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

Name of designated centre:	Cairdeas Services Belmont
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Waterford
Type of inspection:	Announced
Date of inspection:	12 June 2018
Centre ID:	OSV-0005077
Fieldwork ID:	MON-0021949

About the designated centre

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

The statement of purpose details that the centre provides long-term care on a full time basis to 11 adult residents, both male and female with moderate to severe intellectual disability who require nursing interventions and have additional care needs including support with behaviours. The centre comprises two bungalows located on a site in proximity to the local communities and amenities. They have good access to local services and amenities and the premises are suitable in lay out and facilities to meet the current and changing needs of the residents. There are a number of day services attached to the centre, which offer a variety of programmes suitable for the residents and pertinent to their age and needs.

The following information outlines some additional data on this centre.

Current registration end date:	04/10/2021
Number of residents on the date of inspection:	11

How we inspect

To prepare for this inspection the inspector or 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 June 2018	09:30hrs to 19:30hrs	Noelene Dowling	Lead

Views of people who use the service

The inspectors met with four of the residents who communicated in their preferred manner and allowed the inspector to observe some of their daily lives in the centre.

Staff had completed questionnaires on resident's behalf, which indicated overall satisfaction with the care provided. From observation, the residents appeared comfortable in the staff presence and were going about their routines easily with good support evident.

Capacity and capability

While the centre was well managed overall and residents healthcare and social care needs were well supported there were some improvements required to ensure that residents' needs were met on a consistent basis. Improvements were required in the systems in place to monitor the safety and quality of care and also to ensure effective and responsive management systems having regard to the complexity of the assessed needs of the residents.

These primarily related to the systems for monitoring episodes of behaviours that challenge, identifying safeguarding issues among peers in a timely manner and the compatibility of the different needs of the residents in the environment.
These factors impacted on the quality of life in the centre and are detailed in the quality and safety section of this report. The provider did not demonstrate good ability to manage these areas.

The provider had made arrangements to ensure key management positions were appropriately filled. There was a suitable management structure with roles and responsibilities defined. The person in charge was suitably qualified and experienced. However, there was lack of an adequate management response to some significant events which occurred in the centre. For example, oversight, reporting and response to incidents which occurred was not adequate.

The provider did not demonstrate the capacity to gather and use information to improve the service. It was apparent that the reporting systems in place were not being used effectively and auditing was not robust to provide oversight and inform changes to practice when needed. Concerns about the accuracy of the information collected was also noted. Inspectors found significant discrepancies between the data made available for review by senior managers or the various review

committees and that available in one unit.

Accurate details of incidents of behaviours that challenge or peer-to-peer incidents were not therefore reviewed to inform changes to practice or identify the level of incidents which were occurring.These factors may be influenced by the fact that the person in charge had been unable to use the protected time allocated to the role for some period and to staff shortages and changing behaviours.

These issues affected the quality improvement systems and ultimately the residents quality of life in the environment.

The required unannounced inspections had taken place although the quality of the reviews differed. The most recent visit did identify a number of the issues noted by this report. The annual review for 2017 had been prepared and included the views of the residents and their relatives, which were primarily positive. This review did require some improvements in detail to provide an analysis of the information available and a transparent review of the quality and safety of care. It was however in a format suitable for access by the residents. Additional safety spot checks by other managers were also undertaken and these detailed areas for improvement were identified. The actions from the previous inspection had also been addressed.

The skill mix and staffing levels were appropriate to the assessed needs for residents who required fulltime-nursing care and health care needs were very well identified and supported. The inspector saw that the provider was responsive to changing needs and additional staff had been allocated in some instances to provide one to one supports. This ensured the residents had the care and support needed.

A significant number of agency staff had been used for some months due to unavoidable shortages. From a review of incident reports and rosters, however, this of itself does not account for the discrepancies found in behaviour support systems, safeguarding and restrictive practices.

The records of the staff supervision which took place did not focus on staff performance and development, or residents care and development, which may also affect the findings of this report.There was some evidence on records that staff may not have been adhering to the residents' behaviour support plans but this was not addressed sufficiently.

