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:	Parkside Residential Services Kilmeaden
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	15 September 2021
Centre ID:	OSV-0005106
Fieldwork ID:	MON-0034235

About the designated centre

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

Parkside Residential Services Kilmeaden is a five bedroom two–storey detached house located in a rural area. The centre provides residential care for four men with mild to moderate intellectual disability ranging in age from 28 to 54 and has a maximum capacity for four residents. It is open 365 days of the year on a 24 hour basis. Each resident has their own bedroom and other facilities throughout the centre include a kitchen, a dining room, two living rooms, bathroom facilities and garden areas. Staff support is provided by social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 15 September 2021	10:30 am to 7:00 pm	Lisa Redmond	Lead

What residents told us and what inspectors observed

On the day of this unannounced inspection, the inspector met with the four residents that lived in the designated centre. This inspection was completed during the COVID-19 pandemic. The inspector carried out all necessary precautions in line with COVID-19 prevention against infection guidance and adhered to public health guidance at all times. On arrival to the designated centre the residents were not home. The inspector therefore awaited the return of all residents to the centre, to ensure to get an insight into what it was like for them to live in the centre.

Overall the inspector found that there were a number of practices that impacted on the quality of service provided to residents. The management of complaints, the implementation of appropriate safeguarding procedures and the management and oversight of the centre all required improvements.

The inspector spoke with and observed care delivery to all residents. A number of residents presented as very content living in the centre however others residents did not. Two of the residents had moved into this centre in the last 12 months.

The inspector observed that some residents had recently commenced more independent activities such as cycling to and from their day service. A resident told the inspector that they hoped to one day live independently, and spoke about their plans to get a job in their local community. They also told the inspector that they would like to be able to do the designated centre's grocery shopping in the supermarket, rather than having it ordered online. The registered provider advised that shopping was completed online due to the risks associated with the COVID-19 pandemic. Some residents communicated and were observed participating in other activities that they enjoyed such as listening to music, going to the pub, going for walks, art and watching television. This was found to be very positive.

There were three sitting room areas in the designated centre. One was used by two residents. The other two sitting rooms were used for the other two residents separately. The inspector noted some compatibility issues between certain residents and the measures apparent in communal areas were designed to reduce contact between these residents.

A resident told the inspector that they wanted to retire from day service. The registered provider advised that the resident's request to reduce their attendance at day services to four days each week was under review by the multi-disciplinary team.

One resident told the inspector that they did not like living with one particular resident. They told the inspector that the behaviours displayed by this resident caused them to be unable to sleep at night, and they told the inspector about their frustrations and fears about this. This resident had made a complaint about their wishes not to live with the other resident anymore. However, they told the inspector

that the complaints process was 'slow'. There were also safeguarding issues raised by this resident with the inspector that were of concern. These were communicated directly with the person in charge on the day of inspection.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

The inspector found that the oversight and review of care delivery, safeguarding, complaints and the notification of incidents required improvement. This had a negative impact on the experience of residents who lived in the designated centre.

This designated centre had six changes to the role of the person in charge in the last three years. Three of these person in charge changes had occurred since April 2021. At the time of this inspection, the current person in charge had been in the role for a period of approximately 10 weeks. Consistent management and oversight had not been maintained in the designated centre throughout this period.The inspector reviewed the designated centre's statement of purpose and found that it did not reflect the governance and management structure in the centre, and that it referenced an individual who no longer worked in the centre as the person in charge. The statement of purpose indicated that staff members reported directly to the person in charge, who then reported to the services manager. During the inspection, it was identified that the staff members working in this designated centre did not actually report to the person in charge, and that they reported to the residential services manager. There were not clear lines of authority and accountability in the designated centre, in line with the statement of purpose.

The inspector was concerned following full review of the incident log, observations and discussions with staff members, that allegations of suspected abuse were not being managed and followed up appropriately. These incidents were of a safeguarding nature and included financial discrepancies, and allegations of physical abuse/peer to peer incidents and suspected neglect. More robust governance, oversight, understanding and implementation of appropriate safeguarding procedures were found to be required in this centre.

Residents living in the centre had made complaints about the service provided in their home. The inspector requested the complaints log, and all information relating to the status of all complaints and the work completed by the provider to address these complaints. This information was not made available for the inspector to review, despite multiple requests for this information over an eight hour period. The person in charge informed the inspector that they did not have full oversight of the management of all complaints within the designated centre. Furthermore full investigation and follow up with complainants was not found to be taking place. This

did not demonstrate effective governance.

An annual review of the supports provided in the designated centre had been completed for the year 2020. An unannounced six monthly visit report had been completed in December 2020, and although the person in charge at that time had visited the centre on a number of occasions throughout the COVID-19 pandemic, and documented these visits, there was no evidence of a six monthly unannounced visit report being completed since December 2020.

