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

Issued by the Chief Inspector

Name of designated centre:	Rosslodge Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	25 August 2021
Centre ID:	OSV-0004945
Fieldwork ID:	MON-0028842

About the designated centre

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

Rosslodge services provides residential respite service to up to five residents at a time, who are over the age of 18 years. Rosslodge can accommodate residents who may have a moderate to severe intellectual disability. Residents who use this service may also require additional supports relating to behaviours of concern and mental health needs. Residents receive respite on a planned and recurrent basis, with each resident having their own bedroom for the duration of their stay. Residents are supported by a combination of social care workers, support workers and a nursing staff. The provider also has a waking staff in place at night-time to meet residents' needs, as and when required. The centre is located within a short drive of a local village and also in close proximity to a large city. There is transport available for residents to access their local community if they so wish, and public transport links are also readily available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 25 August 2021	09:50hrs to 16:50hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

The inspector found that Rosslodge Services provided a homely environment where person-centred care was provided to residents. Residents were supported to make choices and decisions in their day-to-day lives and were kept informed about the centre through pictorial rotas about the staffing arrangements, and about who was availing of respite that day.

On the day of inspection, Rosslodge Services was providing respite care to three residents. On arrival to the centre, the inspector met with a support worker who was working with residents for the day. The support worker was working alone as there was a staff shortage that morning due to unplanned leave, and they informed the inspector that another staff member was coming in later to support with residents' care. One resident was reported to have gone to a day service that morning, and two residents were reported to be availing of day activities at home for the day. Residents were reported to be in their bedrooms at that time, and the inspector got the opportunity to meet with them later during the day.

The inspector spoke with staff members and members of the management team during the day. Staff spoken with talked about individual residents' needs and they appeared to be knowledgeable and familiar with residents' support requirements. Interactions between residents and staff were observed to be respectful and caring throughout the day, and residents appeared comfortable around staff and in their environment. Staff spoken with described how residents made choices and communicated their preferences, which was described as through gestures, pictures and social stories.

The house appeared bright, clean and had a homely atmosphere, with individual photographs of residents on display throughout the home. There was a large back garden area, which contained garden furniture and a 'polytunnel', in which vegetables were growing. Residents were reported to enjoy gardening, and there were photographs available for review which showed residents engaging in this activity.

The inspector met briefly with residents throughout the day while adhering to the public health measures of the wearing of a face mask and physical distancing. Residents interacted with the inspector on their own terms, and were observed to be moving freely around the centre and relaxing in either their bedroom or communal areas. One resident interacted with the inspector during the day, by bringing items into the office where the inspector was located, and the inspector was informed that this behaviour indicated that the resident may be displaying some anxiety. The resident was observed to be supported in a caring manner by staff, and later in the day the resident was supported with their choice to go out for a walk.

A review of documentation indicated that residents took part in a variety of activities based on their individual preferences; such as day trips on the bus, walks to local

amenities, going to the beach, swimming, gardening, music and eating out.

Overall, residents appeared to be supported with their individual needs, and arrangements were in place to ensure that they were consulted about the running of the centre and in making choices in their lives. The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The inspector found that in general, Rosslodge services provided a safe and homely service to residents availing of respite, and that there was a good governance and management structure in place. However, improvements were required in the following areas: assessment of needs for new admissions, residents' annual reviews, refresher training for staff, risk management, fire drills and in the ongoing oversight and monitoring by the management team to ensure that documentation was accurate and that actions to ensure compliance with the regulations were identified in a timely manner.

The service had experienced some changes in management in the past year due to the regional reconfiguration by the provider. There had been three persons in charge since the last inspection by the Health Information and Quality Authority (HIQA) in September 2019, with the current person in charge in place since March 2021. While there was a good management structure in place, the auditing and oversight by the management team required improvements to ensure that they were effective in identifying areas for improvement. A non-compliance was identified on this inspection in the area of residents' individual assessments and personal plans. The inspector found that a resident who was reported to have been admitted to the centre prior to the COVID-19 pandemic, had commenced availing of weekend respite in the last six weeks. The inspector found that the person in charge did not ensure that a comprehensive assessment of the health, personal and social care needs of the resident had not been completed prior to their admission to assess if the centre would meet their individual needs. Furthermore, personal support plans for the resident had not been updated since their move to the centre. The inspector was informed that a multidisciplinary meeting was planned for the following week where an assessment of needs and support plans would then be developed. However, as a comprehensive assessment of needs had not been completed prior to the admission, this created a risk that the centre would not suit the resident's individual care and support requirements.

