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:	Leeside
Name of provider:	Health Service Executive
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	27 March 2024
Centre ID:	OSV-0003319
Fieldwork ID:	MON-0038321

About the designated centre

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

Leeside is a designated centre operated by the Health Service Executive (HSE). The designated centre provides community residential care for up to three adults. The premises comprised of a dormer bungalow which has been divided into main house and an adjoining apartment. The downstairs of the main house comprised of a kitchen, dining room, two sitting rooms, office and two individual bedrooms. The upstairs is comprised office, meeting room and storage space. The adjoining apartment consisted of individualised en-suite bedroom and living area. There is a secure accessible garden to the rear of the house. The staff team consists of a social care leader and social care workers. 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:	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 (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 27 March 2024	10:00hrs to 18:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted to monitor on-going compliance with the regulations. The inspector had the opportunity to meet the three residents living in the designated centre over the course of the inspection.

On arrival, the inspector met with two of the three residents as they prepared for the day as one resident had already left the centre to attend their day service. The first resident welcomed the inspector and the resident showed the inspector around their home. The resident told the inspector that they wished to move out of the centre. The resident had communicated this wish with the provider previously and the inspector observed evidence of the provider supporting the resident to explore this wish. The resident was observed in the afternoon relaxing in the living room having a cup of tea.

The inspector met the second resident in the office. This resident used alternative communication methods and the staff team assisted them to communicate with the inspector. They appeared content in the centre and in the presence of the staff team and management. Later in the morning, the second resident was supported to access the community.

In the afternoon, the third resident had returned home. This resident noted that they liked living in the centre and showed the inspector their bedroom and living area. The resident spoke briefly about their day and then communicated that they would like to be left alone. This was respected.

The centre consists of a dormer bungalow which has been divided into main house and adjoining apartment. The inspector carried out a walk-through of the centre accompanied by the person in charge. The downstairs of the main house comprised of a kitchen, dining room, two sitting rooms, office, two individual bedrooms. It was decorated in a homely manner and well maintained. The adjoining apartment consisted of individualised bedroom and living area. This area for the most part was well maintained. However, one area of flooring required improvement as it was worn from use. This had been self-identified by the provider.

Overall, the residents appeared content and comfortable in their home and the staff team were observed supporting residents in an appropriate and caring manner. However, there were areas for improvement identified including governance and management, personal plans, fire safety, premises and restrictive practices.

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, the inspector found that there were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. However, some improvement was required in governance and management.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. There was evidence of quality assurance audits taking place including the annual review for 2022 and the six-monthly provider visits to ensure the service quality was effectively monitored. However, some improvement was required in the annual review.

On the day of the inspection, the inspector observed that there was an appropriate number of staff to support the residents' assessed needs. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably experienced. The person in charge was responsible for this designated centre alone.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual staffing roster. The inspector reviewed a sample of the roster and found that there was an established staff team in place which ensured continuity of care and support to the residents. While, the centre was operating with a number of vacancies and staff on leave, this was managed through the existing staff team and the use of regular agency staff. The inspector was informed that the provider was actively recruiting to fill the vacancies. On the day of the unannounced inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents. For example, the three residents were supported by three staff members during the day and two staff members on waking night shifts. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring

manner.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of a sample of training records, the majority of the staff team had up-to-date mandatory training including safeguarding, de-escalation and intervention techniques and manual handling. Where members of the staff team required refresher training, this had been self-identified by the provider and plans were in place to address same.

A staff supervision system was in place and the staff team in this centre took part in formal supervision. The inspector reviewed the supervision schedule and a sample of supervision records and found that staff received supervision in line with the provider's policy. Overall, the inspector found that the training and development systems in place ensured all staff had up to date skills and knowledge to support the residents with their assessed needs.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to Social Care Manager and Director of Nursing, who in turn reported to the General Disability Services Manager. There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to residents' needs. The quality assurance audits included the annual review 2022 and six-monthly provider visits. In addition, local audits were taking place of the designated centre. These audits identified areas for improvement and action plans were developed in response.

However, some improvement was required in the annual review, as it was not evident that the annual review provided for consultation with residents and their representatives.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of adverse accidents and incidents occurring in the centre and found that the Chief Inspector of Social Services was notified as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the management systems in place ensured the service provided appropriate care and support to the residents. However, some improvements were required in the personal plans, premises, restrictive practices and fire safety.

The inspector reviewed a sample of residents' personal files. Each resident had an up-to-date comprehensive assessment of their social, personal and health needs. The assessment informed the residents' personal plans which were found to be up-to-date and suitably guided the staff team in supporting the residents with their assessed needs. However, some improvement was required in the assessment and personal plans to further promote the residents' autonomy and personal development.

There were positive behaviour supports in place to support residents to manage their behaviour. The inspector reviewed a sample of positive behaviour support plans and found that they were up to date and appropriately guided the staff team. However, some restrictive practices in place required review.

There were effective systems in place for safeguarding residents. The inspector reviewed a sample of adverse incidents occurring in the centre which demonstrated that incidents were reviewed and appropriately responded to.

There were suitable systems in place for fire safety management. These included suitable fire safety equipment and the completion of regular fire drills. However, some improvement was required in night-time fire drills and fire containment measures.

Regulation 17: Premises

The designated centre was decorated in a homely manner and was generally well maintained. All residents had their own bedrooms which were decorated to reflect the individual tastes of the residents with personal items on display. However, the flooring in the apartment was observed to be worn and required review. This had been self-identified by the provider.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had systems in place to identify and manage risk. The inspector reviewed the risk register and found that general and individual risk assessments were in place, reflected the control measures in place and were up to date.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers. However, two fire extinguishers which were located externally required review as it was not evident that they had been serviced.

