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

Issued by the Chief Inspector

Name of designated centre:	Hillcourt
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	12 October 2021
Centre ID:	OSV-0003000
Fieldwork ID:	MON-0031147

About the designated centre

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

This centre comprises two community houses located ten kilometres away from each other in Co. Louth. One community house is a detached bungalow where four adults live. The other house is a four-bedroom semi-detached property where four adults live. All residents have their own bedrooms. The houses are located close to community amenities. Transport is also available in each house so as residents can have access to amenities that are further away. Both properties have a well-equipped kitchen, dining area, and adequate communal space. There is a garden to the back of each property, which has been furnished with outdoor seating for residents. The staff skill mix includes nurses and health care assistants. There is a waking night staff on duty in both houses, and two staff are on duty during the day. The staff team from both houses work collaboratively to support residents in the centre.

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
Tuesday 12 October 2021	9:30 am to 5:30 pm	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspector visited both houses that make up the designated centre and the inspection began in the Strandhill house. The inspector observed two of the residents relaxing in their sitting room waiting to be collected to attend their day service placements. A third resident was sitting at the kitchen table and had been interacting with staff, while the fourth resident had yet to begin their day and was relaxing in bed.

The residents appeared comfortable in their environment and were being supported by a staff member when required. The inspector interacted with one of the residents intermittently as the resident chose not to sit and speak with the inspector. The resident, when moving through the house, would say hello to the inspector and ask if they were alright. The inspector observed residents move freely throughout their home and that, for the most part the Strandhill house was well maintained. There were, however, issues identified regarding the premises at both houses and in particular the Westcourt house, which is discussed in more detail in Section 2 of this report: Quality and Safety.

On arrival to the Westcourt house the inspector observed that one resident was being supported on a one-to-one basis while the other three residents were attending their day service placements. The inspector spoke with two of the residents and observed that the other two residents appeared comfortable in their home. On returning from their day service, one resident engaged in their preferred activities and briefly spoke with the inspector. The other resident also spoke with the inspector about their hobbies, interests, and their family. The resident appeared at ease in their home and showed the inspector collages that had been created to capture some of the activities they had taken part in during travel restrictions previously imposed due to the COVID-19 pandemic. There were images of residents baking, going for walks, and hosting 'come dine with me' evenings. The resident spoke positively of the staff team and was happy that they lived close to their family which meant they could visit them.

A review of residents information across both services found that there were discrepancies regarding the monitoring of the service being provided in both houses. The inspector found that there were more thorough monitoring practices employed in regard to the residents living in the Westcourt house. Nonetheless, It was found that record-keeping across a number of areas was not appropriate and as a result, there were elements of residents’ information that had not been appropriately maintained. The inspector reviewed a sample of residents' information and found that the majority of residents' person-centered plans and personal goals had not been reviewed since 2020. The information available for review also established that some residents had not been supported to develop individual goals for 2021.

While the inspection found that there were a number of areas that required consideration to be compliant with the regulations, the inspector noted that the

residents appeared happy in their home. The inspector did not have the opportunity to speak with residents' family members on this occasion but reviewed feedback from them in the 2020 annual review of the quality and safety of care. Family members had submitted positive feedback regarding the service at that time. Furthermore, the inspector reviewed a questionnaire that had been submitted for the 2021 review. The feedback was again positive.

The inspector also observed warm and considerate interactions between residents and those supporting them throughout the day. Some residents had recently started re-attending day services and those that spoke with the inspector, expressed that they were happy to return. The inspector reviewed a sample of residents' daily notes; these demonstrated that when possible, the residents' wishes were respected. For the most part, residents were engaged in their daily preferred activities with the support of the staff teams.

Overall, the inspection found that there were a number of areas that required improvement. The existing management and oversight arrangements were not leading to the effective oversight of all aspects of care being provided to the residents. This, in some areas, was negatively impacting the service being provided and is discussed in more detail in the following two sections of the report.

The following two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

There was a management structure in place that was led by a person in charge and the provider had also appointed a house manager to the service. From a review of the management team's roles the inspector found that the person in charge was responsible for three other designated centres and the house manager was responsible for one other designated centre. The management team's extensive remit impacted on their ability to be present in this centre regularly. There were also occasions where the house manager had to complete shifts due to previous staffing shortages. These issues were impacting the management's team being able to provide effective oversight of the service being provided.

While there were monitoring systems in place, the inspection found that these systems were not effective. As mentioned above, there were elements of the residents notes along with other organisational recordings such as staff training that were not being appropriately monitored or maintained. The inspector also found that in some cases, care plans had not been updated despite the required actions or follow-ups being completed.

The inspector noted that the house manager was regularly based in the Westcourt

house and, there was evidence of increased monitoring in this part of the service compared to the Strandhill residents' records and general information. The inspector also found that there were enhancements required to the amount of support and guidance staff members were receiving in the Strandhill house when compared to the supports and on site management provided in the Westcourt house.

