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:	The Court - Kingsriver
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	21 April 2022
Centre ID:	OSV-0007915
Fieldwork ID:	MON-0031952

About the designated centre

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

The Court - Kingsriver is a designated centre operated by Kingsriver Community Holdings CLG. The designated centre provides a community residential service for up to nine adults with a disability. The centre comprises of three houses within a close proximity to each other in an urban area in County Kilkenny. Each house comprises of a sitting room, dining area, kitchen, bathrooms and individual resident bedrooms. The designated centre is staffed by team leaders, social care workers and health care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	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 (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
Thursday 21 April 2022	10:00hrs to 15:30hrs	Conan O'Hara	Lead
Thursday 21 April 2022	09:00hrs to 15:30hrs	Conor Brady	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic. As such, the inspectors followed all public health guidance and HIQA's enhanced COVID-19 inspection methodology at all times. The inspectors ensured physical distancing measures and the use of appropriate personal protective equipment (PPE) during all interactions with the residents, staff team and management over the course of this inspection.

The purpose of this inspection was to review actions taken by the provider to address the significant findings of non-compliance identified in the two previous inspections undertaken in December 2021 and January 2022.

Following the December 2021 inspection, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of the centre due to an absence of safe quality services being provided in this designated centre. Kingsriver Community Holdings CLG submitted formal representation to the Chief Inspector outlining their proposed actions to improve the standards of care and support in the centre and come into compliance with the Health Act. This short-term announced inspection was completed to provide assurance that safe and quality care was now being provided to residents in this centre and that the provider was completing actions as set out in their representation.

On the day of the inspection, the inspectors visited the provider's main office and two of the three premises that comprised this designated centre in Co. Kilkenny. Inspectors spoke with residents, members of the staff team and members of the management team as part of this inspection. It was evident that the provider had taken a number of steps to improve their services. For example, the provider had completed a detailed review of the organisation's resources, staffing arrangements and the assessed needs of residents. Since the January 2022 inspection, the provider had successfully recruited a Chief Operations Officer, increased oversight arrangements were in place and a strategic plan for the organisation had been developed.

The strategic plan outlined the organisation's plans to come into compliance. The inspectors were informed that a central aspect of the strategic plan was the reopening of the provider's second centre. The second centre was previously home for some residents and was vacated to allow for extensive renovation works. The provider planned to support five residents to transition back to the second centre and reduce the capacity and footprint of this centre. The completion date of the works was estimated to be late May 2022.

While there were clear plans in place and evidence of actions achieved to address areas for improvement and come back into compliance with the regulations, the inspectors found that there remained a significant level of non-compliance in the centre. Further improvements were required to ensure the provision of a safe and

quality service to the residents in this centre.

The inspectors met four of the eight residents present in the centre, albeit this time was limited. All residents expressed their views verbally to inspectors. The residents spoken with outlined that transitions had been discussed with them and there was evidence of transition plans being developed. Residents noted that they were happy with the plans. Some residents spoken with expressed that they were happy with the changes while other were critical of some of the changes and the timelines. One resident requested notice before HIQA inspectors visited their home in future stating that she not like unannounced visits.

Of the staff spoken with, they highlighted that the improvements since December 2021 were very welcome and cited the introduction of the on-call system, changes in the local and senior management team, increased oversight and support arrangements and additional staffing as having a positive impact. The staff team spoken with noted the positive impact that the proposed transition plans would have on the quality and care of the support provided.

In summary, inspectors noted that there was improvements in the governance and oversight of the centre and clear plans were in place to come into compliance with the regulations. The provider had completed a number of actions in order to stabilise the service and completed a number of detailed audits which informed the provider's strategy. However, based on what the residents communicated with the inspectors and what was observed, it was evident that there continued to be areas of non-compliance in the service. There were poor findings in relation to practices for safeguarding residents' finances, governance and management, staffing arrangements and staff training.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, this inspection found that the registered provider had implemented the actions as set out in their representation response to the Chief Inspector. While, there remained high levels of non-compliance in the centre which negatively impacted on the care and support provided, clear plans were in place to address same. The inspectors found that further improvements were required to ensure the provision of a safe and quality service to residents in this centre in the areas of governance and management, resources, staffing arrangements and staff training and development.