There was evidence of regular fire evacuation drills taking place in the centre. A personal emergency evacuation plan (PEEP) had been developed for each resident to guide staff in the effective evacuation of the centre, if needed. However, some improvement in fire drills was required. One resident had recently been admitted to the service and it was not evident that an 'hour of darkness' fire drill had been completed since the admission.

In addition, some improvement was required in fire containment measures. For example, in an internal audit, the provider had self-identified improvements required in installing self-closing devices on a number of fire doors to protect the escape routes. This was in process and funding had been approved at the time of the inspection. In addition, the inspector observed two fire doors not closing fully. This was reviewed and addressed shortly following the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the residents' personal files. Each resident had a comprehensive assessment which identified the residents' health, social and personal needs. The assessment informed the residents' personal plans which guided the staff team in supporting residents with identified needs. As noted, one resident stated that they wished to move from the centre. There was evidence that the provider had actively engaged with the resident regarding this and supported

the resident to access advocacy services and clinical supports.

However, some improvement was required in the assessment and personal plans to promote residents' autonomy and personal development, particularly in relation to finances and the self-administration of medication.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' health care supports had been appropriately identified and assessed. The health care plans appropriately guided the staff team in supporting the residents with their health needs. The provider had ensured that the residents were facilitated to access appropriate allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The residents were supported to manage their behaviours and positive behaviour support guidelines were in place which appropriately guided staff in supporting the residents.

There were a number of restrictive practices in use in the designated centre. There were appropriate systems in place to identify, assess and review restrictive practices. However, some practices required review by the provider's human rights committee to ensure they were not restrictive in nature including perspex covering one resident's monitor. In addition, the inspector observed a bedroom door alarm in place on a resident's bedroom door which required review. The inspector was informed that it was used for a previous resident and was not in use.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence that incidents were appropriately reviewed, managed and responded to. The residents were observed to appear content in their home and spoke positively about living in the designated centre.

The previous inspection found improvement was required in the system in place to

safeguard residents' finances. This had been addressed and new system in place for the oversight and safeguarding of resident finances.

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 (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 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Leeside OSV-0003319

Inspection ID: MON-0038321

Date of inspection: 27/03/2024

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:
The annual review of the quality and safety of care and support for 2024 was completed on 28.03.2024 by the provider. An additional section was added to the template (taken from the six monthly unannounced visit template section 3 and 4) to capture the consultation with both the residents and their family representatives as part of the review.

Going forward this will be included in all annual reviews similar to the six monthly unannounced visits, in addition a section has been added to the family views questionnaire detailing the date of the next annual review, allowing family/representatives opportunity for input on this.</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:
Meeting arranged with maintenance department for 30.04.2024 to review request for flooring in apartment to be replaced and plan completion of works

The PIC and provider will strive to ensure the premises is kept in sound construction and good state of repair in an on-going manner both internally and externally.</td></tr>
</table>

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Leeside will have a whole site service for fire safety equipment on 20.05.2024 – The PIC will ensure that all fire extinguishers are serviced on this date.

An hour of darkness fire drill has been completed since inspection on 26.04.2024, this drill included all three residents and two night duty staff. The Fire Warden has been advised that going forward two hour of darkness fire drills must occur at least twice per year. The PIC will ensure this occurs.

Maintenance were contacted on 24.04.2024 regarding update on improvement measures to fire doors as previously approved, these works have been agreed and priced, currently awaiting response from the company.

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:
Since inspection the Person in Charge has implemented a new assessment tool for self-administration of medicines. This tool was sourced from the HSE National Framework for Medicines Management in Disability Services.
This assessment will be carried out with all residents and reviewed annually by the IDT, this assessment will ensure that each resident's personal autonomy is being respected and catered for on an individual basis.
This assessment will be added to the medication management policy for the service.

Since inspection a local money management competency assessment has been implemented as per current policy. This assessment will be carried out with each resident to ascertain their individual level of competency in relation to managing their finances thus ensuring as much autonomy as possible is evident for each resident, each resident's care-plan may then be developed around this. The assessment will be reviewed annually in conjunction with the resident and the IDT to ensure the continuous personal development of each resident is considered and assessed on an on-going basis.

The overall assessment and personal plan of each resident will continue to be thoroughly assessed and reviewed, the changing needs, wills and preferences of each resident will be explored to ensure all residents' rights are being upheld.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The bedroom door alarm on one resident's bedroom has been removed since inspection.

Following discussion at the staff team and interdisciplinary team meeting held on 18.04.2024 the decision to remove the Perspex covering the TV monitor in one residents living area. The person in Charge has contacted maintenance and this has since been removed 23.04.2024

The next Restrictive Practice Oversight Group meeting for Leeside is scheduled for the 18.06.2024, all current restrictions will be reviewed by the group and consideration given to practices in place which may be considered restrictive but as of yet not on the restrictive practice log.

All restrictive practices will continue to be monitored and review in an on-going basis, Leeside is committed to a philosophy of a restrictive free environment by adopting a rights based approach.

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	13/09/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	05/04/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/05/2024
Regulation 28(3)(a)	The registered provider shall	Substantially Compliant	Yellow	25/04/2024

	make adequate arrangements for detecting, containing and extinguishing fires.			
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 aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	26/04/2024
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/07/2024
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	Substantially Compliant	Yellow	18/06/2024

	national policy and evidence based practice.			