Office of the Chief Inspector

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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>St. John of God Kildare Services - DC 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>St John of God Community Services Company Limited By Guarantee</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Kildare</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>25 July 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0002944</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0027168</td>
</tr>
</tbody>
</table>
About the designated centre

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

Designated Centre 7 supports 24 individuals, both male and female, living across five terraced homes and one apartment located in a large town in Co. Kildare. Each resident has their own bedroom and share common areas with other residents. Residents with an intellectual disability and mental health issues are supported by social care workers, nursing staff and a healthcare assistant. Some residents attend various day programmes provided by St. John of God Kildare services and some residents are supported to participate in activities in their local community or stay at home on days that they choose. Residents have access through a referral system for the following multi-disciplinary supports psychology, psychiatry and social work. All other clinical support are accessed through community based primary care with a referral from the individuals G.P as the need arises. The centres' registration is subject to a de-congregation plan to reduce the capacity of each house from five adults to a maximum capacity of four residents.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 24 |
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:**
<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 July 2019</td>
<td>09:30hrs to 14:30hrs</td>
<td>Erin Clarke</td>
<td>Lead</td>
</tr>
</tbody>
</table>
What residents told us and what inspectors observed

As this was an unannounced inspection, a number of residents had left for their day services and so were unavailable to give their views. The inspectors' judgements in relation to the views of the people who use the service, relied upon brief interaction with some residents, documentation, observation of residents, and discussions with staff. The inspector had the opportunity to spend time during the morning routine in a communal area of one of the houses.

The inspector observed staff and residents interacting with each other over the course of the inspection, and found that residents appeared comfortable expressing their needs, and were directing the care and support they received. The residents communicated with the inspector on their own terms. Staff members were observed coming and going on individualised activities and appointments with residents. Residents were observed to be well cared for and presented as very happy and content with the staff supporting them.

One resident relayed an aspect of the service that they were not fully satisfied with and this was relayed back to the person in charge for review.

Capacity and capability

The purpose of this unannounced inspection was to assess the progress made by the provider in relation to a condition of registration, whereby the centre would be de-congregated in line with a compliance plan submitted by the provider in 2016. Prior to this inspection the provider had submitted an application to vary, to extend the time frame of completion.

It was found that the provider had made some progress towards reducing the capacity of the five terraced houses by three residents to a total capacity of 21 residents. The provider had secured alternative properties in the community, however due to external restrictions these were not ready for completion as previously communicated to the Chief Inspector of Social Services. Due to the delay in transiting to these properties the provider completed an internal review of community vacancies. One resident was identified who expressed interest in moving to one vacancy identified in the community. There was a transition plan in place and the resident had visited the house on several occasions and had informed staff that they were happy with this intended move and was due to fully move in the coming weeks.

There was evidence of an effective governance structure and strong leadership in the centre. There were clear lines of accountability and staff who spoke with the
inspector of social services were clear on their responsibilities and the reporting structures in place. The person in charge, the residential coordinator was also the person in charge for one other centre. He was supported in his role by two full time social care leaders, ensuring effective and consistent governance of the centre. The person in charge had not changed since the centre's previous inspection and this person was found to be professionally knowledgeable and experienced and demonstrated a very good understanding of the residents' assessed needs, allocation of resources, managerial oversight of care delivery and regulatory requirements.

There were adequate staff resources and skill mix to meet the residents' assessed needs thus ensuring a high standard of care to the resident. Staff were appropriately trained and there was a competent workforce in place and a staff training matrix was available to view. From a review of the rosters the provider had ensured there was continuity of care. A regular relief staff team was used to cover annual leave and illness which eliminated the need for unknown agency staff. There was evidence that staff received both formal and informal supervision. The timeliness of formal supervision was not in line with the organisation's policy and this was discussed at feedback.

The inspector reviewed quality assurance measures taken by the provider to audit service provision and found the audits were effective in identifying areas of concern or non-compliance with the regulations. In addition, the annual review and the unannounced six-monthly audit completed by the provider, of their assessment of the quality of care and service provision in this centre evidenced that actions had been taken to address identified issues. The resident and staff could raise any concerns regarding the quality and safety of care delivered. An accessible version of the annual review was also developed for residents.

There was a written statement of purpose, dated 06 June 2019. It set out the aims, objectives and ethos of the designated centre. It also stated the facilities and services which were provided for residents. It contained all of the information required in schedule 1 of the regulations.

**Regulation 14: Persons in charge**

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.

Judgment: Compliant

**Regulation 15: Staffing**
The provider had ensured that appropriate staff numbers were in place to meet the assessed needs of residents and continuity of care was provided in the centre.

Judgment: Compliant

**Regulation 16: Training and staff development**

The person in charge ensured that staff were appropriately trained, including refresher training and also training in areas of good practice. Staff received formal and informal supervision by the management team, the timeliness of the formal supervision required review to ensure it was aligned with organisational policy.

