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

## Issued by the Chief Inspector

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|---|---|
| Name of designated centre: | Gallows Hill |
| Name of provider: | KARE, Promoting Inclusion for People with Intellectual Disabilities |
| Address of centre: | Kildare |
| Type of inspection: | Announced |
| Date of inspection: | 26 October 2021 |
| Centre ID: | OSV-0001982 |
| Fieldwork ID: | MON-0026879 |

## About the designated centre

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

This designated centre is a bungalow situated in a rural location on the outskirts of Athy, Co. Kildare. The house accommodates two residents. The house contains a living room, a kitchen-cum-dining area, utility room and four bedrooms. There is a shower/bathroom and a shower room with toilet. There is a lawn with shrubs to the front of the house and a patio area with large garden space to the back of the house. The person in charge also works in one other designated centre. There are five social care workers and two care worker employed in this centre. A vehicle is available to drive residents to and from different activities and the local community.

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

| Number of residents on the date of inspection: | 2 |
| --- | --- |

## 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 26 October 2021 | 11:00hrs to 17:40hrs | Gearoid Harrahill | Lead |

## What residents told us and what inspectors observed

During the day, the inspector had the opportunity to meet with the people living in this designated centre, as well as observe support and interactions between them and staff. The residents were advised that someone would be visiting their home.

The residents were supported by staff who engaged in friendly, patient and supportive interactions. Staff were familiar with how to communicate with residents and were knowledgeable of their interests, routines, hobbies and personalities. Residents were in good form during the day, watching television, listening to music and playing games on their computer. Other activities were available to the residents in the house including art play, tablet computers, and jigsaws made from photographs of their family and favourite places. One resident had an interest in horticulture and tended to chickens and tomato plants in the garden.

One of the residents spoke with the inspector about their job and how they enjoyed the work and the people they knew there. They left in the afternoon to go to their work, and the staff and other resident left to go for a coffee and a walk in the local town. Staff were supporting the residents to pursue meaningful opportunities for social, work and recreational activities that were in line with their wishes and interests. The inspector also read plans regarding staff supporting residents with objectives related to healthy eating, exercise, and exploring new areas when going for walks or drives. Residents were encouraged to be independent and receive appropriate levels of support with activities of daily living such as preparing food, shopping, and self-care. Risk assessments identified the terms under which residents were safe to be in the house independently without staff presence.

The designated centre consisted of a sizable bungalow at the outskirts of a town. The house was decorated to be comfortable and suitable for residents' assessed needs. Residents could personalise their living space, and communal areas featured information of interest for the residents, including boards outlining weekly planners and events coming up. Regular house meetings took place in which residents planned their meals for the coming week so as to know what groceries were required when they went shopping.

While some personal goals were paused or only recently resumed after being paused due to the social restrictions, the inspector found that personal objectives were meaningful to the residents, including being supported to go to rugby and wrestling matches, develop skills with computers, get meaningful employment, and develop social relationships. The residents were looking forward to returning to the gym and to swimming after these services were suspended due to the COVID-19 pandemic.

The residents filled out satisfaction surveys to relay their opinions and experiences in the service. The residents spoke positively on their keyworkers and support staff. They identified things they would like done differently in the house, including

dinners being earlier in the day and to be more involved in household chores. They commented that they enjoyed their own space and routine being respected, liked returning home for family visits or going out to the local community, and disliked times when the service vehicle was unavailable. In the afternoon, the inspector observed that residents and staff leaving for town in their vehicle, which was of a suitable size and design for the residents. The service had exclusive use of this van.

The next two sections of this 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 on the safety and quality of the service being provided.

## Capacity and capability

The residents were supported full-time by a small team of staff who worked sleepover shifts in the designated centre. At the time of the inspection, there was a full complement of staff with no vacancies. Rosters reviewed indicated that where annual leave or unexpected absence required cover, this was done through staff working shifts additional to their contract, and where that was not sufficient, using a consistent relief staff arrangement. The provider had contingency arrangements in place for how to respond to a number of staff being absent at the same time in the event of an outbreak of COVID-19.

The inspector reviewed a sample of supervision records between staff and their respective line manager. These occurred at the start, middle and end of each year and their content was meaningful toward staff development, including opportunities for training and career development, and how to most effectively deliver the support needs of the residents. Routine and specialist training was being monitored to ensure it was up to date for all team members.

There was a clear management and reporting structure, with on-call arrangements for when the person in charge was not on duty. Team meetings took place in which the staff shared learning and updates regarding the centre and the residents' support plans. The provider had conducted an annual review of the service at the end of 2020, with follow-up reviews carried out in June of 2021. Where areas had been identified as in need of improvement or further development, actions were identified. Some improvement was required to ensure that the annual review reflected the commentary and experiences gathered from the residents and their representatives over the year. The provider had composed a quality improvement plan with time bound actions listed. While the provider had attained most of their listed objectives, the service reviews had not identified areas in need of development related to the premises, on maintenance, fire safety, and environmental restrictions. These will be referred later in this report.

