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:	Cluain Meala
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	08 July 2020
Centre ID:	OSV-0005705
Fieldwork ID:	MON-0029844

About the designated centre

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

The statement of purpose, which is a document produced by the provider, describes Cluain Meala as a community based home for one resident over the age of 18 years with an intellectual disability. The centre is located in the centre of Kilkenny city within walking distance of local amenities. The service operates on a 24 hours, seven days a week basis. The centre was a small detached one storey house, consisting of an open plan kitchen/living and dining area. The residents private bedroom opened onto a paved secure garden area. The person in charge held governance responsibilities for this and another designated centre within the organisation. The staff team is made of a whole time equivalent of five health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

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 - 2015 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 8 July 2020	10:00hrs to 15:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

On the inspectors arrival to the centre the resident was out and about partaking in their choice of activities. They had chosen to participate in an art session that morning. On return to their home, the resident sat with the inspector. With the support from staff the resident showed photographs on their computer tablet. These photographs were of their friends and activities they like to participate in.

The resident was supported by staff to make a cup of tea and enjoyed a toasted sandwich for their lunch. The resident relaxed for a while after their lunch listening to music in their bedroom. Staff were observed to support the resident in a professional and jovial manner. Skills training was observed to be completed in a consistent manner including tea making.

The resident used single words to communicate. Staff responded to all forms of communication and ensured that all communication was clearly described. The resident smiled when it was clear his communication was understood. The resident appeared very comfortable in his home and in the presence of staff.

The resident said good bye to the centre and went about their afternoon activities.

Capacity and capability

Cluain Meala presented as a service where the registered provider was implementing measures in striving to achieve a high level of compliance. Through the appointment of a clear governance structure and overall effective monitoring systems, service users were provided with a safe, effective and person centred service. The governance and staff team were actively supporting the resident to have a clear social role and participate in their local community. Since the previous inspection a number of areas of non-compliance had been addressed with some minor improvements required to maintain regulatory compliance.

The registered provider had appointed a clearly defined structure to oversee the governance of the centre. Clear roles and responsibilities had been identified for the person in charge who reported directly to the person participating in management. "Cluster" meetings occurred between all members of the governance team within the organisation to facilitate shared learning. A structured agenda was in place for monthly staff team meetings. These incorporated such areas as complaints, risk management and the needs of the resident.

The registered provider has ensured the appointment of a suitably qualified person in charge. This individual was actively completing their regulatory required duties.

For example, a statement of purpose for the designated centre was in place which was regularly reviewed. The person in charge could clearly articulate their governance role within this centre. They held governance responsibilities for three centres, however they had measures in place to ensure that this was effective. Appropriate systems were in place for the management of the COVID-19 public health emergency in the centre. A risk assessment relating to the prevention of COVID-19 had been put in place in a timely manner. A national policy around infection prevention and control was in place. This incorporated, national standards for infection control including respiratory management and hand hygiene. There was a staff team dedicated to this location only and staff were using personal protective equipment in line with national guidance. An organisational contingency plan was in place which included measures to be implemented in the event of a confirmed case including staffing arrangements, visiting protocols and infection control measures.

The monitoring of day to day operations within the centre was overseen by the person in charge. Such monitoring systems carried out included, regular health and safety audit, medication procedure audits and financial checks. An organisational audit schedule had been developed to ensure that monitoring systems in place were utilised in a consistent manner to best monitor the service provided. The person in charge had self-identified non- adherence to this schedule partially due to the changing needs of the service during the current pandemic.

At organisational level the registered provider had ensured oversight was monitoring of an effective service through the implementation of an annual review of service provision and six monthly unannounced visits to the centre. Following the completion of all systems utilised to monitor the service a robust, time bound action plan was developed and adhered to.

The registered provider had ensured appropriate staffing levels were allocated to the centre to meet the assessed needs of the service users. This was reflected in a current and actual roster maintained by the person in charge. Staff were supported to attend training sessions including refresher training. The person in charge had ensured that all training needs would be identified and a plan would be developed to address any identified training needs.

Whilst some formal staff supervisions were completed in the centre in the form of quality conversations, these were not consistently completed in accordance with local policy. Staff were supported to voice any concerns they may have through the implementation of regular staff and house meetings. The person in charge was also regularly present within the centre to meet with staff and the resident should the need arise.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had completed the process of applying for renewal

of registration is an effective manner.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced individual to the role of person in charge.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the allocation of staffing levels and skill mix appropriate to the assessed needs of the residents. Nursing care was afforded as required. An actual and planned roster was in place.

Judgment: Compliant

Regulation 16: Training and staff development

Measures were in place to ensure all that staff within the centre had received mandatory training including refresher training.