There was a commitment to ongoing staff training evident and all mandatory training was completed with schedules for 2018 available. In addition to this non-nursing staff had range of qualifications with FETAC level five as the minimum entry requirements. Recruitment practices were safe and the required information was procured prior to the agency staff commencing.

From a review of the incident reports, it was evident that the person in charge was not consistently forwarding the required notifications to HIQA. This was of concern as it did not demonstrate that the provider has put adequate systems in place to

ensure that the regulator was informed of key required information.

The statement of purpose and all of the required documentation for the renewal of the registration had been forwarded in a timely manner. The service was operated in accordance with this statement.

The provider had some effective systems in place to listen to the voice of the residents. There was a satisfactory complaints system and procedure in place. Complaints were responded to, however, the documentation in place did not always demonstrate that complaints were satisfactorily addressed.

Registration Regulation 5: Application for registration or renewal of registration

The application was made as required.

Judgment: Compliant

Regulation 14: Persons in charge

The arrangements for the post of person in charge required review. The person in charge did not consistently have sufficient protected time to ensure there was adequate oversight of practices in the centre.

Judgment: Substantially compliant

Regulation 15: Staffing

Arrangements were in place to ensure that residents had the right levels of staff support.

Judgment: Compliant

Regulation 16: Training and staff development

While all the necessary staff training was undertaken staff were not supervised in a manner which ensured they could and did provide the supports needed for the residents.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents contained all of the required information.

Judgment: Compliant

Regulation 22: Insurance

The insurance was current and satisfactory.

Judgment: Compliant

Regulation 23: Governance and management

While there were clearly defined roles and lines of accountability for the service the management arrangements were not always effective and required review.

Systems for reporting,recognition of and responding to incidents which imparted on residents were not robust. Monitoring systems were not satisfactory.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose accurately describes the service to be provided.

Judgment: Compliant

Regulation 34: Complaints procedure

While complaints were dealt with the records seen of these did not demonstrate this satisfactorily.

Judgment: Substantially compliant

Quality and safety

In many areas residents were supported to enjoy a good quality of life. It was apparent that residents' complex age related healthcare, mental health and social care needs were identified and responded to promptly. However, significant areas for improvement and review were identified, particularly with regard to protection and positive behavioural support.

There was good access to multidisciplinary assessments, which were regularly reviewed. Clinical care needs were being met with suitable support plans implemented and amended as resident's needs changed. There was evidence of good communication with families and clinicians in regards to advanced care directives and decision-making. Ill residents were seen to be treated with kindness and care and their wishes for their daily lives and routines listened to and responded to.

Staff also helped the residents to undertake any interventions such as physiotherapy or exercise programmes prescribed to maintain their health and access to activities.

They had good access to speech and language, occupational therapy, neurology and dentistry. Dietary needs, and preferences were well known by staff and these were

seen to be adhered to.Systems for managing residents medicines were good overall but in one instance it was not clear as to why a sedative medicine had been issued.

There was however, a lack of a cohesive approach found in relation to the management and review of complex behaviours that challenge, the use of internal safeguarding protocols and some restrictive practices.

There was evidence that behaviours that challenge were occurring frequently. On occasion, these involved a degree of harm or upset directly to other residents or indirectly via noise and disturbance. There was evidence of frequent multidisciplinary review and behaviour support plans in place. However, it was apparent from the records reviewed that the details of a number of these incidents were not forwarded for full review or consideration. The impact of the incidents or the impact of the environment and the compatibility of the residents was not considered in any review or record seen by inspectors.Staff were however aware of this.

An internal safeguarding protocol was in place which attempted to define the threshold for abusive physical interactions .Inspectors found that this protocol was neither fully understood nor implemented in the centre. The protocol may in fact contribute to the lack of consideration of the impact of such incidents regardless of the number of times they occur. There had been no oversight of the implementation of this.

