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:	Skylark 1
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	17 February 2021
Centre ID:	OSV-0004832
Fieldwork ID:	MON-0030660

About the designated centre

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

Skylark 1 comprises of three, two-storey houses on the outskirts of Limerick city. Two of the houses are within a short walking distance of each other. Each house has its own outdoor area and is located near many social and recreational amenities including local shops and services, and transport links. Each resident living in the centre has their own bedroom, some of which are en-suite. The centre provides a residential service to people aged over 35 years old, who have an intellectual disability.
Skylark 1 is open 365 days a year. When residents are attending day services, the centre is not staffed. It is stated in the statement of purpose for the centre that the purpose of Skylark 1 is to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person.

The following information outlines some additional data on this centre.

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
Wednesday 17 February 2021	10:00hrs to 17:30hrs	Cora McCarthy	Lead

What residents told us and what inspectors observed

On the day of inspection the inspector had the opportunity to meet with the two residents residing in the designated centre. On arrival the residents were watching mass online so the inspector was given a tour of the house until the residents were available. The inspector then joined the residents for a cup of tea. The residents were able to articulate themselves clearly, one resident had a hearing impairment but was still able to give their views. The residents both said they liked living in the centre and the enjoyed keeping their home clean and tidy. The residents had decorated their home beautifully with personal belongings, photographs and homemade items such as St Brigids cross. The residents said they felt safe in their home and the staff were very good to them. The residents home was dated and required upgrade but the residents were moving to a new home shortly which was more suitable to their needs. The staff were observed to be very respectful of the residents and the residents appeared very happy with the care and support provided. The staff were observed to support the residents with making their beds and preparing food for lunch, they encouraged the residents to do everything themselves thus maximising their independence.

Capacity and capability

The findings on the day of this inspection found that the designated centre was not adequately and effectively monitored. There was a clearly defined management structure, which identified the lines of authority and accountability for all areas of service provision. The person in charge held the necessary skills and qualifications to carry out the role and the day-to-day management of the centre. The person in charge was appointed person in charge of more than one centre, however they had not ensured good operational management and administration of this designated centre.

The provider had ensured that staff numbers and skill mix at the centre were in line with the assessed needs of the residents and with the statement of purpose. The inspector reviewed the actual and planned staff rota which indicated continuity of care from a core staff team. The staff members whom the inspector spoke with were very knowledgeable around the residents' assessed needs and their abilities.

The person in charge had a training matrix for review and the inspector noted that all staff had received mandatory training. It was noted that some mandatory training had been cancelled due to the COVID-19 pandemic, however, the person in charge had ensured that staff members were scheduled to access appropriate online trainings until face-to-face training could recommence. Discussions with staff demonstrated that staff were supported to access mandatory training in line with

the provider's policies and procedures in areas such as safeguarding, medication management, fire safety and infection control.

Clear management structures were in place. The provider had also undertaken unannounced inspections of the service and an annual review of the quality and safety of service was carried out December 2020. This annual review included a review of staffing, restrictive practices, quality and safety and safeguarding. However some areas that were identified in the audit process had not been progressed. For example an action to discuss the issue of one residents behaviour had not been addressed . This required to be progressed in line with the providers own audit process time line. Some incidents which were written up in the daily notes as incidents had not been recorded on the providers internal incident recording system. These incidents were discussed at multi disciplinary meetings but again not recorded as such and not considered for notifying to HIQA. As such the provider had not ensured the service was safely and effectively monitored. Given the non compliance on this inspection, governance and management systems required review in this designated centre.

The registered provider had a written statement of purpose in place for the centre, which contained all information required under Schedule 1 of the regulations.

During the inspection incidents were reviewed and it was noted that the person in charge had notified the Chief Inspector of what they determined to be incidents that occurred in the designated centre.

While the provider had a complaints procedure in place the provider had not ensured the residents had access to advocacy services for the purpose of making a complaint. One resident had made a complaint regarding the restrictions around Covid 19 however this complaint was not resolved to the complainants satisfaction and was closed. The resident was not supported to access advocacy services in order to take this matter further.

Regulation 15: Staffing

The person in charge had an actual and planned rota which was in line with the statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had a training matrix for review and the inspector noted that all staff had received mandatory training in line with regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the centre was consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a written statement of purpose in place for the centre, which contained all information required under Schedule 1 of the regulations

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge notified the Chief Inspector of incidents that occurred in the designated centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had not ensured the residents had access to advocacy services for the purpose of making a complaint.

Judgment: Not compliant

Quality and safety

The inspector reviewed the quality and safety of residents in the centre and found there were areas for improvement. The inspector noted that the provider had

implemented the necessary protocols and guidelines in relation to good infection prevention and control to ensure the safety of all residents during the COVID-19 pandemic. These guidelines were in line with the national public health guidelines and were reviewed regularly with information and protocols updated as necessary. For example, when staff were coming into the centre they had to adhere to COVID-19 protocols such as temperature checks, a COVID-19 questionnaire and wear appropriate personal protective equipment (PPE).

