Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Newcastle West Community Residential Houses
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	12 March 2019
Centre ID:	OSV-0004783
Fieldwork ID:	MON-0025867

About the designated centre

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

This designated centre consists of two houses in separate locations but both in close proximity to the range of amenities offered by the busy town. The provider's day service which is used by some residents is also easily accessed from the houses. A maximum of nine residents can be accommodated; four residents live in one house, five in the other. Each resident has their own bedroom and share recreational, dining and bathroom facilities. The model of care is social; the staff team is comprised of social care workers led by the person in charge. The provider states that the centre is not suitable for residents with high physical or medical needs or the requirement for more intensive support in the context of their intellectual disability. The provider aims to provide each resident with a safe but homely environment and support that promotes independence and quality care based on individual needs, requirements and wishes.

The following information outlines some additional data on this centre.

Current registration end date:	30/11/2021
Number of residents on the date of inspection:	9

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
12 March 2019	09:30hrs to 19:00hrs	Mary Moore	Lead

Views of people who use the service

The inspector met with seven residents; two residents chatted with the inspector in the day service and five residents were met with in their home in the evening when they returned from their respective day services.

Residents led this engagement, all were happy to engage; how residents engaged reflected their individuality. For example some residents engaged using gestures and facial expression and what these communicated (comfort and general satisfaction) was explained by staff. Other residents engaged easily and told the inspector (who had explained what it was that she did), that they were fine and that things were good in the house. Residents spoke of family and recent personal losses and other relationships that were important to them. Residents spoke of their interests and what they enjoyed and excused themselves and they went to get ready for Special Olympics training.

Some residents also spoke of their personal dreams and hopes for the future including living more independently. Residents confirmed that they had discussed these hopes with management and at their personal plan reviews. Residents invited the inspector to review their plans and to discuss them with management.

Capacity and capability

Based on these inspection findings the inspector concluded that this was a well managed service where consistent oversight was maintained; residents and the quality and the safety of the service provided to them in the centre were at the centre of its management.

There were management structures that facilitated this effective governance. For example the person in charge was based in the day service and worked closely and collaboratively with the other person in charge based in this geographical location. They worked opposite each other so as to maintain a management presence and oversight and each had good working knowledge of the other designated centre. The area manager was also based locally and had established experience and knowledge of the centre and residents. Therefore there was daily contact and support in addition to the formal reviews that took place weekly.

Oversight and the consistency of this oversight was evident in records seen such the management of incidents and post-incident reviews, the regular reviews of residents personal plans by the person in charge and audits such as the quarterly audit of medicines management practice. In addition the provider was undertaking the annual review and the unannounced reviews (at a minimum six-monthly) as required by the regulations. These provider reviews were thorough, focussed on safety and quality and sought feedback from residents, their representatives and staff. Collectively the purpose of this oversight and these reviews was to establish good practice, self-identify areas that needed to improve and the action necessary

to bring about this improvement. The inspector concluded that while issues and challenges did arise, these were self-identified and responded to with effective action taken to address any areas of concern.

Overall the inspector concluded that staffing levels and arrangements were adequate. There was one staff on duty in each house and the night-time staff was a sleepover staff. Some residents were seen to enjoy a good level of independence in their daily routines. Staff were busy but supported each other across the different houses; this facilitated choice, social activities and engagement for residents in the evening and at weekends.

The person in charge monitored staff attendance at training and was clear on any refresher training required; staff were described as proactive in attending to their training requirements and this was reflected in the training records seen.

Effective procedures for the management of complaints also supported the appropriateness, quality and safety of the service. The inspector found that residents understood what a complaint was, how to complain and who to complain to. Their complaints were listened to and action to taken to resolve the matter of concern to them.

Regulation 14: Persons in charge

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

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were appropriate to the assessed needs of the residents. A core group of regular staff worked in the centre; there was limited requirement for relief staff. These arrangements ensured that residents received continuity of care and supports.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframes; refresher training was completed or scheduled. Staff had completed additional training that supported them to safely meet resident's needs such as updated training on the safe management of medicines.

The person in charge provided support and supervision to staff on a regular basis.

Judgment: Compliant

Regulation 21: Records

The inspector found that any of the requested records as listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. The records were well maintained and the required information was easily extracted by the inspector from the records.

Judgment: Compliant

Regulation 23: Governance and management

The centre was effectively and consistently governed so as to ensure and assure the delivery of safe, quality supports and services to residents. The provider had structured systems of review and utilized the findings of reviews to inform and improve the safety and quality of the service.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on discussions held and records seen in the designated centre there were effective arrangements for ensuring that the prescribed notifications, for example any use of a restrictive practice, were submitted to HIQA.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints log demonstrated that residents knew how to complain and did complain; staff supported residents to record and progress their complaints. The escalation of complaints that staff could not resolve to the person in charge was evident as was the action taken in response by the person in charge.