Since the last inspection, there had been changes made to the management team to ensure clear lines of accountability when managing this centre. A new Chief Operations Officer (COO) had been recruited to oversee the day-to-day operations

of the centre and ensure cohesive organisational, strategic and operational objectives. As noted, the service had developed a clear strategic plan which included the reconfiguration of this centre to remove one unit and reduce the capacity of the centre to four residents. Five residents would be supported to transition to the provider's second centre which was being renovated at the time of the inspection.

At the time of the last inspection, the provider had completed an audit of a number of aspects of the service and action plans were developed. From a review of the actions taken the provider was in the process of addressing the key areas identified. In addition, the inspectors were shown a schedule of audits for the year and there was a clear schedule in place for regular staff meetings and governance meetings between the board and the senior management team. The new COO had clear governance arrangements in place and was overseeing a number of change management initiatives. Improved auditing and oversight, more robust system checks and monthly reporting to the Board were all features of the new governance regime.

The inspectors reviewed a sample of rosters which demonstrated that the provider had stabilised the consistency of staffing and identified core staff teams to work in particular locations. However, the registered provider had completed an assessment of staffing requirements for this centre based on residents' assessed needs as part of their service audits and identified this as a key area for improvement for the delivery of safe, quality and sustainable residential care into the future. The inspectors reviewed a formal application for funding submitted by the provider to their funder (the HSE). At the time of the inspection, the provider was expecting a response and sanction within 2 weeks. This is a key and critical component in order for this service to move forward in the provision of safe and quality services.

Regulation 15: Staffing

There was a planned and actual roster. From a review of the roster, it was demonstrable that the consistency of staff had stabilised in the units. However, the provider had completed a detailed review of staffing arrangements and identified the need for increased staffing resources in order to safely meet the assessed needs of the residents. These staffing ratios were not yet funded nor in place. The provider had submitted a business case to their funder and at the time of the inspection, the provider was expecting a response.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The

inspectors reviewed a sample of staff training and found that staff were being supported to access refresher training. However, there remained gaps in mandatory training for the staff team. This meant that not all of the staff team had the up-to-date knowledge and skills to support the residents with their assessed needs. The provider had self-identified this as an area for improvement through an audit and was in the process of addressing same.

There was a supervision system in place and all staff engaged in formal supervision. The inspectors reviewed a supervision schedule and a sample of completed supervisions. However, this was in the early stages of being implemented and required full roll out across all staff teams.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, there was now a sustainable governance and management system in place. Since the last inspection, the provider had appointed of Chief Operations Officer (COO) who was now in place. The inspectors found that there was a defined management structure in place. The team leaders in each unit reported to person in charge, who in turn reported to COO. The COO reported to the Board.

The provider had developed a clear strategic plan to come back into compliance with the requirements of the Health Act . There was evidence of actions completed to date and future plans for reconfiguration of the service. In addition, inspectors reviewed schedules in place for future audit and meetings at local and senior level including reporting to the board.

However, at the time of the inspection, the need to improve the effectiveness of the oversight systems remained. For example, the inspectors reviewed a sample of residents' finances and found that the practices in place to safeguard residents' finances required significant improvement. In addition, many of the new governance systems were newly implemented or awaiting implementation.

Judgment: Not compliant

Regulation 4: Written policies and procedures

During the course of the inspection, the inspectors reviewed two policies and found that some organisational policies required significant review in order to appropriately guide the staff team practices. For example, the residents' finances policy did not guide the staff team in the day-to-day financial practices when supporting residents with their finances. Parts of the infection control policy reviewed was not

organisation specific to appropriately guide the staff teams practice.

Judgment: Not compliant

Quality and safety

On this inspection, inspectors found that while the provider had identified and were actively working to address areas of non-compliance, there continued to remain areas for significant improvement including the premises and improving some safeguarding arrangements and reporting systems. Whilst there was a clear plan to address these areas and the provider was in a demonstrable much better position than they were previously - the outstanding areas were found to be both necessary and crucial in terms of the ongoing safe and quality service delivery to residents.

While it was evident that the provider was attempting to improve the quality and safety of the service, there continued to be non-compliance in meeting the assessed support and care needs of residents.