The person in charge had not ensured that all staff had received appropriate supervision.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had ensured the centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had allocated a clear governance structure to the centre. Regulatory required monitoring systems had been implemented in a comprehensive manner with clear time lines in place to address areas of concern.

At centre level, there was non adherence to the organisational audit schedule in place to ensure ongoing monitoring of service provision.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose containing the information set out in Schedule 1. This document was reviewed as required.

Judgment: Compliant

Quality and safety

The inspector reviewed the quality and safety of Cluain Meala and overall the resident were afforded with a good quality of life. Social activities were encouraged in accordance with the current national restrictions with participation in meaningful activities supported and facilitated by staff members. Through comprehensive individualised personal plans residents were supported to implement all multidisciplinary recommendations to achieve a high quality of life

The person in charge had ensured the development of a comprehensive individual personal plan for the resident. These plans incorporated multidisciplinary recommendations and guidance. A number of support needs were addressed and regularly reviewed by staff members. The resident was supported to engage in wide range of activities such as shopping trips, art sessions and visits to their family home. The resident showed the inspector photographs of recent activities including art and meeting their sister for a cup of coffee. Whilst goals had been developed with the resident through a visioning meeting, some improvement was required to ensure that the progression of all goals were clear. Skills training was encouraged for the resident with the inspector observing staff members adhering to plans in place.

Staff spoken with on the day of the inspection had a clear understanding to the needs of the resident in the area of behaviours which may challenge. They could

clearly articulate the proactive strategies utilised by the staff team to support the resident. However, the guidelines available within the personal plan were dated 2016 and did not reflect the current needs of the resident. Through the use of the proactive strategies utilised there had been a marked decrease in the number of incidents which the resident engaged in.

The areas of risk management and safeguarding were reviewed on this inspection and residents were found to be well protected and safeguarded by policies, systems and practices in place. A risk register was used by the provider which outlined the predominant risks in the centre such as falls, behavioural risks and environmental risk. There was evidence of ongoing review of risk. Safeguarding policies and practices were clearly understood by staff and there was evidence in place of follow up and appropriate investigation where allegations were made. Safeguarding plans were in place as required and were regularly reviewed.

The registered provider had ensured effective measures were in place for the detection of fire. Through ongoing monitoring by the staff team, through daily and weekly checks, any issues were identified and addressed in a timely manner. Whilst evacuation drills occurred on a monthly basis the length of time taken to safely evacuate was not documented in a consistent manner.

The person in charge had not ensured the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, and administration of medicinal products. Some improvement was required with regard to the storage of medications including measures to ensure stock checking of all medicinal products. Medications in general were supplied through a venalink system. Whilst the number of venalink packets supplied were counted weekly, the contents did not appear to be checked and verified against the medication administration record sheet. An error noted on one administration record sheet from June had not been identified. The person in charge ensured the inspector that this would be reviewed and appropriate actions taken to address same,

Regulation 20: Information for residents

The registered provider had prepared in writing a guide in respect of the designated centre and ensured a copy was made available.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured the development of a risk management policy

incorporating the regulatory required information. Effective measures were in place for the ongoing assessment, management, and review of risk within the centre.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had ensured effective measures were in place to ensure adherence with best practice with regard to infection control.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, the registered provider had ensured effective systems were in place for the containment and detection of fire within the service. Through regular fire evacuation drills and personal emergency evacuation plans residents were supported to safely evacuate the building in the event of an emergency. Some improvements were required with regard to the documentation of all evacuations.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, and administration of medicinal products. Some improvement was required with regard to the storage of medications including measures to ensure stock checking of all medicinal products.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not ensured the resident had an individualised personal plan in place which was reviewed on a regular basis. There was clear evidence consultation with the required members of the multi-disciplinary team to

ensure supports were afforded to residents in a holistic manner.

There was also evidence of consultation with resident with regard to the development of personal plans. Some improvement was required to ensure the progression of all goals was clear.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where a restrictive intervention was used, it was used in the least restrictive manner and for the shortest time necessary to ensure the safety of all in the centre.

The person in charge had not ensured staff were provided with up-to-date knowledge and guidance to respond to behaviour that is challenging.

Judgment: Substantially compliant

Regulation 8: Protection

Through an organisational policy and staff training the resident was protected from all forms of abuse. Where a safeguarding concern was present adherence to national and local policy was present.

