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

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| Name of designated centre: | St. John of God Kildare Services - DC 2 |
| Name of provider: | St John of God Community Services Company Limited By Guarantee |
| Address of centre: | Kildare |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 06 July 2020 |
| Centre ID: | OSV-0002934 |
| Fieldwork ID: | MON-0025988 |

## About the designated centre

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

DC2 is a designated centre for adults with intellectual disabilities operated by St. John of God Kildare Services. The centre is located in a congregated campus setting situated in a town in County Kildare. The centre comprises of two residential units beside each other. One residential unit has the capacity for six residents and the other unit has capacity for four residents. The designated centre provides residential services for adults both male and female with intellectual disabilities with additional healthcare and behaviour support needs. The provider has refurbished parts of the designated centre to ensure residents are provided with a homely, comfortable environment with assisted bathroom aids available also. The centre is managed by a person in charge who is supported by a senior manager. The staff team comprises of nurses with health and social care workers also working in the centre to support residents. Some vacancies have arisen in the centre as a result of the provider's ongoing de-congregation process for the campus.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 8 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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 |
|---|---|---|---|
| Monday 6 July 2020 | 10:20hrs to 15:20hrs | Ann-Marie O'Neill | Lead |

## What residents told us and what inspectors observed

The inspector met with residents living in the larger residential unit on the day of inspection. At the time of inspection a resident was not present in the centre as they were receiving treatment in hospital.

At the commencement of the inspection the inspector greeted and spoke with three residents who were preparing to go to their day activity programme.

This day activity programme was only attended by residents living in the designated centre which meant the provider could continue to offer them a daily programme of meaningful activities which were in line with Public Health Guidelines in relation to the management of COVID-19. Day activity staff, re-deployed to the centre, supported residents during their daily activity programme which ensured appropriate staff cohort arrangements were in place to prevent the spread of any possible or potential infection from COVID -19.

Residents spoken with indicated they were content and happy to be attending their day programme. One resident mentioned bus to indicate they enjoyed this activity and to also tell the inspector they liked holidays and trips.

Another older resident was observed to remain in the centre during the course of the inspection. It was noted that they were afforded the opportunity to wake up when they wished. The inspector spoke to this resident for brief periods during the course of the inspection while ensuring social distancing guidelines were adhered to at all times.

When asked the resident said they liked their home 'most of the time' and said the food was nice. They mentioned their family members by name and how important they were to them. The resident was observed to be at ease in their home and engaging in some chores and watching TV during the course of the inspection. The inspector also noted a number of recent photographs of the resident engaging in gardening and tending to food at a barbecue that recently occurred at the centre. The resident was observed to be smiling and happy in the photographs.

Staff interactions with residents was observed to be pleasant and helpful to residents at all times. Some jovial interactions were also observed between staff and residents during the course of the inspection.

## Capacity and capability

The findings from this inspection demonstrated the provider had the capacity and

capability to provide an improved quality service to meet the needs of residents as a result of progression with de-congregation planning for the campus and enhanced staffing supports for residents. Some improvement was required in relation to the whole-time-equivalent staffing numbers in the centre and the timely completion of an annual report for the centre by the provider.

Since the previous inspection of the centre in 2018, the provider had progressed with their de-congregation planning for the centre. The number of residents living in the centre had reduced from 12 to eight residents. In addition, the provider had also increased staffing numbers in the centre with a focus on evening hours to ensure residents had greater opportunities to engage in activities in the evening time and to provide for greater supervision and support of residents. This resulted in the improved compliance findings on this inspection and evidence that residents were experiencing an enhanced quality of life and experiencing fewer peer-to-peer safeguarding incidents in their home.

The provider had appointed a new person in charge to the centre in January 2020. As required by the regulations, the provider submitted a notification to the Chief Inspector in relation to the newly appointed person in charge. The person in charge was responsible for this designated centre only. The matters of regulation 14 in relation to management experience and qualifications for the person in charge were found to be in compliance.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. The person in charge was supported in their role by a person participating in management and a senior manager.

There were arrangements in place to monitor the quality of care and support in the centre. The provider had completed a six-monthly provider led audits of the the centre. These were found to be of a good quality and reviewed specific regulations in detail, providing a quality action plan for any areas that required improvement . It was noted that most actions from the most recent six-monthly provider led audit had been completed. The person in charge also completed some centre specific audits, for example, infection control management and personal planning.

