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:	DC5
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	29 August 2024
Centre ID:	OSV-0003642
Fieldwork ID:	MON-0044453

About the designated centre

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

St John of God, Designated Centre 5 is a designated centre located within a campus setting in County Kildare. The centre provides residential services to 13 adults with an intellectual disability. The centre is a purpose built building which consists of three kitchens, four dining rooms, four sitting rooms, staff office, two sensory rooms and 13 individual resident bedrooms. The centre is located close to a town with access to local shops and transport links. The centre is staffed by a person in charge, clinical nurse manager, staff nurses, social care workers and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 29 August 2024	10:05hrs to 15:15hrs	Erin Clarke	Lead
Thursday 29 August 2024	10:05hrs to 15:15hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This report presents the findings of an unannounced risk-based inspection undertaken in August 2024. It was scheduled subsequent to high levels of non-compliance found on a recent inspection in the designated centre in April 2024. The inspection was conducted to assess compliance with the regulations and to assess the implementation of the compliance plan submitted to the Office of The Chief Inspector following a warning meeting with the provider.

In conducting this inspection, inspectors monitored compliance with the regulations and also sought to determine if the actions and assurances submitted by the provider had improved the service and brought about sufficient positive change in the quality and safety of care provided to residents who used this service. Overall, inspectors found that the provider had made significant progress in addressing regulatory non-compliances in line with their stated compliance plan and warning meeting response, as laid out in this report.

DC5 designated centre is comprised of an institutional-type single-storey premises located on a campus operated by St. John of Gods Community Services Limited in County Kildare. Due to the nature of the setting, building, and number of residents, this centre is classified as a congregated setting.

Inspectors spoke to one resident who was waiting in the dining area of the centre while staff was making breakfast. The resident mentioned that they were about to have their breakfast and then attend their day service. The resident was relaxing beside a large window in the dining room, enjoying the view of the garden and the entrance to the centre. The resident told the inspectors that they like to sit at this window while they have breakfast in the morning. The inspectors asked the resident about the food from the newly renovated kitchen, to which the resident responded positively, stating that the food was great. The resident demonstrated to the inspectors how they use an accessible tablet and switch button to play music that they like. The resident played a number of songs of the inspectors on their tablet, which led to a WiFi-connected radio system at the window they were sitting beside. The resident told the inspector that they like living in their home and like going to their day service.

The inspectors met one resident who was relaxing in their bedroom watching a musical. Support staff informed the inspectors that the resident had been feeling unwell that morning and was taking the morning to rest in bed. The support staff had requested a review by the resident's general practitioner (GP), who was due to visit the resident later in the morning. The resident was observed to be comfortable with staff sitting with the resident, who provided them with a hand massage while discussing the musical in the background.
One resident told the inspectors that they love their home and that the staff are very good to them. They told the inspectors that their room had recently been decorated and that they were very happy with the design they had helped to

choose. The resident told the inspectors that this was the happiest they had been when living in a centre.

Support staff spoken to during the course of the inspection were found to be knowledgeable of residents' assessed needs and their likes and dislikes. Staff spoken with told the inspectors that the new kitchens had been a welcomed addition to the designated centre. Staff discussed how the aromas from freshly cooked meals had increased appetites, and staff found that residents were spending more time coming to the dining room and kitchen area. Staff discussed that meals are cooked daily, Monday to Friday, by a qualified chef, and at the weekends, staff will make meals from the large selection in the kitchen. Staff discussed that residents also had the option to choose food away from the daily menu or make changes to the menu as they required. Residents had access to a large pantry selection of food, and staff were aware of residents' likes and dislikes when assisting with meal preparation.

Overall, inspectors found that there had been positive changes regarding eliminating institutional practices in the centre to provide individual and person-centred care. As covered under Regulation 26: Risk management, some issues remained regarding the application of the admissions process and the documentation of multidisciplinary input and decision-making rationale.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. This risk-based inspection aimed to assess whether the provider had completed its stated actions submitted to the Chief Inspector following the inspection in April 2024 and to verify if these actions had resulted in improvements for residents. Overall, the inspectors found that the provider had significantly enhanced their oversight mechanisms of the designated centre, resulting in a more person-centred and quality service for the residents who lived there.

In April 2024, an announced inspection occurred where inspectors found concerning levels of non-compliance and the provider was required to take urgent action relating to the use of restrictive practices in the centre. The provider was required to submit urgent compliance within five working days following the inspection to the actions they planned to take to address the risks identified in the centre. Furthermore, there were non-compliances in governance and management, risk management, and protection against infection, all of which were impacting negatively on the quality of support for residents.

In May 2024, the provider was issued a warning letter which stated that the Chief Inspector would give consideration to the cancellation of the centre's registration if the provider failed to improve the quality and safety of support for residents and bring the centre into regulatory compliance. In response to the warning meeting and letter, the provider submitted a comprehensive compliance plan setting out the actions they would take to address the deficits identified. The inspectors found that the provider had implemented the actions as set out in their warning meeting response to the Chief Inspector. Overall, the implementation of these actions lead to improvements on the safety and quality of the service experienced by residents.