Guidance for staff to support the resident during personal and intimate care was present within the individual personal plan in a respectful and dignified manner.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner which was respectful to the rights of each individual resident.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cluain Meala OSV-0005705

Inspection ID: MON-0029844

Date of inspection: 08/07/2020

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:
Quality Conversations:
SPC has a Quality Conversations Policy in place, outlining a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for staff. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

The PIC has a schedule for completion of Quality Conversations in place, which will ensure all outstanding Quality Conversations are completed with the staff team by 15/08/2020. Delegated duties and actions are discussed and agreed with staff members at Quality Conversations and followed through by the PIC at the following meeting.

Training Update:
SPC employees are supported to attend mandatory and mandated training. It is also the responsibility of staff to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny).

Staff training is on the agenda of the monthly team meetings and also discussed at Quality Conversations. A centre specific training profile, individual staff training profiles and a training schedule are distributed monthly to the PIC and PPIM of the centre by the Training Department.

The PIC is currently following up with 2 staff members to ensure refresher training for Safeguarding and Children First Training will be completed by the 30/08/2020.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC for Cluain Meala has a remit of 3 SPC designated centres and is dividing her time equally to ensure oversight and management. The PIC is supported by a CSM through informal meetings as needed, Quality Conversations and Cluster meetings. The PIC is also supported by a social care worker and a nurse within her designated centres. Delegated duties are completed by the staff team and followed up by the PIC on regular basis.

During the start of COVID-19 pandemic the PIC was working remotely for a period of approximately 8 weeks, which caused a backlog of completion of audits within Cluain Meala. Since the PIC has recommenced her work within the centre a full review of outstanding audits has been completed and a plan put in place to delegate and complete audits as per schedule.
At the team meeting on the 30/07/2020 the PIC will be discussing further delegation of audits going forward in Cluain Meala to ensure adherence to the audit schedule.
All outstanding audits will be completed by 20/08/2020 and necessary actions being followed up.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
After the inspection took place the PIC had an informal meeting with staff members to highlight identified issues around the documentation of fire drills. The completion of fire drills and documentation of same was discussed. All staff are now aware of the template to be followed when completing a fire drill. The PIC is monitoring the correct use of fire drill documentation and completion of same.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Immediately after the inspection the PIC identified the staff member who did not follow process as regards to stock check of medication. The correct procedure of medication stock checking was discussed with the staff member and the PIC is monitoring the procedure closely.

The PIC has scheduled a team meeting for the 30/07/2020 where the following will be discussed:
• Identified medication errors at HIQA inspection
• Correct procedure of medication stock checks
• Reporting of medication errors
• PIC to provide mentoring regarding weekly stock checks and recording of stock in from Pharmacy.

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:
Since the inspection took place the PIC has discussed the completion of roles based progress sheets with the staff team. The PIC is aware of the mentoring needed for the staff team regarding the documentation and understanding of roles, goals and progress of same. Mentoring for the staff team is provided through team meetings and Quality Conversations.

At the team meeting on the 30/07/2020 the PIC will discuss further:
• Personal Planning Process
• Identification of Roles and Goals
• Capturing the progress and development of roles and goals
• Support for staff team in using the documentation for roles based planning.

SPC has now developed a Personal Plan Policy and Pathway to ensure clear guidance for all staff members on personal planning and the use of documentation to evidence:
• Assessment processes – to assess all support needs for the people supported.
• Annual and monthly reviews – to identify roles and goals and create actions and steps to progress same.
• Weekly progress – to evidence progress on roles and goals.

All documentation is based on the theory of practice Social Role Valorisation and includes person centred and outcome based approach. The development of the new SPC Personal Plan Pathway was deemed necessary to develop progression on personal planning within SPC and amalgamate the MDT pathway and visioning based documentation.

The Personal Plan Policy and Pathway will be rolled out by the CSMs and Quality

Department at the next cluster meeting on the 05/08/2020. All PICs, Team Leaders and identified staff members will be in attendance to ensure rollout within all designated centres in SPC. Additional support and guidance will be given to all staff teams through mentoring by CSMs, Quality Department and Practice Development Lead by attending annual review meetings and providing video based training via SPC Q drive.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC is in the process of developing a Behaviour Management Strategy Plan for the person supported, based on the current supports being provided by the staff team for the person living in Cluain Meala. To ensure all staff members can advise of more detail for this plan based on their knowledge and experience, this plan will be discussed at the team meeting on the 30/07/2020.
The Behaviour Management Plan will also be discussed with the person supported at the next residents meeting.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/08/2020
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	20/08/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	20/07/2020
Regulation 29(4)(a)	The person in charge shall	Substantially Compliant	Yellow	30/07/2020

	ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/08/2020
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/08/2020
Regulation 07(1)	The person in	Substantially	Yellow	30/07/2020

	charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Compliant		