There was also a protocol in place for the management of statements made by residents, which may indicate abusive interactions but may also be a feature of presenting behaviour. This protocol was not followed nor was it sufficiently detailed to ensure there was oversight of the statements being made and the response outcome to them. Inspectors saw that these statements were not adequately recorded, the response was not satisfactory and they were not monitored adequately to ensure residents safety while acknowledging the complexity of the situation. This matter had however been noted at a recent unannounced visit by a senior manager and changes were being made.

There were number of restrictive practices used in the centre. In the main, these had been assessed as necessary and were reviewed frequently. However, inspectors found that one such practise was used for an entirely different reason than that indicated on the assessment. This was an intrusive practice. In discussing this with staff, the inspector found that the necessity for this had not been reassessed nor was it transparently identified to allow for such review.

A further significant intervention was being used. It was apparent to the inspector that its use may in fact be increasing in frequency and increasing in duration. It is acknowledged that this action was taken primarily to protect other residents. However, there was no system for monitoring this. The correlation between the use of the restriction and the environment was not considered. The records were however, very poorly documented.

A number of safeguarding plans had been implemented and these were monitored

with social work support.

However, one safeguarding plan seen suggested that a vulnerable resident should lock himself into his room if others were presenting with behaviours that challenge. While this may be supportive, it did not consider the impact on the resident of having to do this in ones home on a long-term basis.

These findings are of concern as in theory there are a range of monitoring committees and systems in place, which are designed to protect residents and monitor care. However, the findings indicate that there is no effective connection between the practices and incidents in the centre and these committees.

Socially resident's needs were being supported and their preferences, likes and age were considered. According to the own preferences residents had good access to the community and to external activities and attended day service or not as they wished. There were activities in the units for those who did not choose to attend including the use of sensory rooms, board games, tabletop activities access to the safe garden, massage and going out for tea. On other occasions, they went shopping to local beauticians and for walks and drives.

Multidisciplinary reviews were held as often as needed but as noted previously not all of the information was available or considered to inform these meetings which may influence the decisions being made. Personal support meetings were also held which residents or their representatives attended as appropriate.

Residents who required additional support with communication were assisted with pictorial images. The support plans for communication were limited in detail however to inform staff and support the residents. Some residents used sign language and this was known by staff.

Guidance on intimate care demonstrated a commitment to protecting resident's dignity and integrity. Residents required support with their financial management and there were good oversight and monitoring systems implemented. Where the provider was action as guardian for residents there was an oversight committee in place for this. The premises promoted residents privacy and all had individual bedrooms and bathrooms with many personal belongings and certificates of various achievement.

There were some improvements required in risk management systems in relation to fire safety. While there were fire doors, in all areas, one door had been removed and some self-closing devices had been removed. The provider was requested to address this and confirmation of this was received on the day following the inspection.

All fire safety management equipment had been serviced as required however and regular fire drills were held with any issues identified and remedied.

There was a current health and safety statement and health and safety audits of practices were held. Each resident had pertinent individual risk management

assessments and manage plans in place for issues such as falls choking, weight loss and seizures.

The management plans included alarms systems to access additional staff promptly should this be necessary.

Regulation 10: Communication

While residents were supported to communicate a number of the communication plans lacked sufficient detail to ensure the residents individual means of communication and its meaning were understood.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents own preferences for day service / training and activities and retirement were well supported .

Judgment: Compliant

Regulation 17: Premises

The premises is suitable for its purpose and meets the needs of the residents.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents nutritional needs were identified and very well supported.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Judgment: Compliant

Regulation 26: Risk management procedures

There were suitable systems for the management of risk which helped to protect residents.

Judgment: Compliant

Regulation 27: Protection against infection

Systems for the prevention of and management of infection was suitable to the environment and the residents needs.

Judgment: Compliant

Regulation 28: Fire precautions

Some improvements were required in the safe management of fire doors to allow for containment of fire and one fire door required to be installed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The records of medicines prescribed and administered for specific interventions did not consistently demonstrate that they were in fact administered for that purpose.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While all residents had personal plans and these were reviewed, the reviews records seen did not demonstrate that due regard was taken of significant factors for residents such as behaviour supports, safeguarding or the impact of the compatibility of the residents.