Regulation 23: Governance and management

The provider had sufficiently addressed the risks identified during the inspection process and through their own auditing systems. This was to ensure that the services received by the residents were safe and consistent. They specifically addressed risks related to the inappropriate use of restrictive practices, laundry management, and waste disposal within the centre. Consequently, all restrictive practices were reviewed, resulting in a significant reduction in line with the residents' needs.

Since the last inspection, the provider had implemented an additional restrictive practice group to respond to, approve and review the use of physical types of restrictive practice such as bed rails, bed bumpers and lap belts.

The provider had significantly enhanced the governance and management arrangements for the designated centre subsequent to the last inspection. There was a clearly defined management structure in place. Staff were aware of their roles and responsibilities and of the reporting structure. Notably, the provider introduced a full-time social care leader position for the first time to complement the existing nurse-led service. They told the inspectors that their focus would be on further developing social care activities for residents and their personal plans and goals. Additionally, they successfully filled the previously vacant clinical nurse manager (CMN) position. Both the new social care leader and the clinical nurse manager were present and met with during the inspection.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspectors found that the provider had enhanced the everyday practices in the centre and this had resulted in

a more person-centred and quality service for residents.

The last inspection of this centre identified a number of issues relating to the prescription, implementation and oversight of restrictive practices, specifically bedrails and bed bumpers. The inspectors found the lack of servicing and poor condition of these devices also posed a risk to their use. The provider identified a number of actions within their compliance plan response regarding how they planned to address these deficits. The inspectors found the provider had implemented the necessary changes to ensure residents were provided with safe services, which met their needs.

The provider's compliance plan, in response to the centre's last inspection, included detailed actions to provide additional oversight of care and improve the provider's response to residents' changing needs. Many of the actions listed were successfully implemented with evidence of good effect. The inspectors were informed that the centre was transitioning towards a combination of social care and nursing service models. Since the previous inspection, the provider conducted training on medicine management and the use of rescue medicine for non-nursing staff. The goal of this training was to facilitate and empower support staff to administer medicine to residents during community outings, thus allowing residents to stay in the community rather than having to return to the centre. This initiative aimed to enhance the frequency and quality of community access for residents with complex medical needs.

An additional enhancement to the quality and safety of care provided in the designated centre was the appointment of a full-time, suitably qualified chef. The chef had experience and training in modifying foods in line with residents' assessed needs. The inspectors saw that the kitchen was well maintained and that foods were prepared and stored in a hygienic condition. Foods were also prepared in line with residents' assessed feeding, eating, drinking and swallowing needs and were presented in a visually appealing manner. Staff spoke highly of the positive impact that the chef had on the quality of food received by the residents.

The inspectors completed a review of restrictive practices in place in the centre, and since the inspection was carried out in April 2024, all restrictive practices were logged, regularly reviewed, and risk assessed in line with the provider's policy. In addition, the person in charge and staff team had referred restrictive practices in place in the centre to be reviewed by the provider's restrictive practice committee. This has led to a number of reductions in the use of restrictive practices for the centre. For example, the provider, person in charge and relevant clinicians had completed a review on bed rails in place for all residents in the centre, leading to the reduction of bed rails and funding of new beds for residents following a business case completed by the provider to their funding body.

Regulation 18: Food and nutrition

Residents with assessed needs in feeding, eating, drinking, and swallowing (FEDS)

had up-to-date FEDS care plans. The inspector reviewed one resident's FEDS care plan and found guidance regarding the resident's mealtime requirements, including the appropriate food consistency and their food likes and dislikes.

The centre had recently moved away from centralised meal preparation located elsewhere on campus, and the centre had been fitted with two purpose-built working kitchens. The designated centre had access to a qualified chef Monday through Friday; inspectors observed that residents had a high selection of choices and variety in the meals provided. From speaking with staff and observing food being made in the centre, residents also had various options for meals on the weekend. Some meals were made in advance, some residents liked to eat out in restaurants, and there was petty cash for staff to purchase ingredients and food to prepare in the centre. Staff spoken with complimented the practice of fresh food being prepared in the centre and spoke of the positive impact this was having on residents.

During the course of the walk around of the designated centre, the inspectors were met with the smell of freshly baked bread. The inspectors observed some residents being assisted with their breakfast-time meal. Inspectors saw that there were sufficient staff on duty to support residents with their meals and that the mealtime experience was relaxed and enjoyable. Inspectors saw staff and residents interacting positively during the meal, chatting to each other in a friendly manner.

The inspectors observed suitable facilities to store food hygienically, and adequate quantities of food and drinks were available in the centre. The fridge and storage presses were well stocked with a variety of different food items. In addition, the centre had access to a cold room, which contained a large fridge. The inspectors were informed that one empty room was planned to be redesigned as a new dining room that could also be used for food preparation skills training for residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Initially, inspectors found the provider was not appropriately, efficiently and effectively responding to some risks in the centre relating to the use of restrictive practices. Under this regulation, the provider was issued an urgent compliance plan during the inspection in April 2024.

