training was also provided to staff. Inspectors observed staff members engaging with residents in a positive and respective manner during the inspection. Formal supervision arrangements for staff were in place while the increased presence of the person in charge in the centre created more opportunities for supervision of staff practice. Staff rosters reviewed indicated a consistency of staff which is important in ensuring that professional relationships and a continuity of care for residents are maintained.

A sample of staff files were also reviewed during this inspection. These were found to contain all of the required information such as two written references, full employment histories, proof of identity and evidence of Garda vetting. It was observed though that the provider's Garda vetting policy, a policy required by the regulations, provided for all staff to be re-vetted every three to five years. Based on the evidence of Garda vetting present in some of the staff files reviewed, this policy was not being fully implemented. It was also noted that the risk management policy, another required policy, was overdue a review at the time of this inspection.

## Regulation 14: Persons in charge

A suitable person in charge was in place who demonstrated a good understanding of residents and their needs. The person in charge was responsible for a total of four designated centres at the time of this inspection but their ability to to ensure effective governance, operational management and administration of this centre had improved since the previous inspection.

Judgment: Compliant

## Regulation 15: Staffing

Appropriate staff arrangements were in place to support residents. This included a continuity of staff. A sample of staff files were reviewed which contained all of the required documents such as two written references and evidence of Garda vetting.

Judgment: Compliant

## Regulation 16: Training and staff development

Training was provided to staff in a range of areas such as first aid, fire safety, medicines and safeguarding. Arrangements were in place for staff to receive formal supervision while there were increased opportunities for the supervision of staff practice. Staff team meetings were also taking place at regular intervals.

Judgment: Compliant

## Regulation 23: Governance and management

The process around unannounced visits required review to ensure that there was no prior knowledge of such visits beforehand and also with regard to the people involved in carrying out such visits. The 2018 annual review carried out did not reflect the outcome of consultation with residents.

Judgment: Not compliant

## Regulation 3: Statement of purpose

A recently reviewed statement of purpose was in place which accurately reflected the day-to-day operations of the centre and contained all of the required information such as details of the organisational structure, the staffing compliment, arrangements for complaints and a description of the rooms in the centre. The statement of purpose was noted to be available in the designated centre.

Judgment: Compliant

## Regulation 34: Complaints procedure

Residents were supported to raise complaints if required during regular resident meetings while information on how to make complaints was on display in the designated centre. A log of any complaints in the designated centre was maintained which included details of such complaints and any actions taken to respond to them.

Judgment: Compliant

## Regulation 4: Written policies and procedures

The provider's Garda vetting policy, which indicated that staff were to be re-vetted every three to five years, was not being fully implemented. It was also noted that the risk management policy was overdue a review.

Judgment: Not compliant

## Quality and safety

Overall inspectors found that care was generally being delivered to a high standard of quality and safety for residents. The centre was run in a manner that sought to proactively support residents in their daily lives. Residents' rights were largely promoted and access to medical professions was readily available to residents. However, recommended interventions to support one resident maximize their potential had not been provided while some aspects of residents' individual personal plans and fire safety required improvement.

Inspectors saw good evidence that the provider was generally promoting residents' rights and supporting them to engage in activities of their choice. Residents had access to a range of activities including swimming, bocce, boxercise and walking. Although located in a rural setting, the designated centre was within easy reach of local towns and Waterford city. To facilitate external activities, the centre had its own vehicle, which was insured, regularly maintained and serviced. As a result residents were facilitated to access the community, with examples including attending local bars, mass and traditional music sessions. Any activities were planned in consultation with residents during weekly house meetings.

However, at the outset of the inspection, inspectors were informed that the provider had recently taken a decision to limit one resident's choice and control over their daily life. The resident in question expressed to an inspector their unhappiness with this decision. This decision had been made following a recent high risk incident and it was noted that the provider had carefully considered the matter beforehand. The decision had also received support from allied health professionals but it was seen that one key piece of information, which the provider had also used to support this decision, was inaccurate. It was noted though that the provider had referred this decision and its consequences to a human rights committee.