The provider had developed contingency arrangements for responding to possible or actual outbreak of COVID-19 in the service. This included having a plan for how

many relief personnel could be made available to the centre to cover absences due to isolation. A deputation structure of management in the absence of the person in charge was clearly described. Person-specific strategies were outlined for if each resident living in the service is diagnosed is required to isolate, including their assessed ability to follow social distance guidelines and protect themselves from potential exposure. The provider incorporated national guidance on infection control practices into their in-house policies and protocols on the matter.

## Regulation 14: Persons in charge

The person in charged works full-time and holds the required experience and qualifications for the role.

Judgment: Compliant

## Regulation 15: Staffing

The service was operating with a complete complement of staff. Appropriate arrangements were in effect to ensure that planned or unexpected leave could be covered without impacting on continuity of support.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to appropriate training based on the needs of the service users. Staff were appropriately supervised and subject to performance development through their respective line management.

Judgment: Compliant

## Regulation 22: Insurance

The provider had the required property and public liability insurance in effect for this service.

Judgment: Compliant

## Regulation 23: Governance and management

There were suitable management, oversight and reporting structures in effect in this designated centre. The provider has composed an annual report for the service but there was limited reflection on the commentary of the residents and their representatives. Not all quality improvement areas identified by the inspector as in need of review had been identified through the service's own audit and action plan system.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

A statement of purpose for the designated centre was in place which outlined the description of the service as required under Schedule 1 of the regulations.

Judgment: Compliant

## **Quality and safety**

The inspector observed that residents were being supported in their daily lives in a positive manner which allowed them to go about their preferred routine and activities in the house and in the local community, and to feel safe and content in the designated centre. Resident were supported to pursue meaningful personal development goals and stay in contact with family during the COVID-19 pandemic. Development and repair works were required in the house to reduce the impact on the homeliness of the service as well as the ability to effectively protect against associated fire and infection risks.

The inspector found evidence that the residents were supported to pursue their routines based on their individual interests and preferences. Residents were supported to attain employment and one of the resident was looking forward to going to work on the day of inspection. Residents were also returning to the gym and swimming pool, with staff encouraging them to stay active and engage in regular exercise and healthy eating. Residents were being supported with a number of varied personal goals which were meaningful to them, including attending events such as wrestling and ruby matches. Each of these goals and objectives were broken down into steps so that their progress could be tracked and planned out by

the key working team.

The inspector found that support plans were person-centred and specific to each individual and their needs. Staff guidance on supporting residents with medical needs, nutrition support, personal and intimate hygiene and grooming and staying safe when in public were clearly described and kept under review by the staff team. Where information such as fluid intake or behavioural presentation was required to advise clinicians on the relevant supports, this was being consistently recorded. The provider had created pictures or simple language stories for residents to support them to understand and consent to supports including medical appointments. In a sample of plans for key resident support needs, said plans were not available in a format which was accessible to the residents so that they could contribute to their ongoing review. This had been identified by the provider in their own reviews of support planning.

The house was overall of a suitable size and layout for the assessed needs of the residents. Each resident had their own bedroom and a preferred bathroom. Living spaces were large and equipped with important information for the residents regarding planning out the day, reminders of upcoming events and activities, and information on accessing complaints or advocacy processes. Office and staff space was separated from the residents' living environmental to provide a relaxed and comfortable atmosphere in their home. Some areas of the house were in need of maintenance or repair. The provider was in the process of repairing the outside patio and had also identified staining and malodour in the main wet-room. While these matters were identified as in progress on the maintenance log for the designated centre, other maintenance and repair issues had not been communicated for attention. These included cracked bathroom tiles, floorboards with gaps or surface damage, worn or peeled surfaces in the kitchen floor and cabinets, cupboards with damaged handles or hinges, and rusted radiators. While these items did not constitute an injury hazard to people in the centre, they had a negative impact on the homeliness of the living environment as well as compromising the ability for areas with rough, worn, peeling or damaged surfaces to be effectively cleaned and sanitised. There were also small amounts of mildew found in the bathroom and utility room.

Due to identified support needs of one person, environmental restrictive practices were in effect in the house including locking of internal doors. The other resident carried keys for these doors to mitigate the impact on the access around their home. External doors and gates were locked from the inside at all times due to an identified risk of absconding. While the rationale for the introduction of these restraints was specified, it was not clear how this was assessed as being the least restrictive control measure to address the relevant risk. In a review of the risk register, it was identified that incidents related to the restriction had not been attempted in a number of years and that the level of risk was now rated as low. However, outside of local staff team discussions, there had been no multidisciplinary review which considered the appropriateness of continuing the restrictive practice in its current form, or trialling less restrictive alternatives, as the relevant risk had been assessed as reduced.