The current inspection found that the provider had appropriately responded to this risk, and the inspectors found a revised policy and procedure in this area. This meant that there were clear guidelines on the roles and responsibilities of all staff and management in ensuring a restraint-free environment. All dangerous and defective bedrails and bed bumpers had been discontinued and removed from the centre. Funding had been sought and received for the purchase of new beds and approved bedrails.

The inspectors found that some improvements were still required in this area of reviewing risks that presented in the centre and implementing corrective actions or processes to ensure they were reduced. One example of this was the consideration of the written documentation following a review of residents' assessed needs. While it was a positive change that reductions of restrictive practices had occurred, this was not well evidenced in residents' personal plans. Therefore, this gap in up-to-date information did not form part of the patient care plans, and the rationale for such decisions was not evidence-based. On the previous inspection, inspectors found that this rationale was also missing for the implementation of such restrictions and, therefore, did not guide staff practice.

In addition, the inspectors found that the admissions processes were unclear in places and that the roles and responsibilities between the admission committee and those that made up the centre's governance structure were unclear. While it was a requirement for residents' finances and social welfare payments to transfer with the residents so they have access to funds to support a life of their choosing, this had not occurred for the last two admissions into the centre. This resulted in limited funds being made available to these two residents compared to their peers, which had not been resolved at the time of the inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspectors observed overall significant improvements in the management of infection prevention control (IPC) across the designated centre.

Following the inspection completed in April 2024, the provider completed a review of the laundry system in place in the centre. Inspectors found that a new system was in place for the management of residents' laundry. On the day of the inspection, the provider was awaiting new laundry containers that had been purchased for the designated centre. These containers would be stored externally on the centre's grounds and would be collected daily. As an interim measure, each compartment in the designated centre had enclosed laundry baskets, which were stored in the clean laundry area of the centre while awaiting collection. On return to the centre, the laundry was taken from each resident's individual laundry, packaged, and returned to their bedrooms. Staff present on the day spoke to inspectors about the current laundry system in place and the IPC control measures taken throughout the process. Staff went through the process with inspectors, from the collection of laundry from the centre to the return of clean laundry.

The provider had also sourced a new waste management company; inspectors completed a walk-through of the centre and observed the new bin disposable system in place internally and externally. Inspectors observed additionally bins in place in communal areas in the centre and found all bins to be in working order. Inspectors found that staff spoken to on the day were knowledgeable in relation to

the new waste disposal process and informed inspectors of the process of removing bins from the centre while maintaining IPC controls.

Overall, the inspectors found the centre was clean, tidy and clutter-free. The inspectors observed that the refurbishment work completed by the provider had enhanced the homeliness of the centre, further promoting the protection against infection within the centre, including internal paintwork and new furniture in place throughout the designated centre. There was also evidence of shared learning in the centre, with IPC updates completed at staff meetings in May and June 2024.

Judgment: Compliant

Regulation 7: Positive behavioural support

Designated centres for people with disabilities are required to have a policy in place on the use of restrictive practices. All designated centres are required to review this policy every three years. These policies should be in line with national policy and make reference to other relevant legislation, regulations or enactments. Policies should clearly guide staff on the prevention, appropriate use and management of restrictive practices so that they inform the quality and safe of care and promote autonomy and the rights of residents. The policy has been revised and updated in June 2024 to encompass all restrictive practices within the oversight of a committee. This meant that the reasons and justifications for all restrictive practices were carefully examined and evaluated through a multidisciplinary approach, with the aim of using the least restrictive option for the shortest duration possible.

Following the previous inspection and a review of residents' assessed needs, it was determined that the least restrictive option was not in place or trialled with alternatives. As a result, the number of bedrails was reduced from six to five, and the bed bumpers were decreased from five to four. The inspectors observed that wedges and enablers such as grab rails and levers were now in place for some residents, while others did not require such interventions. Residents' beds had been replaced with electric low-profile beds that could be lowered to the ground and used with crash mats. This helped maximise safety for individuals who were at risk of falling out of bed without the risk of engagement or entrapment that bedrails posed to some individuals.

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions. The inspectors reviewed four behaviour support plans for residents. The plans detailed proactive and reactive strategies to support residents in managing their behaviour. They were devised in consultation with the clinical team and reviewed regularly as per the provider's policy.

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 23: Governance and management	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for DC5 OSV-0003642

Inspection ID: MON-0044453

Date of inspection: 29/08/2024

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 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A comprehensive review of the assessed need for bedrails and bed bumpers was completed April 2024. All Residents personal plan reviewed in September 2024 and up to date information provided. Information includes the initial assessment for bedrail and bed bumpers, MDT meeting and rationale for removal as well as trial prior to complete removal of bedrails and bed bumpers. Only one Resident remain with bedrails and bumpers. Rationale for such decision evidence in their personal plan.

Admission process was reviewed in June 2024. The Programme Manager is a member of the Admissions, Discharge and Transfers committee who liaises with the PIC and/or Coordinators/PPIM prior to and during any compatibility and transitions that maybe planned at the ADT committee meetings.

Updated transition plans have been developed. Meetings have been scheduled with contact persons for Residents without their own accounts with St John of God from 08.10.2024. They will be supported to have their finances and social welfare payments transferred as required.

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 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/12/2024