When reviewing information relating to this decision, it was also observed that, in February 2016, an allied health professional had recommended that the resident receive particular interventions with the aim of improving the resident's abilities. While it was observed that the provider had given many supports to the resident since then, no evidence was provided during inspection that the recommended interventions had been introduced. This reduced the opportunities for the resident to make the best possible use of their abilities in order to achieve maximum individual development. The recommendation was contained within the resident's individual personal plan, which is important in setting out the needs of any

resident and the supports required to meet such needs.

Such plans were in place for all residents and had been reviewed annually at a 'circle of support' meeting for each resident. These meetings included input from residents, their family, staff members and management. Residents' plans were generally detailed and included allied health professionals' input but some parts of the plans did not adequately address all identified needs. For example, a diet and nutrition plan did not reflect updates around the management of fluid intake. Additionally, while staff demonstrated good knowledge concerning diabetes care management for one resident, this care was not fully reflected in the resident's personal plan. However, it was noted that residents were provided with good support to ensure they enjoyed the best possible health.

As set out in their personal plans, residents within this centre preferred established routines and planned happenings. Structure was of high importance to residents with the centre organised around a proactive ethos. Where change was required, staff were careful to offer residents advance notice. In some cases this was required by behavioural support plans which were developed by relevant professionals. These plans reflected the proactive ethos of the centre and created a routine that involved daily talk times, constructive feedback, managing change, managing family contact and support in a range of other areas of daily life. Such an approach sought to minimise any possible anxiety for residents. Staff members present on inspection demonstrated a good understanding of such plans which provided assurance that the provider was committed to promoting positive behaviour amongst residents.

A high standard of safeguarding was also evident within the centre. Residents each had a support plan in relation to the provision of intimate personal care. These were informed by evidence based assessments of residents' capacity to undertake routine daily tasks and provided guidance to staff when supporting residents in such areas. Plans were also in place to support residents in managing their monies. These were also evidence based as they were informed by money management capacity assessments. Safeguarding training for all staff was up to date and staff met by inspectors presented themselves as knowledgeable on the subject. Staff were observed to be respectful towards residents and were seen to interact with residents in an appropriate and dignified manner.

The designated centre itself was comprised of two-story detached house. On the day of inspection the house was observed to be clean, well maintained and presented in a homely manner. The boiler, emergency lighting, fire safety equipment and fire alarm system servicing were all up to date. Quarterly fire drills were held in the house which involved both staff and residents. These drills occurred at both day and night. Since the previous inspection the provider had improved fire containment measures in the centre however further review was required based on this inspection.

## Regulation 13: General welfare and development

No evidence was provided during inspection that particular interventions, as

recommended by an allied health professional in February 2016, had been provided for one resident. Such intervention could have improved this resident's abilities to achieve maximum individual development.

Judgment: Not compliant

## Regulation 17: Premises

The premises was laid out in a manner that met the needs of residents. There was sufficient common and private areas. Each of the rooms in the common areas were each designated primarily for each of the three current residents, and had been decorated in accordance with their individual preferences. The house was clean, well maintained and observed to be in a good state of repair on the day of inspection.

Judgment: Compliant

## Regulation 20: Information for residents

A residents' guide was in place which contained all of the required information such as details on how to access HIQA inspection reports and the arrangements for visiting.

