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:	Carrowkeel Lodge
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	10 May 2022
Centre ID:	OSV-0008110
Fieldwork ID:	MON-0034689

About the designated centre

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

Carrowkeel provided full-time care and support to up to four residents with an intellectual disability and sensory impairments. The house was a large four bedroom bungalow and had ample communal areas for residents to enjoy including; a large living room, kitchen and dining area and a room that was used for visitors and doing activities. Each resident had their own bedroom and there were level access shower rooms available. There was a large garden area surrounding the house, and the exit points had ramps and handrails available for ease of access and exit. The house was located in the countryside and there was a large town nearby. The centre had transport available to support residents to access community activities in line with their individual needs and preferences. The staffing arrangements consisted of a skill mix of nursing staff and healthcare assistants. Waking night cover was provided by a nurse and healthcare assistant each night to support residents with their needs.

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 (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
Tuesday 10 May 2022	10:35hrs to 17:00hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was the first inspection of the centre since it's registration in October 2021. There were four residents living in Carrowkeel at the time of inspection. All residents had lived together previously in a congregated setting and had moved to Carrowkeel in November 2021. The inspector found that residents were supported with the transition to their new home, and were provided with a comfortable and spacious house that met their individual needs.

Carrowkeel was a large bungalow located in the countryside and in short driving distance to some towns. There was transport available for residents to access their local community in line with their wishes and preferences. The house was found to be clean, comfortable and spacious for the needs of the residents.

On arrival to the centre, the inspector met with two staff members and two residents. One resident was reported to be having a lie-in and another resident was attending a healthcare appointment with support staff. The inspector got the opportunity to meet and speak with all residents and staff throughout the day. Residents did not communicate verbally, but acknowledged and greeted the inspector in their own way. They were observed to be comfortable and relaxed in their environment and with staff.

Residents were observed listening to music, getting their hair and nails done, and receiving hand and foot massages throughout the day. They appeared to be relaxed and comfortable in their surroundings. Two residents went out for their tea later in the day, which was something that residents reportedly enjoyed doing.

The house was nicely decorated with soft furnishings, photographs and personal belongings, which created a warm and homely atmosphere. Residents had televisions in their bedrooms and access to DVDs, games and table top activities in the centre. There was a 'smart television' in the main living area which had music playing throughout the day. Some residents were reported to enjoy music and one resident had their own 'boombox' which they could play music through.

Residents were reported to have settled well into their new home in general, and where difficulties were experienced, there was evidence that appropriate supports were provided. Residents were reported to enjoy their new community and some residents attended weekly horse riding sessions and sensory classes in a nearby town. A review of documentation and discussions with staff showed that residents enjoyed a variety of activities in Carrowkeel; such as going for walks, day trips, having meals out, attending the local church and there were photographs of residents' achievements of personal goals such as visiting pet farms, going on shopping trips and going to visit the local seaweed baths.

Overall, residents were observed to be comfortable and content in their home and staff were observed to be treating residents with dignity and respect. The following

sections of the report outline the management arrangements and how this impacts on the quality and safety of care.

Capacity and capability

Overall, the inspector found that residents were provided with a safe and comfortable home that met their care and support needs. There was a good management structure in place with clear lines of responsibility and accountability. However, some improvements were required to ensure full compliance with the regulations. Areas requiring improvements included; staff training, the ongoing oversight and monitoring of systems, fire safety, care plans and in the submission of notifications to the Chief Inspector of Social Services.

The local governance structure consisted of a person in charge who worked full-time and who had responsibility for one other designated centre located nearby. The person in charge had the experience and qualifications to manage the service and they appeared to be very knowledgeable about the individual needs of residents. The person in charge was supported by a Director of Nursing (DON) and Assistant Director of Nursing (ADON) who had responsibility for a number of designated centres in their area.

The staff team consisted of a skill mix of nursing staff and healthcare assistants, who provided cover both day and night to support residents. A review of the roster indicated that in general there was a consistent staff team in place to support residents. A number of staff had worked with the residents in their previous home and were very familiar to residents. This helped to ensure consistent care and support, which was reported to be very important to residents. There was a planned and actual roster in place which was well maintained and clearly outlined who was working each day.