The assessment of need in some areas was positive. For example the provider had ensured that a assessment by an occupation therapist was carried out for one resident. This assessment was sought as a result of residents mobility issues. The residents mobility was assessed and appropriate equipment was provided for the resident such as handrails and a special armchair for support. This assessment was comprehensive and the actions addressed.

However one resident was diagnosed with a mental health condition and there was no mental health support plan for the resident. This meant that there was no clear guidance for staff in how to manage the residents behaviour which was linked to their mental health issues.

There was a behaviour support plan in place which provided guidance to the staff regarding one residents behaviour however as a lot of the incidents were not recognised as such and not recorded on the incident recording system there was little evidence to inform this plan and no mental health care plan to support it.

Staff demonstrated a good knowledge of the residents' health care needs and how to support them. For example staff members with whom the inspector spoke were knowledgeable about the residents needs and were aware of one residents renal care needs. The residents had access to a GP and other health care professionals.

Residents were supported to achieve their personal goals although these had been subject to changes due to the effects of COVID-19 public health restrictions. For example where residents had aspired to go to particular events such as a music concert this had to be postponed due to COVID 19.

Appropriate user friendly information with visuals was provided to the residents to support their understanding of COVID-19 and the restrictions in place. Other visuals in place included how to make a complaint or report alleged abuse. A visual rota and menu and were required as per recommendations to aid the residents' understanding.

The provider ensured that each resident received appropriate care and support, having regard to the nature and extent of the residents' disability, assessed needs and their wishes. There was evidence of access to facilities for occupation and recreation prior to COVID-19. Prior to the COVID-19 restrictions the residents were noted to have been active in their community and were regulars in the local cafes and restaurants. The residents were out for a walk on the day of inspection and one resident was viewing mass on their tablet.

The premises was not maintained to a good standard and were not appropriate to

residents needs but the residents were moving in the coming days to a new home which was renovated to a high standard with their needs in mind. However the centre was clean and personalised throughout with the resident's belongings. The residents' bedrooms were decorated to their individual tastes and there were family photographs throughout the centre.

The provider had a risk management policy in place and all identified risks had a risk management plan in place including the risks attached to COVID-19. However the risks associated with not informing the residents they were moving house in the coming days had not been identified nor a support plan developed for the residents.

The provider ensured that there was a system in place in the centre for responding to emergencies.The provider had ensured that residents who may be at risk of an infection such as COVID-19 were protected by adopting procedures consistent with the standards for infection prevention and control. The person in charge had ensured that the risk control measures were proportional to the risk. In this sense residents were still able to engage in activities such as walks and drives. Staff were observed to wear masks and practice appropriate hand hygiene during the inspection. There was adequate supply of PPE in the centre and hand sanitiser while all staff were trained in infection prevention and control.

The person in charge had ensured that all fire equipment was maintained and that there was emergency lighting and an L1 fire alarm system in place. The inspector reviewed evacuation drills which were carried out quarterly and found that they indicated that all residents could be safely evacuated in under one minute. There were no fire doors or containment measure in place but this had been previously highlighted and the residents were moving to a new premises that was fully fire compliant.

The inspector observed that there were systems and measures in operation in the centre to protect the residents from possible abuse. Staff were facilitated with training in the safeguarding of vulnerable persons. The inspector spoke with one staff member regarding safeguarding of residents. The staff member was able to clearly outline the process of recording and reporting safeguarding concerns.

The provider had not ensured that the residents had the freedom to exercise choice and control in their lives as they had not been informed of the move to their new home. They had also not been provided with advocacy supports in order to make a complaint.

Regulation 10: Communication

The provider had ensured that the residents were supported to communicate in accordance with their needs.

Judgment: Compliant

Regulation 13: General welfare and development

The provider ensured that each resident received 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 their wishes.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place however all risks were not identified nor was there a risk management plan in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had ensured that residents who may be at risk of an infection such as COVID-19 were protected by adopting procedures consistent with the standards for infection prevention and control.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had developed a plan however it did not reflect all of the residents needs nor did it outline supports for all areas.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had ensured that each resident was supported to access appropriate

health care however there were no support plans for renal care or mental health.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had not ensured that every effort was made to identify and alleviate the cause of the residents challenging behaviour.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured there were systems in place to protect residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that the residents had the freedom to exercise choice and control in their lives.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
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 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Skylark 1 OSV-0004832

Inspection ID: MON-0030660

Date of inspection: 17/02/2021

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Governance and management systems have been reviewed in the area to ensure that the service provided is safe, appropriate to resident's needs, consistent and effectively monitored. • PIC organized an MDT meeting. Here it was agreed that staff would document the number of times per day one resident is vocal, and complete an AIRS report. An informal check in with the second resident is to occur when the resident is having 1:1 staff time, to explore if her peer vocalising is having a negative impact on her. It is acknowledged that the resident is not presenting as distressed when her peer vocalises, and staff manage these instances very well. When AIRS forms are reviewed, and if the resident were to tell staff that her peer vocalising upsets her or staff observed same, at that point a CP1 should be considered with an NFO6. PIC has informed all staff members to complete challenging behaviour reports on AIRS after any incident. PIC will send an e mail to the MDT to inform them of the challenging behaviour reports as they arise for review. Area manager will insure this is upheld when the PIC is off duty. PIC is linking with relevant MDT team members to review one residents Behaviour Support Plan based on the recorded challenging behaviour AIRs reports and also develop new support plans based on the resident's needs. PIC will ensure staff read and are familiar with the support plans.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:	