Judgment: Compliant

## Regulation 26: Risk management procedures

An in-date health and safety statement was available to staff while risk management procedures were in place. These were reflected in the risk register and the individual risk assessments. However, these did require some review to ensure consistency between both sets of documents and consistent risk ratings. Suitable arrangements were in place to ensure the road worthiness and insurance of the vehicle used by this centre.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Since the last inspection the provider had improved containment measures in the centre but as noted during the two previous HIQA inspections of this centre in February 2016 and March 2018, such fire containment measures were not present throughout the centre.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Each resident had an individual assessment and personal plan in place. Each of these had been reviewed in the previous twelve months with input from residents, their family, staff and management. Personal plans were multidisciplinary and covered a range of health and social care aspects of residents' lives. However, improvement was required in relation to some aspects of residents' personal plans in order for them to be reflective of changing circumstances. In some cases pertinent plans for identified needs were either not on file or did not fully reflect the needs of residents.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had access to a range of healthcare professionals, such as a general practitioner, in accordance with their individually assessed needs. Residents were supported at times of illness and were supported to access relevant national screening programmes.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Positive behavioural support plans were in place to support residents in the management of behaviours. These plans were designed with appropriate allied health profession input. Staff had appropriate training to implement these plans while staff present on inspection demonstrated a good understanding of the positive behaviour support plans in place.

Judgment: Compliant

## Regulation 8: Protection

All staff had up-to-date safeguarding training in place while staff present on inspection demonstrated a good knowledge in this area. Where safeguarding situations arose the provider responded with interventions to protect residents. Intimate care plans were in place for residents to provide guidance for staff in this area. A sample of residents' finances were reviewed and adequate safeguarding processes for these were in place.

Judgment: Compliant

## Regulation 9: Residents' rights

Practice within the centre found that many aspects of residents rights were being promoted. Residents were being supported to access advocacy, house meetings were being held weekly and independence was supported and encouraged in relation to the activities of daily living and the daily operations of the centre. A recent decision had been made to limit one resident's choice and control over their life. This decision was partially based on a key piece of information which was shown during this inspection to be inaccurate.

Judgment: Substantially compliant

**Appendix 1 - Full list of regulations considered under each dimension**

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Views of people who use the service** | |
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Not compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Not compliant |
| Regulation 17: Premises | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Parkside Residential Services Kilmeaden OSV-0005106

## Inspection ID: MON-0022608

## Date of inspection: 27/02/2019

**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 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• An amendment to the 2018 Annual Report will be undertaken to include the additional information incorporating the feedback from the residents gathered from the residents survey<br><br>• Review of the process of unannounced visits ensuring that there is no prior knowledge of such visits beforehand | |
| Regulation 4: Written policies and procedures | Not Compliant |
| Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:<br>• The organisation is currently in the process of re-vetting all the relevant staff ensuring that practices are in line with the organisations policy<br><br>• The Risk management policy is being reviewed at a national level | |
| Regulation 13: General welfare and development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 13: General welfare and development:<br>• The intervention recommended in the 2016 report will be escalated to the services manager to be actioned by psychology supports with in the multidisciplinary team | |

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| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>• A full review of the risk register and the individual risk assessments will take place, ensuring consistency between both sets of documents | |
| Regulation 28: Fire precautions | Not Compliant |
| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>• A costing to replace the three doors downstairs to create a fire corridor will be submitted to HSE with a view to replacing in 2019 | |
| 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:<br>• A review of the identified personal plans will be carried out and with a focus on reflecting changing circumstances | |
| Regulation 9: Residents' rights | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>• Clarification will be sought from the author of the report in relation to the inaccuracies highlighted during the assessment.<br>• This clarification will be discussed and actioned accordingly through the Multi-Disciplinary Team process | |

## 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 13(1) | The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes. | Not Compliant | Orange | 12/04/2019 |
| Regulation 23(1)(e) | The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives. | Substantially Compliant | Yellow | 30/04/2019 |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and | Not Compliant | Orange | 30/04/2019 |

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| | support. | | | |
| 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 | | 07/05/2019 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 13/05/2019 |
| Regulation 04(1) | The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5. | Not Compliant | Orange | 30/09/2019 |
| Regulation 04(3) | The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice. | Substantially Compliant | Yellow | 30/09/2019 |
| Regulation 05(6)(d) | 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 take into account changes in circumstances and new developments. | Substantially Compliant | Yellow | 01/05/2019 |
| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Substantially Compliant | Yellow | 12/05/2019 |