While it was found six-monthly provider led audits had been carried out in the centre to a high standard and at appropriate intervals, the provider had not completed an annual report for 2019.

The provider had made comprehensive arrangements to ensure adequate staffing levels were in place in the centre and had robust staffing contingency measures to manage any staff absences should they occur due to COVID-19. The inspector noted there was a planned and actual roster in place and staffing levels had been maintained as per the statement of purpose for the centre for the most part. Redeployed staff were available to manage any staff shortfalls in the short-term.

While at the time of inspection staffing levels in the centre were adequate, there were some staffing vacancies, bringing the total whole-time-equivalent staffing vacancies to approximately 1.64. It was noted, that the provider was in an active process to recruit staff and the inspector was informed, by the person in charge,

that the nurse vacancy post was due to be filled shortly. Given the clear evidence that staffing supervision and support for residents was critical for the ongoing ensuring of compliance and mitigation of safeguarding incidents, the provider was required to put in place suitable arrangements for filling any staffing vacancies in a timely way.

## Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre that met the requirements of Regulation 14. The person in charge was responsible for this designated centre only, demonstrating the provider's commitment to strengthening and ensuring good governance and management oversight of the designated centre.

Judgment: Compliant

## Regulation 15: Staffing

The provider was required to put in place suitable arrangements for filling any staffing vacancies in a timely way.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Six-monthly audits, completed on behalf of the provider, were of a high standard and carried out at intervals in compliance with the regulations.

The provider had not completed an annual report for 2019.

Judgment: Substantially compliant

## Quality and safety

Overall, residents living in the centre were in receipt of a safer and improved quality service. Some improvements which had occurred since the previous inspection included, a reduction in resident numbers in the centre, increased staffing and improved meaningful activity arrangements and resident integration and

participation with their wider community outside of the congregated campus setting.

There was evidence residents were provided opportunities to maintain their general welfare and development while COVID-19 pandemic restrictions were in place. The provider had made arrangements so that residents could still attend a day activity service by implementing cohorting procedures whereby only residents living in the centre could attend the specific day service supported by staff from the centre. This ensured Public Health guidelines, in relation to the management of COVID-19, were adhered to by minimising the risk of infection that could occur should residents mix with residents or staff from outside the designated centre.

In addition residents were supported to maintain contact with their family through the use of electronic devices and technology, for example. The provider had also increased the staffing hours in the centre in the evening time to provide residents with greater supervision and opportunities to engage in evening time activities, for example.

Staff were trained in safeguarding vulnerable adults. There was evidence of the provider's implementation of National Safeguarding policies and procedures in the centre. An up-to-date safeguarding vulnerable adults policy was in place and contact details of the designated officer were on display in the centre. Where safeguarding incidents occurred, they were referred to the designated officer and a preliminary screening carried out. The inspector reviewed a sample of safeguarding plans which had been developed as a result of safeguarding incidents. It was noted that there had been a significant reduction in the frequency of peer-to-peer safeguarding incidents occurring in the centre following a review of a sample of recorded incidents for 2018 and 2020. For example, peer-to-peer safeguarding incidents were a weekly occurrence in the centre in 2018 while in 2020 only three such incidents had been recorded to date.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required. The person in charge ensured that all staff were made aware of public health guidance and any changes in procedure relating to this. There was a folder with information on COVID-19 infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment was in good supply and hand washing facilities were available in the centre with a good supply of hand soap and alcohol hand gels available also. Each staff member and resident had their temperature checked daily as a further precaution.

In addition the provider had made arrangements to refurbish and improve the bathing and washing facilities in the centre which in turn provided residents with the most optimum facilities for hygiene purposes and also good infection control management.

The inspector reviewed a sample of residents' personal plans and noted, for the most part, they provided good detail in relation to the support needs of the resident.

Informative support care planning was in place and had been updated. The most recent six-monthly provider led audit had identified improvements were required in relation to personal plan documentation and it was demonstrated on inspection that the person in charge had undertaken to address this. In addition, each resident had received an up-to-date personal outcome measure meeting and had personal goals identified in their plans. In some instances residents' personal plans contained colour photos of them attending their personal planning meetings demonstrating their inclusion in the process.

