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:	The Weir
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	21 August 2020
Centre ID:	OSV-0005625
Fieldwork ID:	MON-0030240

About the designated centre

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

This is a service comprising of 3 separate houses providing care and support for up to sixteen adults (both male and female) with disabilities in close proximity to Kilkenny city. Each house is spacious and tastefully decorated and has private well maintained gardens for residents to avail of as they please. All residents have their own private bedrooms which are decorated to their individual style and preference. The centre is managed by a qualified and experienced person in charge and is staffed on a 24/7 basis by a team of social care workers, health care assistants and recreational assistants. Residents are supported to attend a range of day service options where they can engage in skills development, hobbies and activities of their preference and choosing. They are also supported to use local community based amenities such as local gymnasiums, hotels, shops and restaurants. Residents healthcare needs are comprehensively provided for and they have as required access to GP services and a range of other allied healthcare professionals.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Friday 21 August 2020	10:00hrs to 16:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This centre is currently home to 10 residents and the inspector had the opportunity to meet with four residents. This inspection took place in the middle of the COVID-19 pandemic and communication with residents, staff and management took place from at least a two metre distance and was time limited in adherence with national guidance.

All four residents lived together in one home visited by the inspector which was on the first floor of an apartment complex. When the inspector arrived three residents were engaged in a game of BINGO and the fourth resident was quietly sitting with their crochet and waiting for a favourite television programme to begin. This resident explained to the inspector that they liked their home but that they would like to live in a home where they did not have to use stairs. They showed the inspector their crutch which they have to use should the lift not be operational and stated that they were worried about having to evacuate quickly.

The other residents following their game, made a cup of tea and were seen to come to the kitchen to tidy afterwards. The staff were seen to encourage independence and were respectful in their engagements with the residents. One resident had requested to go to the shop and the staff team were preparing for one of them to accompany the resident. The resident explained to the inspector that they had a new face mask and understood the reason for wearing it.

Residents also told the inspector that they liked the staff who worked in their home and that they had been nervous of new people when the day service staff were allocated to the centre during the COVID-19 pandemic however now they said they could have a laugh with them and felt well supported.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents. A number of areas were identified for improvement such as staff training and development, resident personal plans and positive behavioural support and these will be outlined across both sections of this report. However, in general there was improved compliance with the regulations since the last inspection.

The provider had appointed a suitably qualified individual to the role of person in charge since the last inspection. They had a reporting role to an assistant director of services within the organisation and this governance structure was clear and lines of accountability were in place. The person in charge is also responsible for another

centre supported by a team leader there thus ensuring sufficient time could be given to this centre. The inspector was satisfied that they had oversight and governance of this centre and was familiar with all the residents individual needs.

There was an annual review of the quality and safety of care for 2018 and the report for 2019 was being finalised. Six monthly unannounced visits by the provider or their representative had also taken place in May 2020 and previously one had also been completed in February 2020. The registered provider had an audit schedule for both the annual and six monthly audits that was reviewed regularly. The inspector found that learning and improvements were brought about as a result of the findings of these reviews. There were also some audits completed however as yet there had been no actions identified from these audits. Staff meetings had not been held as regularly as before the COVID-19 pandemic but they were resuming and review of recent minutes demonstrated that the agenda items were found to be resident focused.

There was a core team of staff employed in the centre ensuring consistent support was provided for residents. The inspector found that the use of agency staff had significantly decreased since the last inspection with only occasional use.There appeared to be effective recruitment and selection arrangements in place for staff. Review of a selection of staff files reviewed by the inspector for members of staff, contained all of the documents as required by schedule 2 of the regulations. The inspector reviewed rosters from all houses that make up this centre and found they accurately reflected the level of staffing present and required for residents assessed needs.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the providers training department. A review of training records however, showed that not all staff were up-to-date with refresher mandatory training requirements. This included staff requiring refresher training in key areas such as administration of medication, fire safety and management of behaviour that is challenging. All staff had completed training in areas of importance during the COVID-19 pandemic, such as hand hygiene and use of personal protective equipment (PPE). A number of staff had last completed their refresher training in the safe administration of medication in 2014 and the inspector was provided with assurances immediately following inspection that these staff had been scheduled for training and that oversight of practices and competency assessments had been put in place.

The inspector reviewed a sample of staff supervision files and found that supervision had not been undertaken in line with the frequency proposed in the providers policy. Where staff were new to the centre there was evidence that supervision in line with induction systems had taken place. However, on going quality conversation, (formal supervision) had in some instances not taken place since November 2019 with the provider policy requiring quarterly meetings. This was considered important to support staff to perform their duties to the best of their abilities.

The registered provider had ensured a contract or service provision agreement

between the organisation and the resident was in place. This document detailed the services and supports to be provided including any fees to be incurred. These were in place for all residents and were reviewed when changes arose, for example during the COVID-19 pandemic charges for transport had been altered to reflect the fact that residents were not moving to day services or partaking in journeys. Residents were registered as required with the Residential Tenancy Board and had access to easy ready information to support their understanding of their housing agreement.