Judgment: Not compliant

Regulation 6: Health care

Residents health care needs were promptly identified and all supports and interventions necessary were made available .

Judgment: Compliant

Regulation 7: Positive behavioural support

While behaviour support plans were in place there was a lack of adequate review of the incidents and therefore the effectiveness of the plans. This was not helped by the lack of adequate reporting and recording of such incidents.

The assessment of the need for, and frequency of the use and suitability of some established restrictive practices was not transparent and did not take account of potentially contributing factors such as the environment.

Judgment: Not compliant

Regulation 8: Protection

While there were safeguarding plans in place the systems for recognising and responding appropriately to either incidents of peer to peer harm or statements made by residents in this regard were not clear, understood or implemented in some instances.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents had choice in their day to day lives and access to activities and were supported appropriately to manage their finances, medicines with appropriate consultation with their relatives.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cairdeas Services Belmont OSV-0005077

Inspection ID: MON-0021949

Date of inspection: 12/06/2018

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • The service has come to an agreement with an agency in the last number of months, therefore in the absence of staff the agency provide further staffing, thus providing the P.I.C. with the protected time required.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The house induction template has been revised to ensure consistency in staff knowledge of individual supports- staff will then sign their signature to same to confirm they understand and read the relevant plans.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Monitoring systems have been reviewed, the P.I.C. will now attend the management and monitoring meetings. • The introduction of monthly analysis/review of incidents/accidents will commence with immediate effect. • Reporting systems have also been reviewed and staff are aware to report all allegations and ensure the necessary follow up is implemented.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Any complaints received in the future will be recorded in the complaints recording log and followed up with immediate urgency.	

Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: • Communication plans will be reviewed in liaison with the Speech and Language Therapist.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • A fire door will be installed in the laundry room as soon as is possible. • Door closures will be installed where necessary within the house, these have been ordered.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • A Team meeting has been held with staff reiterating the importance of ensuring adequate follow up is in place in relation to the administration of medications-PRN medications will clearly identify the reasons as to why they were administered and the effectiveness of same.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Monitoring systems have been reviewed, the P.I.C. will now attend the management and monitoring meetings. • The introduction of monthly analysis/review of incidents/accidents will commence with immediate effect. • Reporting systems have also been reviewed and staff are aware to report all allegations and ensure the necessary follow up is implemented.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Behaviour support plans will all be reviewed and updated. • A team meeting was held immediately following the recent HIQA visit, emphasis was given to the importance of appropriate reporting/recording of incidence's plus the prompt response to review incidences/restrictive practices.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection:	

- A review of protection plans in place for individuals has been carried out in conjunction with the MDT. These are now more specific in guiding staff to follow through appropriately and efficiently with incidences i.e. Peer to Peer.
- A Staff meeting was held to reinforce the importance of ensuring protection plans are adhered to, providing greater guidance to staff in supporting individuals
- Staff are adhering to and implementing safeguarding plans as per recommended by Management and Monitoring Team.
- A Staff meeting was held to reinforce the importance of ensuring safeguarding plans are adhered to, providing greater guidance to staff in supporting individuals with regards safeguarding issues.
- Reporting systems have also been reviewed and staff are aware to report all allegations and ensure the necessary follow up is implemented.

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31 October 2018
Regulation 14(2)	The person in charge shall be fulltime and shall require the qualification, skill and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of residents.	Substantially Compliant	Yellow	30 June 2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	10 July 2018
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30 July 2018
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	Not Compliant	Orange	10 July 2018

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 34(2)(f)	The nominated person makes a record of all complaints including details of any investigation into a complaint, outcome of a complaint , any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30 July 2018
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Yellow	30 August 2018 or sooner if possible.
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	Immediately July 2018
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	10 July 2018
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	30 August 2018
Regulation 7(4)	The registered provider shall ensure that where restrictive procedures including physical, chemical or environmental restraint are sued; such procedures are	Not Compliant	Orange	30 June 2018

	applied in accordance with national policy and evidenced based practice.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Yellow	30 June 2018 and ongoing
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	12 June 2018 and ongoing