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:	Ford Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	09 August 2022
Centre ID:	OSV-0004940
Fieldwork ID:	MON-0034156

About the designated centre

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

Ford Services provides a full-time residential service to four adult residents. The centre is comprised of four self-contained apartments in a rural town, close to amenities such as public transport, shops, restaurants, churches, post office and bank. Three of the four apartments are at ground floor level and could accommodate people who have a physical disability. The fourth apartment is located at first floor level within the same compact development. Residents have access to a nearby facility with a garden where they engage in a range of activities supported by staff. The model of care is social and is based on the process of individualised assessment. A staffing presence is maintained at all times and the night-time arrangement is a staff on sleepover duty in one of the apartments.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 9 August 2022	11:00hrs to 16:45hrs	Mary Moore	Lead

What residents told us and what inspectors observed

From what was discussed and observed, it was clear that residents were enjoying a good quality life. Residents were supported to be active participants in decisions about their daily lives, to be visible and integrated into their local community. However, improvement was needed in some of the systems that informed the care, support and services provided so as to better assure the quality and safety of the service. For example, there was a need to review and update records such as the personal plan and a review of risks and their control was also needed. The provider had completed the fire safety upgrading works committed to at the time of the last HIQA (Health Information and Quality Authority) inspection. However, improvement was needed in how the provider tested the effectiveness of its evacuation procedures.

The inspector had the opportunity to meet and speak with all four residents. Residents were in good form and gracious in welcoming the inspector into their individualised apartments. It was evident that residents enjoyed having their own personal space. One apartment did accommodate facilities for staff such as the staff office and the staff sleepover room. Staff described how this arrangement was managed so as to not impact on resident privacy. However, it was also a suitable arrangement in the context of the somewhat higher need for support from staff.

The main topic of discussion was how residents had spent and planned to continue spending the summer. Residents supported by the staff team were engaging with life in general, with family and pursuing their personal goals and objectives. For example, one resident spoke of his enjoyment of his recent trip to Spain supported by a staff member. Staff described how the trip was planned to meet the residents expressed preferences such as a not too long flight. The resident had also reconnected and had recently spent some time with family. Another resident had just returned from a weekend spent with family while day trips and a short vacation away with staff were imminent for other residents. A resident shared with the inspector photographs taken at a recent family celebration. Residents had their own mobile phones and personal tablets and used these to contact staff and to stay in touch with family.

The variation in these activities reflected the individuality of the service and how it was tailored to meet the needs and abilities of each resident. Each resident had their own self-contained apartment with pleasant outdoor spaces created with support from staff at the rear of two apartments. One resident had yet to decide how he wanted to complete his outdoor space. The location of the centre offered residents security but was also well suited to ready access to the local community, amenities and services. A staffing presence was maintained at all times but residents had the freedom to walk down town independently or to be accompanied by staff as needed. Residents were also supported to have independence in their daily routines while staff provided any support needed or requested.

There was an easy and relaxed rapport between the staff members on duty and all four residents. While the assessed needs of the residents included communication differences staff described how each resident could and would clearly communicate their agreement or not with any proposal and plans. Staff described how they supported residents to be independent and to exercise choice and control but also ensured that residents were well and safe. For example, staff monitored resident health and well-being and ensured residents had access to the clinicians and services that they needed. There were risks and controls designed to manage these risks without impacting on resident quality of life. However, the personal plan and the risk assessments reviewed by the inspector were in need of review and update.

In summary, this was a person centred service where the individuality and ability of residents was respected and promoted and where residents enjoyed a good quality life. There was a general need however to consolidate the governance arrangements following recent changes and, to review and update systems that informed and underpinned the quality and safety of the service.

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

Capacity and capability

Management and oversight was focused on ensuring residents received a safe, quality service. There was evidence the provider sought to improve the quality and safety of the service. For example, the provider had completed the required fire safety upgrade works and had completed the redecoration of the apartments needed after these works. External resurfacing works were imminent. However, there had been changes to the governance structure some of which were very recent. Potentially this change contributed to some of the gaps identified by this HIQA inspection and highlighted the need for the new governance structure to establish itself and re-establish consistency of oversight.

The person in charge was on planned leave and the inspection was facilitated by the new team leader. The very recently appointed area manager met with and was also available to the inspector. The team leader was aware of the arrangements in place for the management of the centre during the planned absence. The team leader had since appointment developed good knowledge of each resident's needs and preferences and of the general administration of the centre. For example, the team leader described the operation of systems of oversight such as formal staff supervision's, regular staff meetings, systems for maintaining the security of residents personal finances and, for logging and reviewing any accident and incidents that occurred.

The 2021 annual review of the quality and safety of the service had been completed

and a six-monthly provider review had also been completed in December 2021. Residents and their representatives were supported to contribute to these reviews. However, while some preparatory work had been done on the next six-monthly provider review its completion was overdue.