A complaints log was present within the centre with a record maintained of any complaints, comments are compliments maintained. There was documented evidence that all complains were dealt with in a timely effective manner. Details of investigations were recorded and it was noted if a resident was happy or not with the outcome of their complaint. For example an increase in recreational hours was made in one house following a resident complaint and changes in access to the house car was made again following a resident complaint.

Registration Regulation 5: Application for registration or renewal of registration

All documentation required by regulation has been submitted with an application to renew registration of the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a new person in charge to this centre who had the required skills, knowledge and experience to meet regulatory requirements.

Judgment: Compliant

Regulation 15: Staffing

There was an accurate roster in place for staff which was seen to reflect practice in the houses on the day of inspection. Residents were supported by a consistent staff team with a reduction in the numbers of agency staff used. Staff personnel files contained the documents as required by Schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff required refresher training for key areas such as administration of medication. In addition formal supervision was not being provided to staff as laid out in the providers own policy.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had systems in place to ensure the implementation of an annual audit of service provision. In addition six monthly unannounced visits to assess the safety and quality of care provided to residents were taking place as required by regulation.

The provider and person in charge had implemented some audits however, they were not ensuring that actions required in all areas had been identified, this was seen for example in the staff training gaps.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had ensured there was a contract / service provision agreement in place for all residents in this centre. This reflected all charges and fees that applied and were signed.

Judgment: Compliant

Regulation 34: Complaints procedure

A complaints policy was in place to guide staff in relation to the complaints procedure, it was currently being reviewed and updated. Details of the complaints officer was visible in the house visited and residents could outline the process clearly to the inspector they would follow. A complaints log was maintained with evidence of complaints being dealt with in a timely and effective manner.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had in place all policies as required and set out in Schedule 5. These had recently been audited by the provider and a number were found not to have been reviewed and updated in accordance with best practice as stated in the regulations

Judgment: Not compliant

Quality and safety

The residents living in this centre received care and support which was of a good quality, safe, person centred and which promoted their rights. Some improvements were identified in relation to the establishment of social goals and programmes to guide the support of behaviour that challenges for some residents.

The residents' well-being and welfare was maintained by a good standard of care and support. Care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social needs and choices. However, while personal plans in place were reviewed at regular intervals some of these had not concluded in specific goals being set. For one individual there were no personal goals identified despite records from individual key working sessions identifying activities and wishes that had been stated by the resident. In other instances where some goals had been set there was no evidence that these had been reviewed or were being worked towards.

The residents were each supported to engage in meaningful activities in their home and prior to COVID-19 within the community. The inspector saw that staff facilitated and supported the residents to enjoy hobbies and to have time to explore these individually or with peers. As the COVID-19 restrictions were easing residents were supported to understand the importance of mask wearing, hand hygiene and social distance and were again being supported to access their community safely.

The inspector found that the provider and person in charge were promoting a positive approach to responding to behaviours that challenge. However, in the residents' files reviewed, there were no positive behaviour support plans in place to guide staff practice in supporting residents to manage their behaviour. Although staff who spoke with the inspector were knowledgeable in relation to residents' behaviour support needs, this information was not available should a familiar staff member not be available. In addition not all staff were up to date in

their training with respect to managing behaviour that challenges as outlined already in this report. The inspector found that there were some restrictive practices in use on the day of inspection such as the locking of a garden gate or the external doors of a house however, these were reviewed and the risks relating to these were assessed.

The provider and person in charge had systems to keep residents in the centre safe. There were policies and procedures in place and safeguarding plans were developed as necessary in conjunction with the designated officer and these were reviewed as required. Staff were found to be knowledgeable in relation to keeping residents safe and reporting allegations of abuse. The inspector reviewed a number of residents' intimate care plans and found they were detailed and guiding staff practice in supporting residents. There was evidence of appropriate onward referral for assessment or support should this be required to support residents in keeping safe, such as for medical or psychology review.

There were risk management arrangements in place which included environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified and a number were being reviewed by the person in charge at the time of the inspection. There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences from occurring. There was evidence of positive risk taking and the development of one off risk assessments to support residents, such as, the risk of contracting COVID-19 when a resident wished to meet with a friend for a coffee in town.

There were suitable arrangements to detect, contain and extinguish fires in the centre. Works had been completed in relation to fire drills and fire checks since the last inspection. Suitable equipment was available and there was evidence that it maintained and regularly serviced. Each resident had a personal emergency evacuation procedure which was reviewed and each house had an up to date bespoke evacuation procedure. Fire procedures were also available in an accessible format and on display. Staff had completed fire training and fire drills and fire walks were occurring. Where an issue had been identified of residents refusing to leave their home during a drill there was evidence of a phased plan that the resident was supported to engage in with staff. In one of the houses the provider had identified a concern regarding the time taken to evacuate for some residents with decreased mobility and this was being reviewed. A resident spoke to the inspector regarding the use of crutches to evacuate down a flight of stairs and how they managed this.

