Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	The Court - Kingsriver
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	25 January 2022
Centre ID:	OSV-0007915
Fieldwork ID:	MON-0035276

About the designated centre

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

The Court - Kingsriver is a designated centre operated by Kingsriver Community Holdings CLG. The designated centre provides a community residential service for up to nine adults with a disability. The centre comprises of three houses within a close proximity to each other in an urban area in County Kilkenny. Each house comprises of a sitting room, dining area, kitchen, bathrooms and individual resident bedrooms. The designated centre is staffed by team leaders, social care workers and care assistants. The staff team are supported by a person in charge.

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 (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 25 January 2022	08:30hrs to 16:45hrs	Conan O'Hara	Lead
Wednesday 26 January 2022	10:00hrs to 14:00hrs	Conan O'Hara	Lead
Tuesday 25 January 2022	08:30hrs to 16:45hrs	Conor Brady	Support
Wednesday 26 January 2022	10:00hrs to 14:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and was completed over two days. As such, the inspectors followed all public health guidance and HIQA's enhanced COVID-19 inspection methodology at all times. The inspectors ensured physical distancing measures and the use of appropriate personal protective equipment (PPE) during all interactions with the residents, staff team and management over the course of this inspection.

Following a December 2021 unannounced inspection, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of the centre due to an absence of safe quality services being provided in this designated centre. Furthermore, the absence in effective governance at this time was of particular concern. Kingsriver Community Holdings CLG submitted formal representation to the Chief Inspector outlining their proposed actions to improve the standards of care and support in the centre and come into compliance with the Health Act. This unannounced inspection was completed to provide assurance that safe and quality care was now being provided to residents in this centre.

The inspectors visited the provider's main office and three premises that comprised this designated centre in Co. Kilkenny. Inspectors spoke with residents, families, staff and members of management as part of this inspection.

While it was evident that the provider had taken steps to improve their services, the inspectors found that there remained a significant level of non-compliance in the centre. The provider had taken a number of measures to stabilise the safety concerns that were identified on the previous inspection. Increased oversight arrangements were now found in place. The provider had been required to submit weekly reports to the Chief Inspector since December 2021, due to the level of concern prevalent in the centre.

The inspectors met seven of the residents present in the centre over the two days of inspection. All residents expressed their views verbally to inspectors. The residents spoken with stated that they liked living in the houses but were dissatisfied with the staffing arrangements in place. Residents outlined the negative impact on their daily life. For example, on the day of the inspection one resident's plans were cancelled due to an unplanned reduction in staffing levels. Residents' representatives spoken with spoke positively about the service, but noted the challenges in staffing consistency and recent changes in the governance structure. Of the staff spoken with, they highlighted that recent improvements were very welcome and cited the introduction of the on-call system and additional staffing (introduced following the last inspection) as having a positive impact.

In summary, inspectors noted that there was a stabilisation in the governance of the centre and clear plans in place to come into compliance with the regulations. However, based on what the residents communicated with the inspectors and what

was observed, it was evident that the residents' continued to receive a poor quality of care and support in this service. There were poor findings in relation to resident safeguarding, governance, infection prevention control, staffing arrangements, staff training and resident assessment and support planning. While clear plans were put forward to address these areas, these were yet to be fully embedded.

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

Capacity and capability

Overall, this inspection found that the registered provider had demonstrated an ability to implement the majority of actions set out in their representation response to the Chief Inspector. The provider's former Board Chairperson, stepped into a full-time interim managerial role to stabilise the safety arrangements for residents in this centre since the last inspection. Inspectors found that this intervention, albeit an interim arrangement, had been implemented effectively and had brought about the required stability. However, it was also noted that this was a not a sustainable solution.

There remained high levels of non-compliance in the centre which negatively impacted on the quality of life of residents. The inspectors found that further improvements were required to ensure the provision of a safe and quality service to residents in this centre in the areas of staffing arrangements, staff training and development and managerial oversight and governance.