It was noted that there were not many actions or areas for improvement identified from the 2020 annual review of services provided in the designated centre. This was the last time such a review took place. It also noted that residents were generally happy living in the designated centre at this time. However there was no specific references to what residents were asked about the service they received, how many residents were spoken with or what they had said about the supports they received in their home during the annual review.

Following their appointment, the current person in charge had completed an oversight plan for the designated centre. This plan had specific actions, which were time-framed, and outlined the plan they had to complete audits, and review the quality of service provided to residents in the designated centre. This was in the early stages of commencement, at the time of this inspection.

Following a thorough review of the incident log and discussions with staff members, it was identified that a number of allegations/suspected safeguarding concerns were not notified to the Health Information and Quality Authority (HIQA) in line with the regulations.

Regulation 23: Governance and management

Oversight of the designated centre was found to be poor. This was evidenced by the high level of not compliant findings in this inspection. Regular changes of the role of person in charge did not ensure that consistent management and oversight had been maintained. Person in charge oversight and follow up in key areas was not evident. For example, safeguarding and complaints.

The provider was not demonstrating that this centre was ensuring the effective delivery of care and support in accordance with the statement of purpose. Provider auditing, action planning and follow up required further improvement to ensure the quality and safety of care and support was being reviewed in the context of all residents assessed support needs.

Judgment: Not compliant

Regulation 31: Notification of incidents

Safeguarding allegations had not been notified to HIQA, in line with the regulations. For example, an incident of alleged physical abuse documented in the incident log was not notified to HIQA. A review of incidents where the person in charge had documented suspected/alleged neglect had not been notified to HIQA. Staff members also informed the inspector about other alleged incidents including a discrepancy noted in the residents' finances. These allegations had not been notified.

After this inspection was completed, and the inspector had identified that allegations of suspected abuse had not been reported to HIQA, three allegations of suspected abuse were notified to the chief inspector. All three of these alleged incidents had occurred before this inspection had taken place.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents living in the centre had made complaints about the service provided in their home. The complaints log, and all correspondence relating to complaints in the designated centre were not available for the inspector to review, despite multiple requests for this information. The person in charge told the inspector that they did not have oversight on the management of complaints in the designated centre. This did not demonstrate effective governance.

The registered provider had not ensured that an effective complaints procedure was available to staff and residents on the day of the inspection. The complaints policy on site was dated November 2014. This policy did not reflect the current practices regarding the management of complaints in the centre. For example, the complaints policy stated that all complaints should be documented in the complaints log located in the centre. However, the complaints log was held off-site. It was also noted that it did not refer to the use of the accessible complaints procedure for residents that was currently in use in the designated centre.

Judgment: Not compliant

Quality and safety

Whilst there were some good examples of care and support to residents, overall the

provision of quality and safe care in this centre required substantial improvement.

Staff members were observed to support residents to communicate effectively, and residents appeared comfortable in the presence of the staff members supporting them on the day of inspection. However, it was evident that some residents living in the centre where not compatible with each other. As a result of this, there was a high level of incidents found to be occurring in the designated centre which was negatively impacting on residents.

The inspector reviewed the designated centre's policy on the safeguarding of vulnerable adults in addition to a document that outlined the protocols and thresholds for reporting peer-to-peer abuse. There were inconsistencies identified between these two documents. For example, while the policy identified that all suspicions or allegations of abuse were referred to the designated officer, the threshold of abuse protocol stated that only reoccurring incidents, or those of a certain very high severity were reported to the designated officer. The policies, protocol and practices were found to be inconsistent.

Incidents of a safeguarding nature were not appropriately reported or managed. For example, the inspector reviewed documentation relating to an allegation of suspected neglect. It was identified that this was not reviewed as a safeguarding incident, the incident was not reported or managed in line with safeguarding guidance, and an investigation into the incident had not occurred. A safeguarding plan required to support one resident was not accessible to staff members. Therefore, staff members did not have appropriate guidance on how to support the resident to ensure they were appropriately safeguarded. Furthermore one resident informed the inspector directly of an alleged incident whereby a couch had to be pulled in front of a door to prevent another resident who was displaying behaviours that challenge from accessing them. This resident expressed being afraid at this time to the inspector. There was no records or follow up made available to the inspector regarding this incident when requested. The inspector was therefore not assured with safeguarding practices in the centre.

In line with the regulations, residents are required to have a comprehensive assessment of their health, personal and social care needs on an annual basis. A personal plan is then developed, in line with the residents' assessed needs. Staff members told the inspector that the residents' assessments and personal plans were documented in their integrated health care and personal plan. The inspector reviewed a sample of the residents' integrated health care and personal plans and noted that these had not been subject to review on an annual basis. Although it was evident that there was some multi-disciplinary review of some residents' specific support needs, it was not evident that residents' integrated health care and personal plans had been updated to reflect the outcome of these multidisciplinary reviews.