• The BOCSILR Regional Advocacy Council commenced online zoom based advocacy meetings on 04/06/2021. Communication was sent via the regional advocacy council e-magazine 'Did you know' advising all people supported of this and how to join meetings. Representatives from across the services attend these meetings and raise issues that are of concern to people supported. The issue of COVID related restrictions was raised at the Regional Advocacy meeting on 18/06/20201 and was escalated to the National Advocacy Council who wrote to the Chief Executive regarding same. The resident made the complaint on the 2/7/20. On 09/07/20201 The BOCSI issued guidance on support people through the easing of restrictions safely and on 10/07/2021 the HSE issued 'Interim Rights Based Guidance on Implementing Infection Prevention and Control Measures and Mitigating Risk in Disability Services'. Following issuing of these guidance documents Skylark 1 immediately commenced risk assessments to support residents to access community based activities in line with public health guidance If the resident was not happy with the outcome of a complaint in the future PIC would insure the resident is supported to access external advocacy supports.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• PIC developed a risk assessment associated with not informing the residents they were moving house. MDT was held the 18th February and residents informed of the move. Transition plans put in place immediately to support the residents with their move.

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:
CNSp Age Related Care Nurse is supporting PIC in creating health care plans for the residents to reflect their current presentation. A support plan for renal care is currently been developed for the resident. CNSp in Age related Care is supporting the PIC to develop the support plan. Information from the GP has been obtained to develop the support plan. Once the support plan is finalized an information session on the renal support plan will be delivered to staff supporting the resident.
A support for Mental Health is been developed for the resident. CNSp Positive Behavior Support is supporting the PIC to develop the plan. The support plan will also be reviewed

by resident psychiatrist and resident psychologist. Once the support plan is finalized an information session on the mental health support plan will be delivered to staff supporting the resident

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A support plan for renal care is currently been developed for the resident. CNSp in Age related Care is supporting the PIC to develop the support plan. Information from the GP has been obtained to develop the support plan. Once the support plan is finalized an information session on the renal support plan will be delivered to staff supporting the resident. A support for Mental Health is been developed for the resident. CNSp Positive Behavior Support is supporting the PIC to develop the plan. The support plan will also be reviewed by resident psychiatrist and resident psychologist. Once the support plan is finalized an information session on the mental health support plan will be delivered to staff supporting the resident

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• All staff have been informed to complete challenging behavior reports on AIRS after any incident. PIC is monitoring care notes and AIRS in order to alert members of the MDT of the residents challenging behavior in order that an intervention can take place in a timely manner. After a number of AIRS have been recorded CNSp Positive Behavior support will review the AIRS and with the PIC & frontline staff and review the Behavior Support plan to reflect the trends in the recorded AIRS report.
A support plan for Mental Health is been developed for the resident. CNSp Positive Behavior Support is supporting the PIC to develop the plan. The support plan will also be reviewed by the resident's psychologist. Once the support plan is finalized an information session on the mental health support plan will be delivered to staff supporting the resident. PIC is engaging with MDT members to put in place a comprehensive understanding of the complexities of the residents.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• MDT was held on 18/03/2021 to discuss the move to the new home and informing residents. The Area Manager met with the two residents to discuss the move to a new, brighter and better home. Both residents agreed that they would like to move to the house and they began preparations, supported by staff to buy new fixtures and fittings and personal items for their new home. This was done immediately and the residents moved into their new home on 07/03/2021.MDT held 18th February team discussed why the move to 2 Clonile was not discussed with residents. This was due to resident's anxiety around dates and changes.
• At the MDT meeting on the 18/03/2221 the MDT discussed their concerns that a long wait for a move would be upsetting for residents as building projects often get delayed. This decision had not been recorded in previous MDT minutes in relation to the move. Any future MDT with a similar team decisions will be recorded to reflect the teams view. Going forward to support residents to exercise rights and choice and control in their lives PIC will insure residents receive information on changes in a timely way. Offer the appropriate emotional support when receiving information and support in planning for life changing events. Appropriate support plans will be developed to support the residents with change. This will allow residents the freedom to exercise choice and control in their lives. On receiving the information residents will be supported to make a complaint if they are not happy and will be supported to access internal & external Advocacy supports if required

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 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	30/03/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	18/02/2021
Regulation 34(1)(c)	The registered provider shall provide an effective	Not Compliant	Orange	30/03/2021

	complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure the resident has access to advocacy services for the purposes of making a complaint.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Substantially Compliant	Yellow	30/05/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/05/2021
Regulation 06(1)	The registered	Substantially	Yellow	30/05/2021

	provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Compliant		
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/05/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/05/2021
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.	Not Compliant	Orange	30/03/2021