The provider had completed a 2020 annual review of the quality and safety of care and support provided to the residents. The review had identified areas that required attention, and these had been added to the quality improvement plan. The appraisal of the plan found that there had been delays in addressing issues being raised through internal audits completed by the centre's management team and through reviews completed by the provider's senior management. The inspector found that the problems identified at the Westcourt premises had been identified in January 2020 and had yet to be addressed despite the issues impacting upon infection prevention and control measures and also significantly impacting the appearance of the residents' home. A member of the provider's senior management team visited the house to review the issues on 10.09.21, and steps were being taken to addresss the problems. However, these issues were long-standing, and the provider had not responded to them in an adequate time frame.

The inspector reviewed the staffing rosters for both houses and found that the teams comprised staff nurses and Care Assistants. The review found that there had been a number of changes to the Strandhill staffing team in the early months of this year but that there had been a stable team in place for a number of months. The group of residents were receiving continuity of care. This was also found following the review of the Westcourt rosters. This was despite the provider relying on on-call staff to cover shifts on a regular basis. The study of information demonstrated that there were a number of staff on long-term leave. However, the provider had ensured that there was consistent on-call staff supporting the residents leading to continuity of care.

The training needs of the staff team supporting the residents were under regular review by the management team. There was evidence of staff team being identified for training when required. The COVID-19 pandemic had impacted certain training being provided, the provider was in the process of addressing this, and the inspector was shown a list of dates where staff would be completing training in the coming weeks. However, the recording and upkeep of documentation regarding the completion of staff training required improvement. There were a number of occasions throughout the day where it was unclear if staff had or hadn't completed required training. In turn, the centre's management team had to contact the provider's human resource department on a number of occasions to confirm if training had been completed as records had not been updated.

In summary, the inspection found that the provider had not ensured that the governance and management arrangements were appropriate. There were systems to identify actions, but improvements were required to ensure that all actions were addressed in a proper time frame.

Regulation 15: Staffing

The provider had ensured that the number of staff members supporting the residents was appropriate. Residents were also receiving continuity of care.

Judgment: Compliant

Regulation 16: Training and staff development

The training needs of the staff team supporting the residents were under regular review by the management team. The house manager also showed the inspector upcoming training dates that addressed the training needs of the staff team.

Judgment: Compliant

Regulation 21: Records

The existing management of residents and the organisational records were not appropriate. This negatively impacted the service provided to residents.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that the existing management arrangements had not been effective in addressing actions that had been identified via audits and reports. There were also improvements required to ensure that there were appropriate oversight arrangements in place that ensured that the best possible service was provided to each resident.

Judgment: Not compliant

Quality and safety

The inspector found that the provider had failed to ensure that the interior of both

houses had been suitably maintained. The Westcourt house required repairs to a number of areas, including flooring, damage to doors and doorways as well as grouting in the main upstairs bathroom. The bathroom required particular attention as the issues in the bathroom had led to a leak in the roof in the kitchen area. The provider's audits had noted that this had in the past led to mould forming. There were tears in the flooring covering in the residents' sitting room and upstairs bathroom.

There were also enhancements required to the Strandhill property. There were painting and repair works required as well as storage issues. During the walk-through of the house, the inspector and house manager found that jump leads for a car had been left on the floor of a room being used for staff members to change in at shift changes. The inspector also observed that there was damage to some of the presses in the kitchen.

Infection control risks were identified during the inspection due to the repairs required to both houses. The damage to the flooring and grouting in the Westcourt house meant that the areas could not be appropriately cleaned. The inspector found that the kitchen presses required repair with scratches and chips from the existing paintwork in the Strandhill house. This impacted the staff team's ability to ensure that the presses which were in regular use were effectively cleaned.

The inspector did find that the provider had overall ensured that there were appropriate arrangements for the prevention and control of infection. The provider had adopted procedures in line with public health guidance in response to COVID-19. There was a COVID-19 contingency plan specific to the centre. Staff had been provided with a range of training in infection control. However, the outstanding maintenance works continued to impact the staff team's efforts to clean all areas of both houses appropriately.

For the most part, the provider had implemented appropriate fire safety systems. However, the inspector found that doors in the Westcourt house had been painted and, in some cases, that the intumescent strips located on the fire doors had also been painted on. This impacted the integrity of the intumescent strips. The provider had not identified this as an issue before the inspection. However, the inspector was provided with assurances in the days following the inspection that all affected doors had had new intumescent strips put in place.

The inspector found that fire fighting equipment had been appropriately maintained and that there were adequate means of escape, including emergency lighting. The review of fire drills demonstrated that the residents and staff members in the Westcourt house could be safely evacuated with maximum and minimum staffing levels during day and night time circumstances. The review of the fire drill records for the Strandhill house revealed that one resident had declined to engage fully in a night time drill completed on 04.08.21. The other residents had been safely evacuated out of their home, but one resident chose not to engage and remained in their room. The inspector found that the staff team had introduced skills teaching piece for the resident following the drill and that this had been implemented. A further night time drill was due to take place and the person in charge was seeking

to arrange a meeting with the local Chief Fire Officer to review the incident with them and identify the Strandhill house as a priority. The inspector notes that the resident had engaged in daytime fire drills without any issue. The staff and management team had been proactive in responding to the issue.

