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:	Parkside Residential Services Kilmeaden
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	16 October 2024
Centre ID:	OSV-0005106
Fieldwork ID:	MON-0043808

About the designated centre

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

Parkside Residential Services Kilmeaden is a five bedroom two–storey detached house located in a rural area. The centre provides residential care for four men with mild to moderate intellectual disability ranging in age from 28 to 54 and has a maximum capacity for four residents. It is open 365 days of the year on a 24 hour basis. Each resident has their own bedroom and other facilities throughout the centre include a kitchen, a dining room, three living rooms, bathroom facilities and garden areas. Staff support is provided by social care workers and care assistants. The designated centre was within easy reach of local towns and Waterford city.

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
Wednesday 16 October 2024	09:15hrs to 16:30hrs	Sarah Mockler	Lead
Wednesday 16 October 2024	09:15hrs to 16:30hrs	Conan O'Hara	Support

What residents told us and what inspectors observed

This unannounced risk based inspection was completed to determine the ongoing compliance of the designated centre, with the relevant regulations and standards. This inspection occurred over a one day and was completed by two inspectors.

An inspection took place in this centre in March 2024, where it was found that the provider had failed to meet the minimum requirements in seven of the regulations inspected. This presented as aspects of care and support not occurring in a safe and effective manner. Overall findings of the current inspection indicated that although residents' were afforded good quality care in aspects of their relevant assessed needs, an overarching issue of incompatibility of the resident group remained. This was being managed by utilising restrictive practices, high staffing and supervision levels.

The designated centre comprises a very large detached two-storey home in a rural setting in Co. Waterford. The designated centre had capacity to accommodate four residents and there were no vacancies on the day of inspection. The inspectors had the opportunity to meet with two residents as they went about their day. The other two residents had left the centre to attend their day service when the inspectors arrived.

On arrival, the inspectors were welcomed into the house by a staff member. The staff member explained to the inspectors that they were currently supporting a resident with their morning routine and asked the inspectors to wait downstairs until they had finished.

The inspectors completed a walk around of the downstairs part of the home. There were three separate sitting rooms set up for the four residents that lived in the home. Two residents were supported to have an individualised sitting room while two residents shared a sitting room. Each sitting room had a large screen television, ample seating areas and personal items on display. This arrangement was in place to manage safeguarding concerns and in line with residents' preferences. Halloween decorations were also hung and displayed in these rooms. There was a kitchen area and located directly off this area was a pantry, boiler room and separate laundry area. New fire containment measures had been installed in the laundry, pantry and boiler room. There was also a bathroom located downstairs. All parts of the centre were presented in a homely manner, clean and well kept.

Upstairs there were five individual bedrooms and two separate bathrooms. Four bedrooms were allocated to residents and the fifth bedroom was used as a staff sleepover and office. A closed circuit television (CCTV) system was observed to be installed in the hall area with the corresponding viewing equipment in the staff sleepover room. This was turned off when the inspectors went into the office. The CCTV being turned off at this time was in line with the relevant guidelines of how it was to be used. Three resident bedroom doors were locked. The person in charge

sought permission from all residents before the inspectors reviewed these rooms. All bedrooms were found to be personalised and had adequate storage for residents' personal belongings.

During the morning, the inspectors met with two residents. One resident returned to the centre with a staff member. They had been out shopping. They were observed to help unpack the shopping and bring items upstairs. The resident went to relax in their sitting room and a staff member sat with them to watch a preferred movie. The resident consented to one of the inspectors viewing their bedroom. They came upstairs and unlocked this room. It was the residents choice to keep this room locked and they carried the key with them. The room had a double bed and wardrobe storage with open shelves. There were lots of personal items in the room. When asked, the resident stated that they liked their room. When leaving this area the resident locked the room and went back downstairs.

Later in the morning the second resident came downstairs. They went to the kitchen area to have their breakfast. The staff member supporting them explained that the resident preferred a later start to the day and it was their role to come to the house to support the resident to get ready at their own pace. The resident was given a choice of what to eat and the staff member helped to prepare the meal. The resident smiled and mainly answered 'yes' or nodded their head when asked questions. They appeared very content in the presence of staff.

Overall, the residents in the home had busy active lives and went out and about into their local community on a regular basis. All four residents availed of a day service provision. However, in line with residents' wishes and assessed needs, some residents took a regular day off or had a later start to their day. Some residents were assessed as being independent and would cycle to visit friends or spend time in the local pub. Other residents, while needing more support, were afforded opportunities to go out and about and maintain relationships with family and friends. On the day of inspection the two residents in the centre were planning a day trip to a local coastal town and to head out for lunch.