The inspectors found that there were some improvements in the systems in place to protect residents. For example, additional staffing had been put in place in one unit and safeguarding plans were in place to manage identified safeguarding concerns. However, there remained concerns on the compatibility of a resident group in one unit of this centre based on the behaviours displayed and the impact of these behaviours on peers. In addition, the inspectors reviewed a sample of residents' finances and found that the system to safeguarding residents' finances required significant improvement.

Regulation 17: Premises

The premises was found to be decorated in homely manner. However, one resident bedroom was a conservatory/sun room and this resident required a transition to suitable accommodation. This was identified in the last inspection. The inspectors discussed the bedroom with the resident and additional heaters were put in place if needed. The resident outlined plans to move to another bedroom in May 2022 when the planned centre reconfiguration occurred and noted that they were happy with this proposal and the interim arrangements in place.

Judgment: Not compliant

Regulation 8: Protection

The inspectors found that the systems in place to safeguard residents finances required significant review. The policy guiding staff practices required review as it did not appropriately guide staff in the day-to-day practices to safeguard residents finances. The inspectors found that the provider did not have appropriate oversight of some resident's finances. In addition, while there were plans for reconfiguring the service and supporting residents to transfer to more appropriate placements, at the time of the inspection there remained concerns on the compatibility of the resident group in one unit in this centre.
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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Court - Kingsriver OSV-0007915

Inspection ID: MON-0031952

Date of inspection: 21/04/2022

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A meeting took place on the 18.05.2022 with the funder to discuss staffing requirements and the need to have these in place to ensure a safe quality service. • The funder has committed to continuing to engage with the organisation to ensure a positive outcome is reached. • Following this meeting, revised submissions were sent to the funder on 25.05.2022. In addition, a separate submission was made at the request of the funder in relation to night duty in the Centre. This was submitted to the funder on 20.05.2022. • The Centre continues to ensure there is consistent staffing in place to ensure the needs of the residents are being met in line with their wishes and preferences. • The Centre has its own core relief staff who have been fully inducted into the residents in the Centre.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A review has taken place by the COO in relation to the training of staff in the Centre. • All staff have been scheduled to complete mandatory training by 31.08.2022 • There is now a system in place to ensure staff are scheduled for refresher training before their training date expires. • All staff have been scheduled to receive formal supervision by 15.06.2022.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A review has taken place in relation to the oversight of resident's finances.
• A more robust system has been implemented to ensure all residents are supported to manage their finances and to ensure all financial transactions are recorded.
• Residents who do not have a bank account will be supported to open their own.
• Since the inspection, 1 resident has successfully opened their own bank account and is being supported by staff with money management skills.
• An audit of finances now takes place weekly by the PIC and findings are reported to the COO.
• The Audit schedule is in place and is working effectively, any findings from the audits continue to be reported to the COO.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The COO is currently reviewing the Finance Policy for the organisation to ensure it includes a clear guide is in place to guide staff practice. This will be updated by 30.06.2022.
• The Infection prevention and Control Policy is currently under review by the COO, this will be updated to ensure that it is Organisational specific to guide staff in their practice. This will be completed by 30.06.2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A transition plan is in place for the resident to move to more suitable accommodation when refurbishments have been completed.
• This Centre will be reconfigured to accommodate residents with additional space and more suitable bedrooms.

• The resident has been supported to make his temporary room suitable by staff. • The resident will have completed his move to a more suitable bedroom by 30.06.2022.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • The COO is currently reviewing the Finance Policy for the organisation to ensure it includes a clear guide is in place to guide staff practice. This will be updated by 30.06.2022. • A review has taken place in relation to the oversight of resident's finances. • A more robust system has been implemented to ensure all residents are supported to manage their finances and to ensure all financial transactions are recorded. • Residents who do not have a bank account will be supported to open their own. • An audit of finances now takes place weekly by the PIC and findings are reported to the COO. • Transition plans are ongoing for residents to return to their newly refurbished house, this will enable the reconfiguration of this Centre to accommodate residents with additional space and more suitable bedrooms and address the compatibility of the resident group. This will be completed by 30.06.2022.	

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.	Not Compliant	Orange	31/08/2022
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	31/08/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/06/2022

Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/06/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/08/2022
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	30/06/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3	Not Compliant	Orange	30/06/2022

	years and, where necessary, review and update them in accordance with best practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/06/2022