Since the last inspection, there had been changes made to the management team to ensure clear lines of accountability when managing this centre. The last inspection identified absent governance mechanisms such as an 'on-call' management system for staff. The inspectors reviewed the on-call log which demonstrated it in use and providing support to the staff team.

In addition, the provider had completed an audit of a number of aspects of the service following the last inspection and action plans were developed. The provider was treating regulatory compliance as a primary indicator and outlined newly developed systems of reporting and oversight. However, at the time of the inspection, many actions were in their early stages of implementation. Therefore they had not yet translated into an improved service for residents and the sustainability of these improvements could not yet be demonstrated.

The inspectors were informed that the provider's main priority had been in addressing the critical safety issues identified by HIQA, but they were now focused on compliance and quality improvement. While assessment reviews had taken place regarding resourcing, staffing and recruitment - these needed formal agreement

with the funder and needed to be implemented, before residents would see the impact.

A new Chief Operations Officer was being recruited to ensure cohesive organisational, strategic and operational objectives. This defined direction was required in this service based on the findings of this inspection.

The registered provider had completed an assessment of staffing requirements for this centre based on residents' assessed needs as part of their service audits. Inspectors found that staffing arrangements remained a continued concern in relation to staffing levels, staff consistency and staff training. This was still impacting negatively on residents.

Regulation 15: Staffing

Inspectors remained concerned with the numbers and consistency of staffing provision in this centre. Of particular concern was the inconsistency of staffing and the negative impact this was having on the quality of life of residents.

Since the last inspection, the provider had recruited one social care worker and one healthcare assistant. The provider also identified an agency staff member to provide support on a recurring basis in one location. In addition, in response to a incident in one unit the provider had put a waking night staff in place in one unit. At the time of the inspection, the provider was actively recruiting two whole time equivalent (WTE) vacancies. The provider had completed a review of staffing arrangements and identified the need for seven additional WTE care assistants and two additional team leaders. The provider highlighted this as a requirement in order to achieve appropriate staffing levels to provide supervision, care and support to residents.

The inspectors reviewed a sample of staff personnel files and found that they contained all of the information required by Schedule 2 of the regulations. The provider had completed Schedule 2 audits (since the last inspection) and were identifying areas for improvement and taking the required actions.

While there had been some improvements in the staff arrangements, from a review of rosters, there remained frequent staff changes which impacted on the ability of staff to deliver a good quality and consistent service. As noted, a number of residents highlighted the negative impact of the inconsistency of staffing on their daily life to the inspectors directly. Inspectors also spoke to staff and while some had very good knowledge, others were very new and did not know the service nor the resident's at all.

Judgment: Not compliant

Regulation 16: Training and staff development

Since the last inspection, the provider had completed a training needs anaylsis which identified a number of members of the staff team as requiring refresher training in de-escalation and intervention techniques, infection prevention and control and manual handling. At the time of the inspection, the provider was in the process of scheduling this training. This meant, on the day of the inspection, that not all of the staff team did not have the up-do-date knowledge and skills to meet the assessed needs of residents.

The previous inspection identified that formal supervision and staff development was not occurring in line with the provider's policy. Inspectors found that significant improvement was still required in terms of the staff teams support and development. The inspectors were shown a planned supervision schedule for the upcoming year. In addition, plans were in place to train team leaders in providing supervision to the staff team. However, at the time of the inspection, no supervisions had taken place.

Judgment: Not compliant

Regulation 23: Governance and management

The previous inspection found that there was an absence of operational governance found in this centre. Following the inspection in December 2021, the registered provider had implemented changes in the management team to provide governance and oversight for this centre. These changes were an interim measure while the provider actively recruited for a number of roles. The changes made resulted in a stabilised governance of the centre. However, further change was necessary to ensure the roles of Chief Operations Officer (COO), person in charge, team leader(s) and social care staff are appropriately filled and supported on an ongoing basis.