The centre was staffed with a mix of nursing staff, a social care worker and support workers. The rota was reviewed which demonstrated that there was a consistent staff team in place to ensure continuity of care for residents. The person in charge was supported in their role by a team leader who worked full-time in the centre,

both supporting residents and carrying out some delegated tasks such as supervision of staff and other administrative duties. There was a management out-of-hours on-call system in place should this be required. Staff spoken with said that they felt supported in their roles and could raise any issues of concern to the management team. The inspector was informed that increased staffing had been put in place at weekends to support a new resident with their needs, and a review of the rota reflected this.

The staff training matrix was reviewed, and while in general staff had completed mandatory and refresher training, the inspector found that some staff were out-of-date for refresher training in safeguarding. In addition, a bespoke on-site training that the inspector was informed had been completed, which related to a specific health related need, had not been included on the training records. Therefore, the monitoring of staff training required improvements to ensure that all staff had refresher mandatory training completed within the required time frames, and that the staff training records were accurate and reflective of training completed.

The provider ensured that an annual review of the quality of care and support provided and six monthly unannounced audits occurred as required by the regulations. Consultation with families was achieved through questionnaires and this feedback was included on the provider reports. Management audits indicated that trends in incidents that occurred were analysed, and where identified, there were actions in place to improve the quality of service. In addition, internal audits were completed in health and safety, medication and fire prevention management. However, improvements were required in the ongoing oversight and monitoring by the management team as areas for improvement that the inspector found on inspection had not been identified by the management team. This included; completion of assessments of needs, residents' annual reviews, inaccurate documentation of some restrictive practices, staff training, risk assessments and ensuring that regular fire drills occurred.

In summary, residents were provided with a service that promoted their safety and individual preferences. However, improvements were required in the ongoing monitoring by the management team to ensure that the areas of non-compliance and areas for improvement that were found on inspection, were identified and addressed in a timely manner.

Regulation 15: Staffing

There was a rota in place which demonstrated that the service was staffed by a consistent staff team to ensure continuity of care. The rota was reviewed and was reflective of what was happening on the day. While the centre was short staffed on the morning of the inspection due to unplanned leave, the contingency plan was effective in ensuring that appropriate numbers and skill mix of staff was available. Staff files to assess against Schedule 2 of the regulations were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with a range of mandatory and refresher training to support with their continuous professional development. However, some staff were found to be out of date for refresher training in safeguarding, and some on-site training had not been included in individual staff's training records.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there was a good management structure in place, improvements were required in the auditing and oversight by the management team to ensure that non-compliance with the regulations, and areas for improvement were identified and addressed in a timely manner.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents received a person-centred service where rights and individuality were respected. Residents who the inspector met with were observed to be comfortable in their environment and with staff supporting them. However, improvements in the assessments of needs, reviews of support plans, assessment of risk and carrying out of regular fire drills were required to ensure that the quality and safety of care of residents were supported at all times.

Residents had personal profiles in place which included information regarding their personalities, preferences and routines. Support plans were in place for residents where this need was identified. However, some aspects of personal planning required updating. For example; some residents' reviews had not occurred annually as required by the regulations. In addition, assessments of needs had not been completed to assess the health, personal and social care needs of a new admission to the centre prior to their admission, and therefore up-to-date personal plans were not in place to guide staff in best supporting the resident while availing of care in this service.

Residents were supported to achieve optimal health by being facilitated to attend

medical and health care services where this was identified as being required. The inspector found that Rosslodge services worked in conjunction with residents' families to ensure that residents' health and wellbeing needs were met. In addition, there was evidence that residents had access to multidisciplinary supports such as physiotherapists, behaviour support staff and psychologists, where required. Residents' weight and wellbeing were monitored on a regular basis, and social stories were developed to support residents' understanding of health related topics such as COVID-19.

Residents who required support with behaviours of concern had plans in place which detailed proactive and reactive strategies required to support them with particular behaviours. There was evidence that support plans were reviewed with the relevant members of the multidisciplinary support team. Plans also included detailed support measures to help support residents with individual anxiety behaviours. Restrictive practices were reviewed by the organisation's rights committee and there was evidence that they were kept under regular review to ensure that they were the least restrictive measure for the shortest duration. However, the documentation with regard to some restrictive practices was not accurate and the monitoring of this by the management team required strengthening to ensure that records reflected who the restrictive practices were in place for.

The centre was found to promote the rights of residents. It was evident through observations on the day and through a documentation review that residents were consulted about the running of the house and about their day-to-day activities. A range of social stories were in place to support residents' understanding of various topics; including complaints and COVID-19. Safeguarding of residents were supported through regular review of incidents that occurred, staff training and the implementation of safeguarding plans where this was required. Staff spoken with were aware if what to do if a concern of abuse arose.