The inspector reviewed a sample of residents' information across both houses. While the provider had ensured that residents had received assessments of their health and social care needs, there were required improvements to the auditing of these assessments and, in some cases, care plans. These issues are reflected in the above comments regarding the lack of oversight and poor record keeping. The inspector notes that for some residents, their information was being updated when required and that it reflected their changing needs. However, this was not consistent across both sets of residents. As noted above, the information available for review confirmed that residents had not been supported to set or achieve person-centred goals for 2021. The management team had raised this issue at a recent team meeting, but the delayed response to identifying the issue confirmed that there were required improvements to the existing oversight of practices being provided to each resident.

The inspector found that residents had access to appropriate healthcare. The records regarding residents' health information and their needs were under review, and the records demonstrated that some residents were supported to access allied healthcare professionals on a regular basis and also that their medications were reviewed when required.

Some of the residents were receiving positive behavioural supports. They were under review by members of the provider's multidisciplinary team, and there was evidence of the changing needs of residents in regard to their behaviours being addressed promptly when required. The behaviour support plans that were reviewed were found to be detailed and focused on supporting staff members to understand the behaviours and how to best support each resident. The review of adverse incidents for both houses demonstrated that the existing control measures to reduce behaviours were effective.

There were arrangements for the identification, recording, and investigation of and learning from serious incidents or adverse events involving residents. The inspector reviewed the centre's adverse incident log and found that incidents were reviewed by the centre's management team and members of the provider's senior management. There was also a local risk register; these were under review by the centre's management team and captured the environmental and social risks.

While the inspection found improvements were required across a number of areas, the inspector observed residents appeared comfortable and happy in their homes. The areas that need improvement were focused on improving existing management arrangements and the level of oversight of the service provided to each resident.

Regulation 17: Premises

The inspection found that the provider had failed to ensure that the interior of both houses had been appropriately maintained.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector observed that there were adequate arrangements in place for the identification and management of risk. There were systems in place to review adverse incidents and to promote learning.

Judgment: Compliant

Regulation 27: Protection against infection

Overall, there were suitable procedures in place for the prevention and control of infection, which were in line with national guidance for the management of COVID-19. However, it was noted that the damage to areas in both houses meant that these areas were difficult to clean from an infection control perspective.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to identify that there were improvements required to their existing fire containment measures. The inspector notes that the issue was addressed in the days following the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had failed to support residents to identify person-centred goals for 2021. There were also improvements required to the monitoring of some residents' information.

Judgment: Substantially compliant

Regulation 6: Health care

The health needs of residents were under review. They had access to appropriate healthcare services on the same basis as others in order to maintain and improve their health status.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were arrangements in place that ensured that residents had access to positive behavioural; support if required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and had their choices and decisions respected.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hillcourt OSV-0003000

Inspection ID: MON-0031147

Date of inspection: 12/10/2021

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The IPP in question was reviewed and updated 12.10.21 .The auditing of IPPs has resumed following the lifting of Covid 19 restrictions, the PIC/CNM1/Senior staff nurses will conduct a monthly audit on chosen IPPs on a rotational basis. All training records are accurate and up to date and all staff are scheduled for refresher training as required for 2021.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Unannounced audits of designated centres will resume 1.11.2021 The PIC/CNM1 will ensure that findings from all audits and inspections are loaded onto the QEP with associated timeframes. All actions which relate to maintenance are reviewed with the PIC/CNM1, Director of Care and Support/ Operations Manager and maintenance Manager to agree timeframes for completion. Progress on these actions will be updated in the QEP and regularly reviewed with the Director of Care & Support and Designated Centre (DC) meetings.9.11.21	

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A programme of works has been agreed to address all issues identified in the QEP relating to "Premises" 28.2.2022	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: A programme of works has been agreed to address all issues identified in the QEP relating to "Protection against infection" 28.2.2022	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The intumescent strips on the relevant doors in 84 Westcourt were replaced on the 13.10.21	
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: All residents IPPS will be audited by management every 8 weeks. Key works will complete their monthly review off goals with residents prior to the Monthly DC meeting and provide feedback on the progress on goals at the meeting.24.11.21 A Full audit of PCPS was conducted 30.10.21. All residents have goals identified and key workers document the progress on same monthly and provide feedback to the staff team at the DC meeting. Additional Training on goal setting will be provided by the Goal Setting Co-ordinator on the 24.11.21 Going forward goals will be audited by management quarterly in line with PCP policy.	

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	31/01/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	12/10/2021
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	08/11/2021

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.	Not Compliant	Orange	24/11/2021
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 support.	Substantially Compliant	Yellow	01/11/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting	Substantially Compliant	Yellow	28/02/2022

	procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	13/10/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident’s personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	24/11/2021