Judgment: Compliant

Quality and safety

Because this centre was effectively and consistently governed and governance focussed on each resident, their needs and changes in these needs, the inspector found that residents were in receipt of an individualised, safe, quality service. The inspector did find however, that improvement in the systems for identifying and progressing residents individual goals and objectives was required; this was required to assure that each resident with due regard to their disability and ability was adequately supported to maximise their potential.

The care and support provided was informed by the assessment of residents needs and the plan that was made based on the assessment findings. Based on the plans reviewed it was evident that residents needs were consistently monitored by staff and the person in charge and the plan was updated as necessary in response to changing needs. In addition the plan, its effectiveness and any changes required was the subject of review by the multi-disciplinary team (MDT). The plans seen were detailed and individualised to each resident and their needs, requirements, wishes and preferences. Records of clinical reviews reflected clinician satisfaction in relation to resident well-being and general progress; this provided assurance that the plan guided daily practice and was effective in promoting positive outcomes with and for residents.

Residents did at times experience deteriorating health and illness. The inspector found that staff monitored residents and sought timely medical advice and review. Residents were also supported to access other healthcare services and professionals as needed and recommendations made were incorporated into the plan and into practice, for example specific dietary requirements. The person in charge had ready knowledge of each resident's eligibility and access to national screening programmes and of challenges that had arisen, such as individual resident understanding and coping skills that required further clinical decision making.

Resident well-being and safety was further promoted by safe medicines management practice. The provider had developed and delivered to staff an enhanced programme of medicines management training. The person in charge reported that the training and the learning gained from it had been well received by staff. The person in charge monitored medicine management practice including the use of any PRN (as required) medicines and any medicines related incidents on a quarterly basis.

Based on the assessed needs of residents the inspector reviewed a purposeful sample of risk assessments to establish that risk was managed so as to promote resident safety. The inspector found that risk, its assessment and management was regularly reviewed as were risk control measures. For example risk was re-evaluated following a change in needs or following an incident. Controls implemented to control the risk were reasonable and proportionate and consideration was given to any adverse impact they may have on a resident.

For example residents did at times exhibit behaviours of concern and risk to themselves and others. The support provided to them was informed by access to psychiatry and behaviour support but also by the risk assessments referenced above. There was evidence of review of behaviour management guidelines, associated risk assessments and of learning post behaviour related incidents.

The provider had measures for protecting residents from harm and abuse. These measures included policies and procedures, training for staff, the management and oversight provided on a daily basis and access to the designated safeguarding officer. There were times when resident's needs were not compatible and this had created risk and at times compromised the quality and safety of the service experienced by residents. This was recognised and managed; its management including working with residents in a positive as opposed to punitive way to understand their own behaviours, the impact on others and the importance of respecting each person's personal space and boundaries. However, at verbal feedback of the inspection findings it was communicated that the provider could optimise the opportunity presented by plans for the reconfiguration of the service to consider where residents lived and who they lived with.

The provider promoted the general welfare and development of residents. Residents spoken with conveyed overall satisfaction with their life in the centre. Residents attended a day service; residents confirmed that they enjoyed local amenities, attended mass if they wished, had ongoing contact with family and peers including telephone contact. Residents and their representatives were consulted with and participated in decisions about their support and care. Three residents had enjoyed a holiday abroad supported by the person in charge. However, residents also spoke about what they did not like as much or more correctly what it was that they hoped and wanted for themselves such as where they lived, who they lived with and a desire for increased independence. These hopes and wishes were to a degree reflected in resident's personal plans. However, based on the records seen and the feedback received from residents improvement was required to ensure that the resident and their objectives drove this process rather than the process and the resources available. This was required to ensure that that the personal planning process was truly individualised, reflected the nature and extent of resident's needs, abilities and wishes and so maximised individual potential and opportunities so that residents enjoyed as fulfilling a life as was reasonably possible.

Previous inspections and internal reviews on behalf of the provider had identified that the provider needed to develop and improve its fire safety management systems. The provider had submitted a plan to HIQA for these works. The inspector saw that the provider had completed the first phase of these works and had

installed emergency lighting, fire detection systems and a priority fire resistant door-set to protect one escape route. However, the provider advised that there was an anticipated delay to the completion of the remaining works including works for containing smoke and fire and protecting escape routes.

The inspector found that the existing fire safety systems had been inspected and tested; staff also completed visual checks of these and tested the fire detection system on a weekly basis. All staff had completed fire safety training, the majority in 2018 or to date in 2019. Monthly simulated evacuation drills were completed; the drills were convened to simulate day and night conditions; based on the records seen all residents participated and good evacuation times were achieved.

Regulation 13: General welfare and development

Residents presented with a broad range of needs in the context of their disability but also other factors such as their age and individual interests. Improvement was required to ensure and assure that individual potential, capacity and residents' wishes were maximised and to identify what supports needed to be put in place to ensure that each resident was adequately supported to maximise their personal development.