An on-call management arrangement had been implemented following an immediate action issued by HIQA on the last inspection. Inspectors reviewed a log of on-call activity which demonstrated the support provided to the staff team. While staff spoke positively about the support of the on-call system, the 'on-call' system was found to be in its infancy and required formalised policy and procedures guiding it's operation.

The provider had completed a number of audits following the December 2021 inspection that had identified areas for improvement and had developed plans to address same. While it was evident that the provider was completing audits of the service and developed aspects of a quality assurance system, the actions and establishment of the quality assurance systems were in the early stages and required further improvement.

The inspectors found that it was not evident that the centre was appropriately resourced. For example, the provider had identified the need for seven additional WTE staff members to meet the needs of the residents. The provider was engaging with their funder regarding staffing requirements at the time of the inspection and this required urgent review.

Overall, the inspectors found that while the provider had stabilised some of the governance and safety concerns identified in the previous inspection, significant and continued managerial and resource input is required to improve the ongoing quality and safety of services for residents.

Judgment: Not compliant

Quality and safety

On this inspection, inspectors found that while the provider had taken steps to identify and address areas of non-compliance, there continued to remain non-compliance in all regulations reviewed. Seven weeks had passed since the previous inspection and while a lot had been achieved in that time-frame to stabilise the centre, there remained considerable work to be done.

While it was evident that the provider was attempting to improve the quality and safety of the service, there continued to be non-compliance in meeting the assessed support and care needs of residents. The inspectors found that significant improvement was required to ensure the designated centre provided a safe and quality service which was in line with the needs of residents. For example, the provider had completed a review of the assessed needs of the residents and identified that a number of residents required the input of specialised medical and allied health professionals. The provider was in the process of seeking this input at the time of the inspection.

In addition, the arrangements in place to meet the assessed needs of residents required improvement. For example, as noted the arrangements in place for staffing levels to support residents to live active and meaningful lives in line with their needs, wishes and preferences.

The inspectors found that there were some improvements in the systems in place to protect residents including safeguarding plans. However, there remained valid concerns on the compatibility of a resident group in one unit of this centre based on the behaviours displayed and the impact of these behaviours on peers.

One resident's living environment required thorough review as they were found to be living in a cold living space with a tiled floor in a conservatory/sun room type of room. The resident complained to inspectors that their room was too cold stating it

'was like a fridge'. The inspector noted the room was very cold on the morning of this inspection.

Regulation 27: Protection against infection

While inspectors observed some improvements since the previous inspection with some infection control practices (such as staff face mask wearing), further improvements were required.

Staff and resident temperature checks and cleaning schedules were found to be in place. All staff had adequate access to a range of personal protective equipment (PPE) and hand gels as required.

Contingency plans for COVID-19 in relation to staffing and the self-isolation of residents required completion. In December 2021, the provider had completed an infection prevention and control audit which outlined a number of actions which included the development of contingency plans. At the time of the inspection, these contingency plans for staffing and the self-isolation of residents were not completed. This did not give the required assurance that the provider was equipped to deal with an outbreak.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed a sample of residents' personal plans and found that there was improvements made in the content of the files. The last inspection identified that the assessments in place did not comprehensively assess the residents' health, personal and social needs. The provider had completed an audit of residents' assessed needs and had identified that a number of residents required the input of specialised medical and allied health professionals. These included psychiatry, psychology and occupational therapy.

It was not yet demonstrable that these personal plans in place appropriately guided the staff team in supporting residents with their assessed needs. Furthermore some residents social care plans and goals needed to be reviewed and updated.

In addition, the arrangements in place to meet the assessed needs of residents required improvement. For example, staffing levels continually impacted on residents' plans.

