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:	Lolek
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	12 November 2020
Centre ID:	OSV-0007740
Fieldwork ID:	MON-0030466

About the designated centre

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

Lolek is a designated centre located in Kilkenny Town. The providers sets out that Lolek "aims to develop services that are individualised, rights based, and empowering; that are person-centred, flexible and accountable; services that energetically promote relationship building and social inclusion - and which are in and of the communities where people supported live." The centre providers 24 hours' supports to two residents over the age of 18 with an intellectual disability. The centre is currently a male gender house. The house consists of a kitchen/dining room, living room, two bedrooms, one bathroom and WC, a visitors room and a dressing room. Lolek is staffed at all times when a person supported is present. The core staffing consists of a combination of Social Care Worker and Health Care Assistants

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Thursday 12 November 2020	09:30hrs to 16:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and interact with both residents on the day of inspection. Residents were observed going about their daily routine in a pleasant manner with positive interactions with staff. Staff spoke very clearly of the needs of the residents including what they like to do. Since moving in an area of the house had been turned into a living area for one resident. They liked to spend time in this area playing their guitar, listening to music on their TV and looking out the window saying hello to the passers-by. This resident showed his guitar proudly to the inspector and could be heard playing and singing in his personal space.

Another resident had a lie in on the day of inspection. Staff spoke of them not enjoying early mornings. This resident loved to watch the news and enjoyed relaxing on the couch watching the news channel after his lunch. Both residents were out and about in the community with the support of staff. Staff supported residents to complete a number of house hold tasks in the community such as collection of medication and some shopping.

Both residents appeared very comfortable in their home and in the company of the staff team.

Capacity and capability

This was the first inspection of Lolek designated centre since it became operational in January 2020. The inspector found both areas of compliance and non-compliance on this inspection in the area of capacity and capability.

The registered provider had appointed a governance structure to the designated centre. A suitably qualified and experienced person in charge to the centre. However, within their current role they held governance responsibilities in three designated centres. Due to the remit of the governance role of this individual, it was not evidenced on the day of inspection that effective systems were in place for effective oversight of this centre. The person in charge stated that due to remit it can be difficult to keep on top of some areas such as staff supervision and team meetings.

The person in charge had a reporting role to the person participating in management of the centre. The role of this individual within the centre was not clear on the day of inspection nor was the communication between the governance team. The last quality conversation recorded between the person in charge and

person participating in management has been completed in July 2020 with no evidence of review of actions required or identification of shortfalls within monitoring systems.

A six monthly unannounced visit to the centre had been completed by a delegated person in October 2020, as part of the report an action plan had been drafted to ensure identified areas of concern were addressed in a timely manner. A number of actions which had been identified as requiring immediate review remained outstanding including staff training needs. A number of inaccuracies had been noted in the report however, these had not been highlighted as part of the review of the report.

At centre level, there was evidence of non-adherence to the organisational audit schedule to ensure an effective oversight of service provision was maintained. This had been developed by the provider to ensure that all areas of non-compliance were identified and addressed in a timely manner. A number of audits remained outstanding since the centre became operational including in the areas of complaints and safeguarding. A number of audits had been completed since the centre had opened including medication management, restrictive practice and health and safety audit.

The registered provider had appointed a staff team to the centre. The staffing levels reflected the current assessed needs of the residents. Staff team meetings were not occurring monthly as set out by the provider and the person in charge had not ensured the staff team were appropriately supervised. Quality conversations according to the organizational policy were to occur six monthly, these were not occurring. Where staff members had voiced concerns relating to the support needs of residents, there was not clear evidence of governance follow through of this evidenced to the inspector.

The mandatory training records of the staff team were reviewed but the inspector. These were found to be unclear and inaccurate. A number of clarifications were required to be obtained to ensure the safety of all residents including training with respect to medication management. This had been identified as part of the six monthly review.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. However, due to the remit of the governance role of this individual it was not evidenced that effective systems were in place for effective oversight of this centre.

Judgment: Substantially compliant

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff were facilitated and supported to access appropriate training including refresher training. The records of training maintained did not evidence a clear reflection of current mandatory training completed within the centre.

Also, the person in charge had not ensured that appropriate supervision was in place for the appointed staff team.

Judgment: Not compliant

Regulation 23: Governance and management

Whilst the registered provider had appointed a governance structure to the centre, however clear lines of responsibility were not clear.

Management systems are in place in the designated centre did ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored

Judgment: Not 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.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had given the chief inspector notice in writing within the allocated time frame of the required notifiable incidents.

Judgment: Compliant

Quality and safety

As stated previously this was the first inspection of Lolek designated centre since opening in January 2020. In this time both residents had become comfortable in their home and in their local environment, they were busy partaking in activities of their choice during the day in adherence to the current national guidelines. With staff support, residents were living meaningful lives in the local community and maintaining friendships and family contact during the pandemic.

Overall the premises were presented as warm and homely. Storage in some areas required review for example archiving files were stored openly in a spare bedroom when an empty cupboard was located and the staff shower could not be used by staff as this was currently used as storage. A small living area had been set up for one resident to use with a TV for their chrome cast and a bird's eye view of the going on in the estate. The main living room however contained a large office area which decreased the homely atmosphere of the room.