In summary, there were positive aspects to residents' care and support needs being met such as good opportunities for residents to engage in activities of their choosing and being supported by a stable, consistent staff team. However, improvements were needed in the use of restrictive practices in the centre and the management of safeguarding incidents within the centre.

The next two sections of the report present the inspection findings in relation to the governance and management and how these arrangements affected the quality and safety of residents' care and support in the centre.

Capacity and capability

Overall, there was a defined management structure present. On the day of

inspection, there were sufficient numbers of staff to meet the residents' assessed needs. However, improvement was required in the effective management of the centre and staff training.

As noted this was the second inspection of this centre in 2024. The provider had submitted a compliance plan in response to the inspection completed in March 2024. On review of the actions outlined in the compliance plan, inspectors found the provider had completed the majority of stated actions to improve aspects of the care and support being provided to residents. However, the provider had failed to effectively address some areas previously identified areas for improvement including the use of restrictive practices and staff training. In addition, the identification of safeguarding incidents required improvement, as although incidents were recorded they were not responded to in line with relevant safeguarding procedures. This is outlined further under Regulation 08: Protection.

Ensuring staff were in receipt of adequate training and refresher training was an ongoing issue within this designated centre. Although the provider had committed that all staff would be trained in relevant areas by the end of September 2024 this had not occurred. This meant that staff did not have up-to-date knowledge and skills to provide evidence based care and support to the residents at all times.

Regulation 15: Staffing

The staff team comprised of social care workers and healthcare assistants. The inspectors reviewed planned and actual rosters for the last four week period. It was found that there were sufficient staff in place to meet the needs of the residents. There were two staff on duty until 11pm each night with one sleepover staff at night. The staff team were consistent with some staff having a long history of providing support to residents over the last 10 years or more.

The staff present on the day of inspection were found to be kind and caring in their interactions. They were seen to sit with residents when having meals. For example, a staff member had their breakfast with a resident in the morning. Staff were heard to offer choices to residents across the morning routine. The staff present were knowledgeable about the residents and their responsibilities in relation to their care and support needs.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had failed to ensure all staff had been adequately trained. For example on review of the training records for five staff it was found that, one staff had not completed training in positive behaviour support including de-escalation techniques,

and two staff required refresher training in this area. On review of incident reports and risk assessments all staff were required to have up-to-date training in de-escalation and intervention techniques. In addition, one staff member required fire safety training and three staff required training in Manual handling techniques. Overall, improvement was required to ensure that the staff team had up -to -date knowledge and skills to meet the care and support needs of residents.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clear management structure in place. A person in charge had been appointed to the centre in 2021 and they were in a full-time post. The person in charge facilitated the inspection and had clear understanding of the residents' needs. They were supported in their role by a senior area manager who was also present for the inspection.

The provider had in place a series of audits both at local and provider level. The inspectors reviewed the most recent six monthly unannounced audit which had occurred in May 2024. Fourteen actions had been identified and 10 actions had been completed to date. Overall the provider audit was identifying areas of improvement.

In addition the provider, in their compliance plan submitted to the Office of the Chief Inspector, had completed the majority of actions as stated, such as premises works and fire safety measures. They had also committed to reviewing the needs of the residents in order to identify the best course of action for living arrangements going forward. This review had taken place by the staff and MDT team in April 2024. While incidents between the residents in the home were low and overall well managed, the compatibility of residents remained a concern. The inspectors reviewed correspondence from the management team to the local housing authority. In the letter it was stated that there were concerns over the suitability of the home and the ongoing management of safeguarding concerns. At the time of the inspection, the safeguarding concerns and incompatibility of the resident group were being managed through staffing, supervision levels and restrictive practices.

However, the general safeguarding culture and management of safeguarding incidents within the centre also required review. When alleged safeguarding events were reported in incidents, these were not always processed, screened and notified as required. These safeguarding incidents were not always related to the peers living together in the home.

Judgment: Substantially compliant

Quality and safety

The inspectors found that residents were being supported to engage in activities that they enjoyed and were supported to maintain relationships with family and friends. However, further action was required to ensure that improvements were completed in relation to care and support so that residents were in receipt of a safe and good-quality service.

Residents were not being protected by the policies, procedures and practices relating to safeguarding in this centre. Incidents that occurred in the centre and out in the community that met the threshold of a safeguarding concern, were not recognised as such, nor were they investigated or managed in line with the safeguarding policies, procedures and practices.