A review of the staff training records found that improvements were required in this area. Some staff were overdue refresher training in manual handling and behaviour management. In addition, there were some gaps in the training records maintained for staff working in the centre, which made it difficult to verify that all staff had completed all of the mandatory training programmes. The person in charge endeavoured to gather various training records throughout the day, and most were then found to have been completed, however there remained some gaps.

The person in charge had developed a schedule to complete supervision meetings with staff. A sample of records reviewed demonstrated that this had occurred with some staff, with dates planned for the remaining meetings to be completed. Team meetings were occurring regularly. They covered a varied range of agenda items, some of which included; safeguarding, incidents, residents' needs, infection prevention and control and maintenance issues. Staff spoken with said they felt well supported in their role and that they could raise any issue of concern to the

management team, if required.

The person in charge had developed an annual schedule for a range of local audits to be completed. This included audits in health and safety, finances, medication, personal plans, restrictive practices, incidents and fire safety checks. However, improvements were required to ensure more effective monitoring and oversight and in identifying actions required for regulatory compliance and to improve the quality and safety. For example; the local audits failed to identify that some quarterly notifications had not been submitted as required to the Chief Inspector. In addition, the oversight arrangements did not identify that there were gaps in the recording system in place to indicate that a daily physiotherapy programme required for a resident who had specific healthcare risks was being completed. The person in charge devised a new template for the daily recording of this, which was available for review by the inspector by the end of inspection.

The provider had recently completed the first unannounced six monthly audit of the centre. While the report covered many areas, it failed to identify specific actions for improvement in the centre and to ensure regulatory compliance; including the failure to submit some notifications as required in the regulations. In addition, while a review of fire safety and fire drills was completed, it failed to identify that a fire drill under the scenario of when all residents would be in bed had not been completed ,and that personal emergency evacuation plans (PEEPS) did not ensure a safe evacuation of all residents to a place of safety at night time.

In summary, the inspector found that there were arrangements for auditing and reviewing systems to promote a quality and safe service. However, improvements were required in the oversight and monitoring of the centre on an ongoing basis to ensure that full compliance with the regulations was achieved and that actions for improvement were identified. Improvements in this would enhance the good care and support provided to residents.

Regulation 14: Persons in charge

The person in charge had the experience and qualifications to manage the designated centre. They were knowledgeable about residents' care and support needs.

Judgment: Compliant

Regulation 15: Staffing

There were the appropriate numbers and skill mix of staff to meet the needs of residents. An actual and planned roster, which was well maintained, was available

for review.

Judgment: Compliant

Regulation 16: Training and staff development

There were gaps in the staff training documentation held in the centre, which made it difficult to verify if all staff had received the mandatory training programmes. In addition, refresher training in behaviour management and manual handling were overdue for some staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements were required in the ongoing oversight and monitoring of the centre to ensure that the auditing systems in place effectively identified areas for improvement to ensure the health and safety of residents at all times.

Provider and local audits failed to identify that some notifications had not been submitted to the Chief Inspector, that a fire drill under the scenario of when all residents were in bed had not been completed, and that a daily physiotherapy programme for one resident due to healthcare risks was not marked as completed on several days over the last few months.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents had written contracts for the provision of services, which included details of the services to be provided and fees to be charged, as appropriate.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge did not ensure that some quarterly notifications were

submitted to the Chief Inspector in line with the regulations.

Judgment: Not compliant

Quality and safety

The inspector found that residents were provided with person-centred care and support and that their health and wellbeing were promoted. However, improvements were required in ensuring that care plans included consistent information and that guidelines for staff to carry out a recommended daily physiotherapy programme were in place. In addition, improvements were required to ensure residents could be evacuated in the event of a fire at night time. Improvements in these areas would further enhance the quality of care and support provided.