Staff spoken with were knowledgeable regarding processes in place for the management of residents finances. Systems were in place for the recording of daily expenditure and these were signed and dated by staff members. Residents personal finances were stored in secure facilities. The inspector discussed with the person in charge on the day of inspection that care was required to ensure the use of language to describe resident finances was appropriate for example, terms such as 'pocket money'. There were daily checks in place and audits were in place monthly by the team leader and annually by the provider with the person in charge carrying

out spot checks to ensure that procedures were followed. All residents were supported as required to manage their personal possessions. The inspector met with one resident who explained how they were supported with their own laundry explaining that they liked to use softener and showed the inspector their personal clothes horse for drying their clothes.

The inspector found that the premises were visibly clean on the day of inspection. Clear cleaning schedules were in place that staff were adhering too. Staff and residents had access to hand washing facilities, alcohol gels and personal protective equipment (PPE). An information folder was in place which contained guidance and protocols regarding best practice for the management of COVID-19, this was available to staff and residents. Social stories and easy read versions of information were also available. Contingency plans were in place for in the event of a suspected or confirmed case of COVID-19. Regular temperature checks were being completed by staff and all contacts in the centre were being recorded. Staff were observed using face masks in line with national guidance on the day of inspection.

The provider and person in charge were seen to have responded appropriately to changing needs of residents and facilitated, where required, residents in moving temporarily to other services to avail of appropriate levels of care and support. Where a resident had as a result of increased falls and changing health, transitioned into a nursing home, this decision was seen by the inspector to have fully involved the resident and the aim was outlined, to assist in returning to optimum health. There were clear transition plans in place and full involvement of residents and all members of the multidisciplinary team where transitions had been implemented. These plans were reviewed by the inspector and were seen to have been regularly reviewed and updated as required.

Regulation 12: Personal possessions

The provider and person in charge had systems in place to support residents in retaining access to and control over their own belongings where possible. There was transparent and safe practice in the management of resident finances.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Residents were supported to transition between residential services and relevant information had been considered and provided between services to support transition. There was evidence that residents were consulted and that planned

supports were in place.

Judgment: Compliant

Regulation 26: Risk management procedures

The safety of residents was promoted through appropriate risk assessment and the implementation of the centres' risk management and emergency planning policies and procedures. There was evidence of incident review in the centre and learning from adverse incidents.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate systems were in place for protection against infection in the centre. Appropriate personal protective equipment was available for staff and residents. National guidance was being adhered to on the day of inspection.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements to detect, contain and extinguish fires in the centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Staff had appropriate training and fire drills were held regularly. Residents' personal evacuation plans were reviewed regularly and they were supported to develop skills in evacuating.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. However, some improvements were required in establishing specific and measurable social goals for residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider and person in charge promoted a positive approach in responding to behaviours that challenge. There were no positive behaviour support plans in place for residents to guide staff to support them to manage their behaviour.

Judgment: Not compliant

Regulation 8: Protection

There were policies and procedures to keep residents safe. Staff had completed training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff who spoke with the inspector were knowledgeable in relation to recognising and reporting suspicions or allegations of abuse.

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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Weir OSV-0005625

Inspection ID: MON-0030240

Date of inspection: 21/08/2020

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 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.

The staff members identified as being out of date for Safe Administration of Medication refresher training had competency assessments completed by a suitable person on their next presentation for work. In addition they completed the refresher training on 10.09.20.

A supervision schedule for all staff for the remainder of 2020 is in place with priority given to those staff members whose supervision record is not in line with stated SOS policy. A supervision schedule for 2021 will be generated in December 2020 to ensure compliance with stated policy.

Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge will ensure that all actions identified in the annual audit and six monthly audit are completed by 31.12.20.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: A full review of SOS clg policies and procedures is underway and is due for completion no later than 29.03.2021.	
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: The Person in Charge will ensure that personal plans are up to date with identified personal goals and wishes an integral part of the plan. Key work sessions will be completed to support the residents in achieving goals where possible. If goals are not achieved through key working additional supports will be identified to support the resident to achieve the goals where possible.	
Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Positive Behaviour Support Plans for all residents will be formulated for each resident with appropriate multi- disciplinary team input. These plans will incorporate all the soft information known by care staff about residents to have it recorded formally for use in the event a familiar staff member is not available to support the residents.	

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 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 place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2020
Regulation 04(3)	The registered	Not Compliant	Orange	29/03/2021

	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.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	31/12/2020
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	31/12/2020
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within	Substantially Compliant	Yellow	31/12/2020

	agreed timescales.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/12/2020