Judgment: Not compliant

Regulation 8: Protection

The inspectors found that while there had been some improvements, including improved identification of safeguarding issues and the development of safeguarding plans - further safeguarding concerns remained in this centre. Resident compatibility required review and action given the frequency and type of incidents occurring between residents in one unit of this centre. Furthermore, one resident had absconded from the centre (unknown to staff on duty) and while this incident was responded to and additional controls have been put in place since, this raised serious questions as to the safeguarding oversight systems in place at the time. Safeguarding requires specific review in the context of this unit in particular, as the residents in other parts of the centre were found to be safe and well at all times.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Court - Kingsriver OSV-0007915

Inspection ID: MON-0035276

Date of inspection: 25/01/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1.Additional staffing secured: SCW(36hrs), HCA (39hrs), 1 relief staff, COO(39hrs), Team Leader(39hrs) 2..Additional staffing requirements identified. Recruitment in process. Closing date: 29.3.2022 3.WTE vacancies identified: Organisational funding requirement submitted to the funder 2.3.2022. Follow up meeting scheduled 16.3.2022	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1.De-escalation techniques training: 12 staff completed training on the 2nd, 3rd and 4th of February 2022. 5 staff will have training completed : 11.3.2022. 2. Manual Handling Training complete: 1.2.2022 3. IPC Training: In progress. Completion date 29.3.2022 4. Mandatory Training to be completed by all staff 29.3.2022 5. Training Audit to be completed quarterly going forward. 6. Induction Process to be reviewed:25.3.2022 7. Training Plan to be put in place: 5.4.2022 8.Supervision Training to be completed by all managers:11.3.2022 9. Supervision for all staff in progress. Completion date: 28.3.2022	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

1. COO commenced employment: 7.3.2022
2. Strategy Committee review ongoing. Awaiting funder response to formulate immediate strategy.
3. Team Leader to commence position:14.3.2022.
4. Training for Board of Directors on regulations: 10.3.2022.
5. Bi weekly meetings with the HSE, next meeting is scheduled for 16.3.2022.
6. Weekly operations meetings in place with team leaders and PIC.
7. From 09.03.2022 COO will be facilitating weekly operational meetings with PIC and team leaders.
8. Staff meetings are held monthly.
9. An on call system has been in place since 9.12.2021, staff are aware of the on call procedure, staff were notified of this procedure via email on 9.12.2021.
10. Handover reports in place for all residential locations.
11. Organisational chart in place to illustrate reporting structure.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1.Covid Response Plan in place.
2.Covid Preparedness Plan in place.
3.Individual Isolation plan in place for all residents.
4.IPC checks including cleaning checklists are reviewed weekly by team leaders.
5. IPC audits will be completed by PIC bi weekly.
7. IPC officer assigned to each residential location: 4.3.2022.
8. All staff will have completed IPC training by 28.3.2022.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1.Clinical Input Audit was completed in January 2022. This audit will be monitored and reviewed regularly by the PIC. Residents who require clinical input, a referral will be made to access these supports.
2. 5 residents have had Assessment of Needs completed. The remaining 3 residents will have the assessment of need completed by 26.03.2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1.Compatibility Assessments for all residents will be completed by the 31.03.2022
2.Designated officer training to be completed by Team Leaders: 8.4.2022
3 There is an overarching safeguarding risk assessment for the centre in place. This will be reviewed monthly by the PIC
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4. There is a safeguarding log in place for the centre, this will be reviewed monthly by the PIC/COO.

5. There is a risk assessment in place for the resident who absconded, this is reviewed monthly by the PIC.
6. All staff have completed safeguarding training and are aware of the procedure to report any suspicions of abuse.
7. All staff training is completed in Safeguarding and this will be refreshers will be completed in a timely manner.
8. Additional heating has been provided to the resident and the temperature is continuously monitored by staff and PIC

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	12/01/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	12/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	06/04/2022

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	28/03/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	17/12/2021
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	09/12/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures	Not Compliant	Orange	28/03/2022

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	26/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	07/02/2022