The premises was found to be spacious, clean and homely. Each resident had their own bedroom which were personalised to their individual tastes. There was a level access communal shower room and overhead hoist track systems available in bedrooms which would support residents in the future should their mobility needs change. There were adequate communal areas for residents to enjoy; including a large living room which had a smart television, large kitchen and dining area and a communal room used for visiting and doing activities. Laundry facilities were available in the utility area and there was ample space for storage throughout the house. There was a large garden area surrounding the house, with ramps and handrails available from the exit doors. The back garden contained garden furniture for residents to sit and enjoy the outdoors should they wish to do so.

A sample of residents' care and support plans were reviewed. Residents were supported to identify goals for the future and there was evidence that these were under review for completion, and there were photographs in residents' personal folders of completion of some goals. Some future goals identified by residents included pet therapy sessions, and this was noted to be in progress for completion.

Assessment of needs had been completed to assess residents' personal, health and social care needs. A range of care and support plans had been developed to guide staff in supporting residents with various needs. However, gaps were identified in one resident's care plan whereby guidance for a specific aspect of daily support as recommended by a member of the multidisciplinary team was missing. In addition, there was inconsistent information detailed about fluid intake requirements. The person in charge was working on getting this addressed as soon as it was brought to their attention.

Residents were supported to achieve the best possible health and wellbeing at this time. Residents had been supported to access allied healthcare professionals in their local community since their move to the centre, and this was reported to be going well. On the day of inspection one resident was facilitated to attend an appointment

to support them with a particular need. Staff spoken with were knowledgeable about how to best support residents with their needs, and where residents required multidisciplinary input, there was evidence that this was available to them. For example; the inspector was informed that some care plans were under review by the relevant members of the multidisciplinary team at present, and that the speech and language therapist had updated 'safe swallowing plans', and was due to attend the centre in the coming weeks to review and update all residents' 'communication passports'.

There was risk management policy in place, and the risk management procedures had been implemented by the person in charge. There were a range of emergency plans in place in the event of adverse events, and a site specific safety statement. The person in charge had in place a risk register for centre specific risks. A sample of risk assessments were reviewed and were found to be up-to-date and provided clear information about what control measures were in place to mitigate risks.

The provider ensured that there were systems in place for infection prevention and control (IPC), including supplies of personal protective equipment (PPE), availability of hand gels and discussions at team meetings about IPC and COVID-19. Regular IPC audits occurred, and the person in charge ensured that HIQA's self-assessment tool for COVID-19 was completed and kept under regular review. There was a centre specific contingency plan in place in the event of COVID-19 and there was evidence that regular communication and guidance was provided to the centre during a recent COVID-19 outbreak.

Fire safety arrangements were reviewed. The provider ensured that there were arrangements for the detection, containment and extinguishing of fires. Regular checks were occurring on fire safety equipment, however the quarterly inspection of the fire alarm panel was overdue. The person in charge explained that this had not occurred at the time due to a COVID-19 outbreak in the centre, and they agreed to follow up to get this completed as soon as possible. Regular fire drills occurred which included minimum staffing levels. However, a fire drill under the scenario of when all residents would be in bed had not been completed since the move to the centre. Furthermore, the personal emergency evacuation plans (PEEP) for residents at night time stated to leave residents in their bedrooms with staff if there was a fire in the hallway. When this was discussed with the person in charge, they organised for a simulated fire drill to occur on the day of inspection which demonstrated that residents could be safely evacuated at night-time, based on a risk of fire in that zone. The person in charge undertook to update all residents' PEEPs to reflect the changes to ensure a safe evacuation from the centre.

Overall, the inspector found that residents had a comfortable home that met their needs. Improvements in fire safety and in ensuring that care plans are accurately recorded, accessible to staff and effectively monitored would further enhance the good care and support provided.