Some residents had achieved goals such as going on a foreign holiday and going for a hotel break. Others had attended a disability specific music festival and others had achieved their goal to place a bet in the local book-keepers for the first time with a photograph of them reviewing their betting slip as a memory of the occasion.

Each resident had been reviewed by their General Practitioner and other allied professionals on a regular basis and had received timely review for any presenting healthcare conditions. Where required residents received emergency service or hospital care and each resident had a hospital passport in place which outlined their medical history and specific requirements for their hospital stay. It was also noted residents had access to National Screening programmes and a collated record of screening dates were maintained.

Positive behaviour support planning was in place for residents that required such supports. Positive behaviour support planning focused on proactive strategies and reducing triggers which may cause the resident to become distressed. It was evidenced that an active daily programme of meaningful activities and good levels of staff support and supervision contributed to the reduction in incidents of behaviours that challenge in the centre.

Most staff had received training in management and prevention of behaviours that challenge. There were some small gaps in the staff training record where some recently employed staff had not received this training yet. This required improvement given the assessed behaviour support needs of some residents. In addition, while most restrictive practices had received review by the provider's Human Rights committee, one physical restraint intervention had not received a review by the committee. This required some improvement to ensure all restrictive practices implemented in the centre were carried out in line with a Human Rights approach.

## Regulation 13: General welfare and development

The provider had made arrangements to support residents to experience a meaningful day as much as possible by making provisions for a day activity programme for residents to attend in line with Public Health guidelines for the management of COVID-19.

Judgment: Compliant

## Regulation 27: Protection against infection

Infection control systems in place reflected Public Health guidelines. Good supplies of personal protective equipment and alcohol hand gel were observed in the centre. Staff were observed to adhere to social distancing and wearing of masks where required.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Personal plans were kept up-to-date and regularly reviewed. Residents' personal goals had also been recorded and evidence of work towards achieving those goals was maintained.

Judgment: Compliant

## Regulation 6: Health care

Residents' healthcare needs were well managed and residents were provided with regular review by their General Practitioner and allied professionals associated with their assessed care needs. Residents had access to National Screening services

Judgment: Compliant

## Regulation 7: Positive behavioural support

Some recently recruited staff had not received training in the management of behaviours that challenge.

A physical restraint used in the centre had not been reviewed by the provider's Human Rights Committee.

Judgment: Substantially compliant

## Regulation 8: Protection

There was evidence of the provider and person in charge's implementation of National Safeguarding policies and procedures for vulnerable adults. There had been a significant reduction in the frequency of peer-to-peer incidents in the centre since the previous 2018 inspection.

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 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for St. John of God Kildare Services - DC 2 OSV-0002934

## Inspection ID: MON-0025988

## Date of inspection: 06/07/2020

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

**Compliance plan provider's response:**

| Regulation Heading | Judgment |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>Additional staff nurse was recruited and commenced their employment on 13th July 2020. As a result all nursing vacancies in the designated center have been filled.<br><br>The number, qualifications and skill mix of staff is considered to be appropriate to the number and assessed needs of the residents. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The Annual Review of the Quality and Safety of Care and Support was completed on 20th July 2020. The review provided for consultation with residents and their representatives. A copy of the review is available to residents and the chief inspector. | |
| Regulation 7: Positive behavioural support | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive | |

behavioural support:
All outstanding staff members will be scheduled to receive MAPA training before 31st August 2020.

All cases of restrictive practices have been referred to Positive Behavior Support Committee and Human Rights Committee for consideration/review. The outcome of both will be communicated to all staff and the relevant resident, and records will be updated with the outcomes by 31/10/2020.

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Substantially Compliant | Yellow | 13/07/2020 |
| Regulation 23(1)(d) | The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards. | Substantially Compliant | Yellow | 20/07/2020 |
| Regulation 07(2) | The person in charge shall ensure that staff receive training in the management | Substantially Compliant | Yellow | 31/08/2020 |

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| | of behaviour that is challenging including de-escalation and intervention techniques. | | | |
| 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 national policy and evidence based practice. | Substantially Compliant | Yellow | 31/10/2020 |