In line with findings of the previous inspection, inspectors found that the systems to ensure that restrictive practices were utilised in an evidence based manner, and for the shortest duration possible, was not occurring. The provider's Human Rights Committee had deemed that the practice of using CCTV did not evidence a least restrictive approach. This practice was still in place on the day of inspection however, despite the findings of the committee.

Regulation 13: General welfare and development

As mentioned previously in the report the residents were afforded good opportunities to get involved in their local community, engage in activities of their choosing and maintain family and friendship relationships.

On the day of inspection the inspectors observed that all residents were up and getting ready for the day. Two residents had left the home before the inspectors had arrived. Two residents had chosen to go on a day trip to a local town and were supported to do this. All four residents availed of day service provision.

On discussion with the person in charge and a review of two residents' personal plans, it was found that residents were afforded a good quality of life. Residents had gone on cruises, engaged in local theatre groups, went on drives, cycles, walks, and enjoyed meals and drinks out in restaurants and pubs. Many residents went on overnight visits to family homes and spent time visiting family and friends. On the walk around of the premises certificates of achievement were on display such as an award in for an achievement for art which was displayed in one resident's sitting room.

Personal Outcome Measures (POMS) were the format the provider utilised to review individual resident goals. On review of one resident's POMS for 2024 they had achieved all four goals, which was to spend a night on a boat, maintain family relationships, start retirement from their work and get a tattoo. The staff team had supported the resident in achieving each goal in line with their wishes and

preferences. For example, they now took one day of from their day service to spend more time at home or out in their local community.

Judgment: Compliant

Regulation 17: Premises

The inspection that occurred in March 2024, identified the need for substantial premises works. On the walk around of the premises the inspectors noted that the majority of works had been completed. The designated centre was an older style property. All the original floors had been sanded and varnished. One bedroom remained outstanding in terms of this work but there were plans to complete this in the coming weeks.

All areas of the home had been painted including doors, door frames and architraves. Areas of dampness and mould had been rectified and a new system had been put in place to ensure that these issues did not re-occur.

Overall the centre was well presented, homely, warm and clean.

Judgment: Compliant

Regulation 28: Fire precautions

The majority of fire safety concerns identified in the previous inspection had been addressed by the provider. On the walk around of the premises inspectors noted the installation of additional fire doors to ensure fire containment was optimised. A fire loft door had been adapted to ensure it also effectively contained fire in the event of an emergency. A new bench (which was fire retardant) had been purchased for residents' that smoked. This was to be built in the coming days and a resident who had an interest in these types of activities was going to take part in assembling this item of furniture.

There was evidence of regular fire evacuation drills taking place including an hour of darkness fire drill. The fire drills demonstrated that all persons could be safely evacuated from the centre in a timely manner.

However, one are of fire safety required further review. A fire risk assessment carried out in 2022 identified that items were stored under a stairway were a fire safety risk as it was a main evacuation route. On the day of inspection, inspectors observed items being stored under the stairs. This practice required review and the provider had committed to removing the items on the day of inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

On the walk around of the premises it was noted that a number of restrictive practices were in place in the designated centre. This included chimes on doors to alert staff when a resident was leaving an area and the use of CCTV in a communal upstairs hallway from 11.30pm to 7.30am. The rationale for the use of these restrictive practices was to ensure residents were adequately safeguarded at all times.

The provider's Human Rights Committee had reviewed the use of the CCTV in January 2024. The inspectors read the correspondence following this review and it stated that the use of this restrictive practice required a review from a MDT perspective and other alternatives were to be explored. On the day of inspection, this practice remained in place and no alternatives had been trialled. The provider discussed that a trail was to occur in relation to ceasing the use of the CCTV, however no date had been decided, risk assessment completed or other actions taken in relation to this. The information provided to the inspectors did not assure them that a least restrictive approach had been adopted in relation to this practice.

In addition, the use of CCTV was not in line with the provider's policy on CCTV. For example, resident's consent to the use of CCTV was not evidenced. There were no consent forms available to review or any other documentation into how consent was obtained in relation to this.

Judgment: Not compliant

Regulation 8: Protection

Overall the approach to safeguarding and the culture in relation to safeguarding was not in line with the requirements of the regulations.

Following a number of incidents between some residents that related to items being taken from bedrooms and verbal altercations between residents the provider and management team had investigated and reported these as required. A safeguarding plan had been developed and was in place with engagement between the Health Service Executive safeguarding and protection team and the centre. This was reviewed by inspectors and a number of control measures and supports were in place. Control measures were the use of CCTV and separation and supervision of residents in the home as much as possible. This level of awareness and reporting was not however, been applied equally to all incidents.