Whilst there were some good procedures in place regarding infection control practices in the centre, suitable contingency planning was not in place. Temperatures were checked and visitor logs maintained. Staff members were observed wearing surgical face masks. However it was identified that the designated centre's contingency plan did not include any specific information on the steps to be

taken in the event of an outbreak of COVID-19, including isolation procedures, donning and doffing areas and waste management specific to the designated centre. It was also noted that mops and buckets were inappropriately stored.

A fire alarm panel and fire resistant doors were in place in the designated centre. It was noted that only three quarterly tests of the fire alarm panel had been completed in 2020. The registered provider advised that this decision had been made to reduce footfall to the designated centre during the COVID-19 pandemic. Each resident had a personal evacuation plan in the event they needed to evacuate the designated centre.

Regulation 10: Communication

It was evident that residents were assisted and supported by staff members to communicate in accordance with their wishes. Staff members were observed using picture references to explain one resident's plan for the next day.

Judgment: Compliant

Regulation 27: Protection against infection

Improvements were required to ensure that residents were protected from all sources of potential infection. It was identified that the designated centre's contingency plan did not include information on the steps to be taken in the event of an outbreak of COVID-19, including isolation procedures, donning and doffing areas and waste management specific to the designated centre. It was also noted that mops and buckets were stored inappropriately.

Judgment: Not compliant

Regulation 28: Fire precautions

A fire alarm system, emergency lighting and fire-resistant doors were provided in the designated centre. Fire fighting equipment was located in a number of areas. Residents participated in regular fire drills, and there was a fire assembly point located in the garden area.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Resident compatibility required review and re-assessment due to a high level of incidents occurring in the designated centre.

Residents were not subject to a comprehensive assessment of their health, personal and social care needs on an annual basis. Following a review of a sample of residents' personal files, it was noted that this assessment had not been reviewed since August 2019, while another had not been completed since October 2019. One of these residents had moved to this designated centre in the previous 12 months. Therefore, this had not been updated since they transitioned to this designated centre to reflect the supports they required in their new home.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured that the safeguarding systems in place protected residents from all forms of abuse.

Inconsistencies between policy and practice were evident in this centre. A resident did not report feeling safe at all times.The identification, reporting and management of safeguarding concerns in centre required improvement.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Parkside Residential Services Kilmeaden OSV-0005106

Inspection ID: MON-0034235

Date of inspection: 15/09/2021

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:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Additional resources have now been allocated to this designated centre for the next six months to address the immediate gaps in governance and oversight and to ensure that there is appropriate oversight by the PIC particularly in the areas of safeguarding and complaints • A review of the governance structures in this designated centre and wider service area will be conducted with a view to finding a permanent solution to governance and oversight in this designated centre. • The Statement of Purpose has been amended to reflect the name of the current Person in Charge • The Statement of Purpose has been amended to reflect the lines of authority and accountability in this Designated Centre • An unannounced six monthly audit will be conducted in this designated centre by November 12th 2021	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Incidents will be notified to HIQA in line with regulations	
Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The current version of the Complaints Policy and Procedure Version 4 will be placed in the folder • The current version of the easy read Complaints Policy (I'm not Happy) for residents will be placed in the folder • The Complaints procedure will be reviewed to ensure that o Complaints are addressed promptly and in a timely manner o A record of all complaints is maintained including details of follow up, outcome, resolution reached o The satisfaction or not of the resident with the outcome will also be noted.

Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • The contingency plan will be updated to accurately reflect detailed arrangements currently in place should an outbreak of Covid-19 occur at this designated centre.	
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 integrated health care plans and personal plans of residents will be updated to reflect outcomes of recent Multi-disciplinary reviews. These will be reviewed at a minimum on an annual basis.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • A submission for additional funding has been submitted to the Health Services Executive to create an individualised service to address the compatibility issues in this designated centre • The residents in this house continue to be supported by the frontline team, the person in charge and the wider Multi-disciplinary team to live together amicably through interventions put in place, A review will take place at a national level to address the inconsistencies and concerns noted during this inspection with respect to the Safeguarding policy and procedures	

currently in place. In the meantime, the threshold document will be removed from policy folders in designated centers to avoid any further confusion

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 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	28/02/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2022
Regulation 23(2)(a)	The registered provider, or a person nominated	Substantially Compliant	Yellow	12/11/2021

	by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	01/11/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	15/09/2021

	incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Not Compliant	Orange	31/12/2021
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/12/2021
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/12/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints	Not Compliant	Orange	31/12/2021

	including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(1)(b)	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 subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/12/2021
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Not Compliant	Orange	31/12/2021
Regulation 08(2)	The registered provider shall protect residents	Not Compliant	Orange	15/09/2021

	from all forms of abuse.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	15/09/2021