There had been some turnover of staff. The inspector saw from records that the impact on residents of the changes to the staff and management teams was acknowledged. These changes were discussed with residents so that they were prepared for the leaving of staff. The team leader advised that a new staff member had been recruited and there was good availability of regular relief staff members who were known to the residents. The inspector's review of a sample of staff rotas saw that consistency of staffing was provided for and the staffing levels were as a described.

Training records were in place for each staff member listed on the staff rota. These records indicated that the completion of training by staff was substantially complete. For example, in fire safety, safeguarding and various infection prevention and control training modules. However, the inspectors review also highlighted refresher training was overdue for some staff in the management of medicines and in de-escalation and intervention techniques.

Regulation 15: Staffing

Based on the evidence available to the inspector staffing levels and arrangements were suited to the number and assessed needs of the residents. For example, staff were on waking duty until 12 midnight. Residents had good independence but a staffing presence was always maintained in the centre. Staff were noted to spend time in each apartment and with each resident. Generally two staff members were on duty for a period of time each day. This ensured a staff member and transport was available so that residents could leave the centre. There had been some recent staff changes but the staff rota indicated consistency of staffing.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors review of training records highlighted refresher training was overdue for some staff in the management of medicines and in de-escalation and intervention techniques. The inspector was advised these interventions were not actively used in the centre. There was one gap in evidencing completion of training on the correct use of personal protective equipment (PPE).

Judgment: Substantially compliant

Regulation 23: Governance and management

There was evidence of management and oversight that was focused on ensuring residents received a safe, quality service. The centre presented as adequately resourced. There was evidence the provider sought to improve the quality and safety of the service. For example, the provider had completed the required fire safety upgrade works. However, there had been changes to the governance structure some of which were very recent. While these inspection findings were overall positive they also highlighted the need for the new governance structure to establish itself and re-establish consistency of oversight. For example, oversight of the review of risks and their control and, ensuring that when a review was completed that review was effective and identified where change was needed.

While some preparatory work had been done on the six-monthly provider review its completion was overdue.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There was evidence of the review of fees charged and the application of nationally agreed charging systems. However, while it was stated the agreed and signed contract for the provision of services had been reviewed it was quite out of date and not reflective of the service currently provided or the fees currently charged.

Judgment: Substantially compliant

Quality and safety

Residents had choice and independence in their daily lives and were supported to enjoy good health. Some improvement was needed however in arrangements such as the management of risks, fire safety and updating the personal plans. This improvement was needed to better assure what was a good quality person centred service.

For example, the inspector reviewed one personal plan. The personal outcomes section of the plan was current, an active document and reflected what the inspector discussed with the resident such as a planned trip away and acquiring

some new hens. However, the other section of the plan, the section that addressed the residents overall needs and the support to be provided (such as in response to any health requirements) was in need of a general update. A review of the plan had been completed in July 2022 but the changes and updates identified as needed were not complete. For example, the plan stated that the resident had six-monthly access to mental health supports but this was not evidenced in the plan.

The team leader had sound knowledge of each residents needs and confirmed this six-monthly review had taken place. Residents were reported to have timely and attentive care from a local General Practitioner (GP) and there were no reported obstacles to residents accessing the services they needed.

The provider had arrangements for identifying and responding to known and new risks. This was important so that residents could safely enjoy the independence that they had. For example, the team leader said staff always knew where residents were and if and when staff should be concerned. There was documentary evidence that the provider monitored the maintenance of the service vehicle and ensured it was roadworthy and driven by authorised staff. However, the sample of risk assessments reviewed by the inspector and what the inspector observed highlighted the need for the review and update of the risk assessments and the controls in place including controls with a restrictive dimension. For example, one resident had a restricted access to cigarettes plan. The risk based plan stated that the resident smoked four times each day. However, the resident and staff said that the resident now only smoked twice a day. Given the stated risk that could present from fire a review of the risk assessment, the designated smoking space and a plan for its daily maintenance was needed as a matter of priority. The provider confirmed to HIQA the day after this inspection that this review and corrective actions had commenced.

As stated in the previous section of this report the provider had completed the fire safety upgrading works it said it would. These works were completed to improve the measures in place to contain the spread of fire in each apartment. The inspector saw that doors with self-closing devices designed to contain fire and its products had been fitted. Staff and residents said that the doors presented no challenges and there was no evidence of the use of interventions such as door wedges. The fire panel had been upgraded and staff described how each activation alerted staff on duty, the team leader and the person in charge. Staff undertook simulated evacuation drills on a regular basis with residents and each resident was reported to have a good understanding of how to evacuate their respective apartment. However, these drills were generally undertaken on an apartment by apartment basis. No drill report seen tested all staffing scenarios such as the ability of one staff member to evacuate all four residents at the same time.

Regulation 13: General welfare and development

Residents had the support and care that was appropriate to their needs, wishes and abilities. Residents had opportunity to engage in activities that they enjoyed and

that reflected their personal interests. Staff supported residents to develop and maintain personal and family relationships.