The inspectors, from the sample of incidents reviewed in the last six months, found

five incidents documented in incident and accident reports that met the threshold of an alleged safeguarding concerns. Only one of the incidents was related to the ongoing incompatibility between the peer group. These incidents related to peer to peer verbal and physical altercations and incidents that occurred out in the community with unknown individuals and some incidents within the home with their peers. For example, an incident occurred in whereby there was a verbal altercation between two peers which resulted in one peer slamming a door. This incident had not been referred to the designated officer, reported to the National Safeguarding Office or reported to the Office of the Chief Inspector.

There was no evidence that these five incidents had been investigated or reported. There had been no follow up, safeguarding plan, risk assessment or care plan developed. There was no evidence that these incidents had been reviewed from a safeguarding perspective. This was poor practice in relation to safeguarding

As part of the inspection process the inspectors reviewed the systems in place to safeguard residents' finances. For two out of four residents' finances reviewed it was found that there were robust systems in place to effectively maintain oversight and safeguard their monies. This included residents having a bank account in their own name, regular checks of bank statements against everyday expenditure and audits and reviews of expenditure. However, for two residents these processes and checks were not in place. Therefore the provider had limited financial oversight of residents expenditure and could not ensure their finances were adequately safeguarded.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Parkside Residential Services Kilmeaden OSV-0005106

Inspection ID: MON-0043808

Date of inspection: 16/10/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge will ensure all staff are adequately trained and have up to date knowledge and skills to meet the care and support needs of the residents. • One staff member who had not completed training in positive behaviour support has been booked on to the course on the 26.11.2024. • Two staff members who required refresher training in positive behavioural supports have been booked in on the course which is taking place on 26.11.2024. • One staff member who required fire safety training has since completed the course. • Three staff who required refresher training in manual handling techniques have been booked in for training on 12.12.2024.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A team based safeguarding refresher training day for the entire staff team including management, will be delivered by the Designated Officer. This will ensure everyone is clear on their roles and responsibilities for reporting safeguarding concerns.	

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 contacted the Buildings Facilities Manager in relation to the containment of under the stairs storage. Works will be completed where neccessary to ensure the area complies will fire regulations.

• The Person In Charge will ensure no items are stored there until such fire containment works are completed.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• The Person in Charge discussed the CCTV at a Multi-Disciplinary Team meeting on 17.10.2024, it was agreed that the cameras would be removed for a month on a trial basis on the 18.11.2024 and will be reviewed weekly at MDT with a view to removing them fully after this.

• The Person in Charge will meet with all residents to inform them of the removal of the CCTV on a trial basis. Residents will be reassured that staff will be monitoring any behaviours of concern and that residents can inform staff, use their I'm not happy card or seek a meeting with the PIC and or Services Manager if they experience any behaviours of concern due to the CCTV removal.

• The Person in Charge will inform the Human Rights Committee when this is complete.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• A team based safeguarding refresher training day for the entire staff team including management, will be delivered by the Designated Officer. This will ensure everyone is clear on their roles and responsibilities for reporting safeguarding concerns.

• The Person in Charge discussed the CCTV at a Multi-Disciplinary Team meeting on 17.10.2024, it was agreed that the cameras would be removed for a month on a trial basis on the 18.11.2024 and will be reviewed weekly at MDT with a view to removing them fully after this.

• The Person in Charge will meet with all residents to inform them of the removal of the CCTV on a trial basis. Residents will be reassured that staff will be monitoring any behaviours of concern and that residents can inform staff, use their I'm not happy card or seek a meeting with the PIC and or Services Manager if they experience any

behaviours of concern due to the CCTV removal.

• The Person in Charge will inform the Human Rights Committee when this is complete.

• The Person in Charge will ensure all incidents recorded on the providers incident management system are reviewed at the weekly Multi-Disciplinary Team meeting and referred to the Designated Officer if required.

• The five incidents have been reviewed and adult safeguarding referral forms have been submitted retrospectively along with NF06's where required.

• The Person in Charge and PPIM will meet with the two residents and their families to ensure arrangements can be made for a clear and transparent system for the residents to manage their own money with supports if required in line with a human rights-based approach.

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.	Not Compliant	Orange	31/12/2024
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	31/12/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Substantially Compliant	Yellow	31/01/2025

	place.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/11/2024
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/11/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2024
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	Orange	23/10/2024