The provider ensured that there were systems in place for the prevention and control of infection. This included staff training, symptom monitoring, posters on display around the house about preventing infection transmission, use of personal protective equipment (PPE) and availability of hand sanitisers. In addition, there were systems in place for the prevention and management of the risks associated with COVID-19; including up-to-date outbreak management plans, risk assessments and resident isolation support plans, should this be required. In addition, HIQA's self-assessment tool for preparedness planning had been completed and was available for review.

There were systems in place for the identification, assessment and management of risk, including a site specific safety statement and emergency plans in the event of adverse events. Risks that had been identified at service and resident level had been assessed. While in general risks were identified and managed well, inspectors found that some risks relating to one resident's healthcare needs and their refusal of medical interventions and recommended medicines, required updating and further review to ensure that the most up-to-date information was included in order to minimise any risks to the resident's health and wellbeing.

The provider had arrangements in place for fire precautions including systems for detecting, containing and extinguishing of fire. An action that was required following the last inspection by HIQA was found to be completed. However, improvements were required in the completion of fire drills to ensure that the organisational requirements were met and that regular fire drills occurred. The inspector found that while the centre did not accommodate residents for five months in 2020 during the COVID-19 pandemic, there were no fire drills completed in 2020 at times when residents were using the service. It was found that the last time a fire drill under minimum staffing levels occurred was in February 2019. This required improvements to ensure that evacuation of all residents could occur in the event of a fire and under different scenarios.

In summary, Rosslodge provided a person centred service where residents' health and wellbeing were supported. Improvements in residents' assessment of needs, annual reviews, risk management and fire drills would enhance the service and ensure that the centre was to a safe and high standard at all times.

Regulation 26: Risk management procedures

A risk assessment for one resident required review and updating with regard to the risks relating to their refusal of medication and medical interventions, in order to ensure that all mitigating control measures are identified to support the resident with their health and wellbeing.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider ensured that there were arrangements in place for infection prevention and control; including outbreak management plans in the event of COVID19.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required in fire evacuation to ensure that regular fire drills occurred as required by the organisation's policy and to ensure that residents could be evacuated safely under scenarios of minimum staffing levels.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need for a new admission to the centre had not been completed and there were no up-to-date personal plans in place since their admission to Rosslodge services. In addition, some residents' reviews had not been completed annually as required by the regulations.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health and wellbeing, and were facilitated to attend medical and healthcare appointments where required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviours of concern had comprehensive support plans in place which were reviewed by the relevant members of the multidisciplinary team. Restrictive practices were found to be kept under regular review to ensure that they were the least restrictive measure for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

Safeguarding of residents were found to be supported. Safeguarding plans were developed where this need had been identified, and were found to be under regular review. Staff spoken with were aware of what to do in the event of a concern of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were supported thorough consultation about the running of the centre and promoting choices in their day-to-day lives. Easy-to-read documents and social stories were in place for a variety of topics. In addition, a review of residents' daily records indicated that residents' choices about how they spend their day was respected.

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:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Rosslodge Services OSV-0004945

Inspection ID: MON-0028842

Date of inspection: 25/08/2021

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 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Team Leader will review staff training records on a quarterly basis and will ensure that all training is up to date and on each individual's record. The Team Leader will book staff into the required refresher trainings and will identify this on the roster.</td></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 Person in Charge and Team Leader have put a plan in place with time lines for the team to work on areas of improvement in relation to documentation which is time bound

Team Leader will allocate time to the individual members of team to complete the documentation.

The Person in Charge will to an audit of the documentation to ensure it is completed and up to date.</td></tr>
</table>

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Team Leader with relevant members of the MDT will complete the necessary risk assessment for the individual supported by the service who requires a risk assessment in relation to the administration of medication and medical procedures.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Team Leader will do a schedule for fire drills for remainder of the year which will ensure that they are completed in line with policy and all the individuals who attend Respite are supported to participate and evacuate safely.
There will be a schedule of drills for each year going forward.

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:
The Team Leader and Person in Charge will link with the relevant members of the MDT to complete a comprehensive assessment of need for the new admission.
This individual's personal plan and goals will be reviewed and updated involving people who know him well.

A review of the other individual's personal plans and goals will occur ensuring that goals are set and individuals are supported to achieve these goals when in Respite.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2021
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.	Substantially Compliant	Yellow	29/10/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	15/10/2021

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	15/10/2021
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	30/09/2021
Regulation 05(4)(c)	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 is developed through a person centred	Not Compliant	Orange	08/10/2021

	approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/10/2021