Judgment: Substantially compliant

**Regulation 23: Governance and management**

The provider had ensured that there were robust governance and management structures in place to oversee the operational management of the service and to provide appropriate oversight of the quality of care provided.

Judgment: Compliant

**Regulation 3: Statement of purpose**

The inspector reviewed the centre's statement of purpose and found that it contained the information as outlined in Schedule 1 of the regulations.

Judgment: Compliant

**Quality and safety**

While matters that impacted on the quality and safety of the service were not fully resolved, the provider had taken mitigating actions and had submitted a further time-bound plan to the Chief Inspector to resolve these matters. The provider's practices ensured that each resident's well-being was promoted at all times and that residents were kept safe. An action arising from a previous inspection, a
requirement for an additional functional shower in one house was not installed as per the submitted compliance plan.

The premises in this centre consisted of five terraced houses and one apartment. Three houses had five residents in them (as cited in previous reports) and living space was found to be limited in these houses. As previously discussed there was evidence that the provider had implemented plans to reduce numbers in these houses. A deep clean of the premises had been completed since the previous inspection, however there still remained prolonged outstanding maintenance issues as raised by management. On review of the maintenance request log, actions identified in February 2019 still remained uncompleted. The inspector also identified during inspection that one bathroom required additional works due to a malodour presenting. Due to the number of residents in one house, there was not adequate shower facilities of a sufficient number and standard suitable to meet the needs of residents. This was due for completion by 31 December 2018 and the status of completion remained unknown during the inspection.

There was no safeguarding concerns at the time of the inspection, evidence was seen that where any possible safeguarding concerns arose, the person in charge ensured that all reasonable and proportionate interim measures were taken to ensure residents were protected pending the outcome of relevant investigations. It was also seen that there robust systems in place to ensure that residents’ finances were appropriately safeguarded. From observations of residents interactions, discussions with management and staff and a review of notifications submitted to the Chief Inspector, residents appeared happy to be living with each other. Such findings indicated that appropriate procedures were in place to ensure that each resident living in the centre was protected from all forms of abuse.

The inspector reviewed fire precautions in the designated centre and found that a fire safety policy and internal emergency response plan were in place. In addition, there were emergency response protocols in place for a range of scenarios including power outages, and loss of water and heating. A sample of records were reviewed by the inspector that demonstrated daily and monthly checks of escape routes, fire alarm system, emergency lighting, and fire fighting equipment. Service records demonstrated that both the fire alarm system and emergency lighting in place were serviced and maintained on a regular basis. During the inspection the inspector observed a fire door wedged open, while there was a checklist to sign that this was being closed at night time, this was not in line with the organisations fire policy and procedures. The wedge was removed when highlighted by the inspector and discussed at feedback as this practice did not ensure effective fire containment measures were in place.

Regulation 17: Premises

Outstanding works submitted in a previous compliance plan, in relation to a shower room was not completed as communicated by the provider. In addition there
remained maintenance works to be completed in the houses.

Judgment: Not compliant

**Regulation 25: Temporary absence, transition and discharge of residents**

There was evidence to support that the person in charge is meeting the requirements of this regulation regarding the planned transition of one resident to another centre.

Judgment: Compliant

**Regulation 28: Fire precautions**

The centre had an established fire management system in place, some improvements were needed to ensure that the fire containment measures were effective.

Judgment: Not compliant

**Regulation 8: Protection**

The inspector observed that there were systems and measures in operation in the centre to protect residents from possible abuse. Staff were facilitated with training in the safeguarding of vulnerable persons.

Judgment: Compliant
Appendix 1 - Full list of regulations considered under each dimension

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

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 25: Temporary absence, transition and discharge of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
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</table>
Compliance Plan for St. John of God Kildare Services - DC 7 OSV-0002944

Inspection ID: MON-0027168

Date of inspection: 25/07/2019

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>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- 16 (1) (b) Local Operational procedures in relation to supervision, Currently supersede the organisation's policy on the supervision of staff. The Organisation's policy on the supervision of staff will be reviewed by the board of Directors by the 31st of October 2019.

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Not Compliant</th>
</tr>
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Outline how you are going to come into compliance with Regulation 17: Premises:

- 17 (1) (a) All Outstanding works will be completed by the 31st of October 2019

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- 28 (3) (a) All fire doors will be closed in-line with the organisation's fire prevention policy, with immediate effect.
- 28 (3) (a) A costing for the installation of automatic door closers, which would be linked to the fire alarm panel, will be sought for all main kitchen doors in the designated...
centre.
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16(1)(b)</td>
<td>The person in charge shall ensure that staff are appropriately supervised.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/10/2019</td>
</tr>
<tr>
<td>Regulation 17(1)(a)</td>
<td>The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/10/2019</td>
</tr>
<tr>
<td>Regulation 28(3)(a)</td>
<td>The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>25/07/2019</td>
</tr>
</tbody>
</table>