In response to residents who may express frustration or distress in a manner which would cause harm to themselves or others, staff were provided detailed guidance to keep all involved safe. Potential risk expressions were clearly described, and guidance on proactive and reactive strategies were in effect to maintain a low-stress environment, avoid factors causing distress, and how to safely respond to actual incidents. How these strategies would differ based on location were also described, such as when in public or using transport. It had been determined that these strategies were sufficient to mitigate the relevant risk, and as such it was determined that there was no requirement to prescribe physical restrictive practices to deescalate incidents.

Among the doors being locked regularly included the doors and gates used in escape routes in the event of a fire. Following the previous inspection, the provider had committed to installing an emergency key next to one locked door for a trial period, and if this was not tampered with, to install the same on the other key-locked routes. While the first locked door had a key in a break-glass box available, no progress had been made on addressing the other affected routes in line with the provider's plan. Improvement was also required to ensure that doors and glass panels along evacuation routes were equipped to provide effective containment of flame and smoke in the event of a fire. The building was zoned with a panel identifying the location of the fire, and all equipment was up to date on their servicing and testing time frames. Practice evacuation drills took place every few months and efficient escape times had been recorded from these. However all drills were announced to staff in advance, and had not been conducted in a way which provided assurance that efficient and safe evacuation could be effected in high-risk scenarios such as during times when all staff and residents in the house would be asleep.

## Regulation 13: General welfare and development

Residents were supported to pursue meaningful recreation, employment, personal development, and social opportunities in accordance with their wishes and assessed needs.

Judgment: Compliant

## Regulation 17: Premises

Areas of the house were in need of repair or replacement in the designated centre. Improvement was required to ensure these matters were identified and raised through the relevant proper maintenance process.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The provider maintained a risk register which outlined potential hazards and the control measures in place to mitigate same. This was kept under review to reflect changing circumstances and adverse incidents.

Judgment: Compliant

## Regulation 27: Protection against infection

Damage to surfaces in areas such as the kitchen and bathroom impacted upon their ability to be effectively cleaned and sanitised.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Improvement was required to the premises to provide effective containment of fire and smoke.

Review to practice evacuation procedures was required to evidence the provider's assurance that efficient and safe evacuation could take place at times of higher risk.

The provider had not progressed plans to mitigate risks associated with having key-locked doors and gates along fire evacuation routes.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Some key personal plans were not available in an accessible format to support the resident to discuss and participate in its progress and review.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

Not all restrictive practices in place in the designated centre were subject to formal review to provide assurance that they remained the least restrictive procedure to control the relevant assessed risk.

Judgment: Substantially compliant

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

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

| Regulation Title | Judgment |
| --- | --- |
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |

# Compliance Plan for Gallows Hill OSV-0001982

## Inspection ID: MON-0026879

## Date of inspection: 26/10/2021

**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:**

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The annual review for 2021 will include increased feedback from service users and representatives.<br><br>The audit template for 2022 will be updated prior to the end of November 2021 to be implemented in 2022.</td></tr>
<tr><td>Regulation 17: Premises</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 17: Premises:<br>All maintenance issues will be addressed prior to the end of March 2022</td></tr>
<tr><td>Regulation 27: Protection against infection</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 27: Protection against infection:<br>All maintenance issues related to infection control will be addressed prior to the end of</td></tr>
</table>

March 2022

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Additional fire doors will be added where required prior to the end of January 2022.

Glass panels above doors will be replaced prior to the end of January 2022.

One unannounced night time fire drill will be scheduled each year starting from January 2022.

Two exit doors will have break glass key added to them prior to the end of December 2021.

| Regulation 5: Individual assessment and personal plan | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All personal plans accessible versions will be attached to the plan on CID database and made available to each person through CID by the end of December 2021.

| Regulation 7: Positive behavioural support | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All restrictive practices will be reviewed by the staff team as usual as well as the audit team on an annual basis commencing January 2022.

## 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. | Substantially Compliant | Yellow | 30/03/2022 |
| 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 | 30/11/2021 |
| Regulation 23(1)(e) | The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation | Substantially Compliant | Yellow | 30/11/2021 |

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| | with residents and their representatives. | | | |
| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | Substantially Compliant | Yellow | 30/03/2022 |
| Regulation 28(2)(c) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 31/12/2021 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/01/2022 |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are | Substantially Compliant | Yellow | 31/01/2021 |

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| | aware of the procedure to be followed in the case of fire. | | | |
| Regulation 05(5) | The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative. | Substantially Compliant | Yellow | 31/12/2021 |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 31/01/2022 |
| Regulation 07(5)(b) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used. | Substantially Compliant | Yellow | 31/01/2022 |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the | Substantially Compliant | Yellow | 31/01/2022 |

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| | least restrictive procedure, for the shortest duration necessary, is used. | | | |