Judgment: Substantially compliant

Regulation 17: Premises

The inspector noted that some areas of the premises and some fittings were in need of redecoration and replacement.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had arrangements for responding to situations where resident or staff safety may have been compromised. These arrangements included the plans for responding to emergencies, the ongoing review of risk and its management and the investigation of and learning from incidents involving residents.

Judgment: Compliant

Regulation 28: Fire precautions

There were outstanding fire safety works; these works were required to contain smoke and fire and to protect escape routes.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had measures that ensured that residents were protected by safe medicines management. Staff attended training and maintained records to account for the management of medicines such as their receipt from and return to the pharmacist and their administration. Medicines management practice was the subject of regular audit.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which detailed their needs and preferences and outlined the supports required to maximise their well-being and quality of life. The plan was developed and reviewed in consultation with the resident and if appropriate their representative. The plan was kept under review.

Judgment: Compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. The provider had responsive arrangements to ensure that each resident has access to the range of healthcare services that they required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of a positive approach to the management of behaviour and plans that detailed how preventative and responsive therapeutic interventions were implemented.

There was policy, procedure and oversight of the use of restrictive practices. Residents however enjoyed routines and an environment free of unnecessary restrictions.

Judgment: Compliant

Regulation 8: Protection

The provider had effective procedures for ensuring that residents were protected from all forms of abuse. These procedures including working with residents to develop both their self-awareness and the social skills required for shared living.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Newcastle West Community Residential Houses OSV-0004783

Inspection ID: MON-0025867

Date of inspection: 12/03/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Regulation 13: General Welfare and Development; To ensure the Registered Provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the person's disability and assessed needs and his or her wishes; • The individual goals and objectives of each resident shall be identified and progressed. Measures are being put in place to progress individual goals and objectives and provide adequate support to maximize potential for residents. • One resident is on the Council waiting list for accommodation which would provide independent living. The person in Charge has contacted a Housing Association and County Council to clarify the resident's position on the waiting list. • Another resident has been referred to Social Work for support in maximizing her independence. • Both residents are completing priorities which will improve their independent skills. • PCP plans and priorities for both residents have been reviewed to ensure priorities include the expressed wishes of the residents. • An upcoming MDT will optimize the opportunity presented by plans for the reconfiguration of the service to ensure individual independence and compatibility with other residents. 13(c) Supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes. • Opportunities are in place for residents to maintain their personal relationship should they wish to do so. Staff will continue to arrange meetings between residents and their chosen peers.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

Regulation 17 (b) To ensure the premises of the Designated Centre is of sound construction and kept in a good state of repair externally and internally;

• A new bathroom unit was installed on the 16/03/2019.

17 (c) To ensure the premises of the Designated Centre is clean and suitably decorated;

• Painting of one residential house will be completed by 30/09/19

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: In regards to Regulation 28(1) The Registered Provider shall ensure that effective fire safety management systems are in place;

• In addressing Condition 8, Phase 1 of fire safety upgrades was completed. Emergency lighting and automated fire detection systems were installed in both houses by the 30th July 2017. A fire door was also fitted between the utility room and the hallway that is an escape route in one house.
• In both houses, there is a Fire Register and there are a number of daily, weekly, monthly, quarterly and annual inspections/tests of the Fire System, which are carried out by staff and specialists in the area of fire alarm systems. Person's supported by the service take part in regular fire drills in the Designated Centre.

In regards to Regulation 28(3) The Registered provider shall make adequate arrangements for;
(c)Detecting, containing and extinguishing fires;

This designated centre comprises of 2 houses: -

House 1
• L1 and Emergency lighting have been installed in both houses and certified by a Fire Safety Engineer.
• A comprehensive programme of fire safety measures are in place in the Designated Centre and these will continue to be implemented as mitigations to the fire safety risk
• Alternative property has been sourced with support from City and County Council.
• Design and Tender process completed.
• Builder appointed and works have commenced.
• Works will be completed by 31st October 2019.
• New House will be registered with HIQA and will replace house 1.
• Application to Vary will be completed once registration on alternative property is complete

House 2
• L1 and Emergency lighting have been installed in both houses and certified by a Fire Safety Engineer.
• This house will be included in HSE Process re fire safety as outlined in the plan submitted to HIQA on 12th April 2019.

• An "Application for the variation or removal of a condition" was submitted to HIQA in February 2019 with respect to Condition 8 and requested in the absence of containment, to operate in the current location until 31st March 2020.
• A comprehensive programme of fire safety measures are in place in the Designated Centre and these will continue to be implemented as mitigations to the fire safety risk.

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Substantially Compliant	Yellow	30/09/2019
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	30/09/2019
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/03/2020