Judgment: Compliant

Regulation 26: Risk management procedures

The sample of risk assessments seen by the inspector had not been reviewed in the previous twelve months so as to assure the controls in place were effective. These risks were active risks such as the risk for falls and the risk posed by smoking. The dedicated smoking area was not well-maintained, contained flammable items and was potentially itself a hazard in the context of the specific assessed risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had completed works to enhance its fire safety arrangements and there was evidence of the oversight of these arrangements. For example, there was documentary evidence that remedial works recently recommended following an inspection of the emergency lighting had been completed. Simulated evacuation drills were regular but generally undertaken on an apartment by apartment basis. No drill report seen by the inspector tested all staffing scenarios such as the ability of one staff member to evacuate all four residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A system of oversight was needed to ensure the personal plan was reviewed and updated as needed so that the appropriateness and effectiveness of the plan was consistently assessed and assured. While a recent review of the plan was documented, the changes and updates needed were not complete.

Judgment: Substantially compliant

Regulation 6: Health care

While there some gaps in records there was sufficient evidence for the inspector to be assured that staff monitored resident well-being and ensured residents had access to any clinicians and services needed. In general, residents were reported to enjoy good health. Residents looked well. Staff regularly monitored resident body weight and vital signs. There was documentary evidence of access as needed and consultation with the GP and other clinicians and services. Medical review included the review of any prescribed medicines. Residents were supported to avail of vaccination including seasonal influenza vaccination.

Judgment: Compliant

Regulation 8: Protection

The inspector was advised there were no current safeguarding concerns and no active safeguarding plans. All staff working in the service had completed safeguarding training and the contact details of the designated safeguarding officer were displayed in each apartment. Residents were described as having an awareness of risks and how to stay safe and would be able to say or demonstrate if they were not happy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents presented with a diverse range of ages, needs and abilities. The operation of the service respected and promoted the individuality of each resident. Residents had privacy, independence and reasonable choice and control in their daily lives while staff provided any guidance, support and assistance that was needed. Staff described how residents had the freedom to make choices and to consent or not to support. Staff described discussion and consultation with residents and monitoring so that residents could safely enjoy the independence that they had.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ford Services OSV-0004940

Inspection ID: MON-0034156

Date of inspection: 09/08/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A comprehensive review of training records was completed by the Person in Charge and Team Leader after inspection and any gaps in training identified were addressed and immediate actions taken, with training dates scheduled as a matter of priority. The gaps identified as part of inspection with respect to de-escalation and intervention techniques has been highlighted to training department. Team based training being scheduled as part of response to same with relevant instructors. In relation to training with respect to PPE for one staff, records have been completed to reflect same and sent to training department. It is expected all future training will be completed and up to date for the current year by end of October.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A Schedule of quarterly reviews in relation to the management and oversight of Personal profiles by Person in Charge has been put in place for the next year. This has been communicated to all Keyworkers. Outstanding actions relating to profile updates and personal plans to be completed by end of September.	

A comprehensive review of current identified risks and control measures in place was conducted by Team Leader and Person in Charge on the 22nd and 23rd of August. Risk register and risks assessments were updated accordingly to reflect any changes following this review.
A schedule of dates to review the risk register and associated risk assessments has been put in place with Team leader to review same and assess effectiveness of controls in place.
A schedule of support and supervision meeting dates between the Person in Charge and the Team Leader have been put in place.
The six monthly provider review was completed on the 18th August and the report will be completed by the end of August.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
A review of the contract for the provision of services has been completed with people supported and signed by relevant parties on the 18th of August 2022 to reflect the service currently provided and fees currently charged.

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 current identified risks and control measures in place was conducted by Team Leader and Person in Charge on the 22nd and 23rd of August. Risk register and risks assessments were updated accordingly to reflect any changes following this review.
A schedule of dates to review the risk register and associated risk assessments has been put in place with Team leader to ensure regular review and responses as required.
A new wall mounted steel awning has been commissioned and is expected to be fitted by mid-September.
The current shed was decommissioned immediately after the inspection

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Following the inspection, a simulated night-time fire drill was carried out on the 25th of August at 7.50am. One staff member conducted the fire drill and evacuated all four residents. The total duration to evacuate all four men was 1minute 34 seconds. A schedule of dates for further fire drills has been put in place in the service.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: A schedule of quarterly reviews in relation to the management and oversight of Personal profiles and Personal plans by Person in Charge has been put in place. This has been communicated by the Team Leader to all keyworkers. Outstanding actions relating to profile updates and personal plans to be completed by end of September.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an	Substantially Compliant	Yellow	31/08/2022

	unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	18/08/2022
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	23/08/2022
Regulation	The registered	Substantially	Yellow	15/09/2022

28(3)(d)	provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Compliant		
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/09/2022