Regulation 17: Premises

The premises was designed and laid out to meet the numbers and needs of residents. The house was accessible and residents who required aids and appliances had these in place. Each resident had their own bedroom and there was ample storage space in the centre. In addition, there was suitable laundry facilities for residents to launder their clothes.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had implemented a risk management process for the identification, assessment and review of risks in the centre. Emergency plans were in place to provide guidance about what to do under a number of possible adverse events.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had systems in place for infection prevention and control (IPC) including; the availability of personal protective equipment (PPE) regular auditing of IPC measures, the completion of self-assessment tools on IPC, discussion at team meetings, staff training and a communication pathway for issues relating to IPC.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for the detection, containment and extinguishing of fires. However, improvements were needed in ensuring that residents could be safely evacuated to a place of safety at night time, and that PEEPs were reviewed and updated to include arrangements for safe evacuation. In addition, the fire alarm panel was overdue it's quarterly inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Assessments of needs were completed for residents with regard to health, personal and social care needs. Care plans were developed as required to provide guidance to staff on how to support residents with their specific needs.

However, in one resident's care plan, there was inconsistent information about what was the recommended fluid intake and a recommended daily physiotherapy programme to minimise a healthcare risk was missing and not available for review. While the person in charge verbally assured the inspector that all staff were familiar and aware to completed this physiotherapy programme, this gap in documentation could create a risk that the resident would not be supported in line with their assessed needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were facilitated to access and attend a range of allied healthcare professional appointments as required. In addition, residents had access to multidisciplinary supports, as required, to support with achieving the best possible health and wellbeing.

Judgment: Compliant

Regulation 8: Protection

Residents were safeguarded through regular reviews of incidents, staff training, regular discussion about safeguarding at team meetings and each resident had comprehensive personal and intimate care plans in place. There were no safeguarding concerns at the time of 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 (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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Carrowkeel Lodge OSV-0008110

Inspection ID: MON-0034689

Date of inspection: 10/05/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge has ensured that all existing staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. • The Person in Charge has a scheduled for all staff to attend both Positive Behavioral Support Training and Manual handling, agreed dates, 14tth and 30th June and July 5th. • The Centre has a training matrix in place to assist with the monitoring and recording the training needs for all staff within the Designated Centre. This Training Matrix is reviewed monthly by the Person in Charge.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Registered Provider has reviewed the management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, and is consistent and effectively monitored. • The Person in Charge has reviewed all Audits and reviews are now completed on a monthly basis within the Designated Centre. • The Person in Charge will ensure that all Notifications are submitted within the timeframe of the regulation. This has been discussed and shared with all Persons in Charge, and a memo of reminder for Quarterly Notifications will be sent by the Director	

of Nursing to all Persons in Charge.
• The Person in Charge has completed a simulated fire drill when all residents were in bed. This is documented in the Centre's fire book in line with regulation.

• The Person in Charge has completed a review of all care plans within the Centre. As part of this review all health care risks for residents have been reviewed and update to reflect each residents current position. There is now a robust system in place for the ongoing review monitoring and over sight of care plans in line with the Centre's audit schedule.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Person in charge will ensure all notifications, including quarterly notifications are submitted within the correct timeframe to the Chief Inspector and in line with regulation
• The Person in Charge will ensure that all Notifications are submitted within the timeframe of the regulation. This has been discussed and shared with all Persons in Charge, and a memo of reminder for Quarterly Notifications will be sent by the Director of Nursing to all Persons in Charge.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Person in Charge has completed a simulated fire drill when all residents are in bed with minimum staff on duty. This is documented in Centre's fire book in line with regulation.
• The registered provider has made adequate arrangements by carrying out an assimilation of a night time fire drill, with the least amount of staff to ensure the safe evacuation of all residents, in the event of a fire in the designated centre.
• The Person in Charge has updated all Personal Emergency Evacuation Plans for all residents within the Designated Centre.
• The Person in Charge has ensured the Quarterly inspection of all fire equipment is completed by the Fire Officer within the Designated Centre.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• The Person in Charge has completed a review of all care plans within the Centre. As part of this review all health care risks for residents have been reviewed and update to reflect each residents current position. There is now a robust system in place for the ongoing review monitoring and over sight of care plans in line with the Centre's audit schedule.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	04/07/2022
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.	Substantially Compliant	Yellow	13/05/2022
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	02/06/2022

Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	02/06/2022
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/07/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	13/05/2022