Whilst the person in charge had ensured that each had an individualised personal plan, however these plans did not reflect the current needs of the residents and required review. Within the organisation a new format of personal plans were in development, the person in charge did inform the inspector that a plan was in place to complete this review and to plan a visioning meeting for the residents. This meeting would incorporate a goal setting process for the residents. Since the transition to the centre goals had not been implemented for the residents, plans had not been reviewed to reflect the current activation and change in the day to day routine of both residents.

Overall, the registered provider had ensured that residents who were protected from infection by adopting procedures consistent with the standards for the prevention and control and current national guidelines. An organisational contingency plan was in place to ensure at all times sufficient staffing levels at all times and areas for isolation as required. However, improvements were required to ensure adherence to PPE use and social distancing were maintained consistently throughout the day. For example during staff break times staff sat together and removed face masks in close proximity to residents.

The registered provider had implemented a number of systems to ensure all

residents were protected from all forms of abuse. This included staff training and an organisational policy. The intimate care needs of the residents had been assessed and supports were set out in a respectful and dignified manner. All interactions observed on the day of inspection were professional and jovial in nature. However, it was not evidence that all potential safeguarding concerns had been addressed and investigated effectively. Where staff members had raised concerns regarding a particular interaction this had not been addressed in accordance with safeguarding policy and procedures.

The registered provider had ensured the development of a risk management policy in accordance with regulatory requirements. A risk register was in place which had been developed as part of the transition to the centre for residents and had been reviewed in April 2020. This was comprehensive in nature and addressed a plethora of identified risk including Slips, trips and falls and epilepsy. However some improvements were required to ensure current control measures identified within the register were in place and effective. For example, medication management risk assessment stated all staff had up to date medication management training when this was not the case.

Regulation 13: General welfare and development

The registered provider had ensured all residents were provided with facilities for recreation and opportunities to participate in activities in accordance with their interests, capacities and developmental needs.

Judgment: Compliant

Regulation 17: Premises

Overall, the registered provider had ensured the premises were designed and laid out to meet the aims and objectives of the service

and the number and needs of residents. However due to the presence of a large computer table and office supplies in the living area of the house, this area did not appear homely in nature.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Improvements were required to ensure that effective systems were in place for the assessment, management and ongoing review of risk. This included an accurate reflection of current control measures in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Whilst overall the registered provider had ensured that residents who were protected from infection by adopting procedures consistent with the standards for the prevention and control and current national guidelines. However, improvements were required to ensure adherence to PPE use and social distancing were maintained consistently throughout the day.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider has ensured that effective fire safety management systems are in place including serviced fire fighting equipment and clear guidance for staff and residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines within the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Whilst the person in charge had ensured that each had an individualised personal plan, however these plans did not reflect the current needs of the residents and

required review.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had implemented a number of systems to ensure all residents were protected from all forms of abuse. This included staff training and an organisational policy. The intimate care needs of the residents had been assessed and supports were set out in a respectful and dignified manner.

However, it was not evidence that all potential safeguarding concerns had been addressed and investigated effectively.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The centre was operated in a manner which was respectful to the needs of the individuals residents.

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	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lolek OSV-0007740

Inspection ID: MON-0030466

Date of inspection: 12/11/2020

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The PIC is employed in full time position and has a remit over three SPC designated centres. The PIC is supported by a PPIM in the management of her designated centres. Since the inspection took place the PIC and PPIM have developed a workplan for the three designated centres to ensure the PIC has oversight over all actions and a list of priorities. The PPIM and PIC discuss progression of the workplan at their monthly Quality Conversations and meet on a day-to-day basis as the need arises. The PIC is also supported through monthly cluster meetings and the PPIM attending team meetings and annual review meetings in Lolek.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: SPC training department has developed a new template for training reports across the service. This will ensure a better oversight in regards to completed and outstanding mandatory training. Training reports are sent to all PICs on a monthly basis and discussed at monthly team meetings in each designated centre. SPC team meetings agenda template has been updated to ensure training needs and the coordination of rosters in regards to training is discussed within the designated centre. To ensure completion of all mandatory training, 2 employees completed the following courses:	

• 1 new employee completed Food Safety training on the 15/12/2020.
• 1 employee completed refresher training Chrildren's First on HSE Land on the 27/12/2020).

As part of the PICs workplan a schedule for completion of Quality Conversations has been developed for 2021 to ensure staff is supervised in accordance to SPC policy. All outstanding Quality Conversations for 2020 were completed since the inspection took place.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure support for the PIC and governance and oversight by both PIC and PPIM a workplan has been developed with the PIC for all three designated centres. Actions and progression of same are discussed at monthly Quality Conversations.

The PIC has developed an action plan folder for the teams in all three designated centres within her remit. This will help the teams and PIC to keep an overlook on delegated duties and progression on actions, which can be discussed at team meetings and Quality Conversations within the houses. The completion of audits within the designated centre will be included in action plans for the team as part of delegated duties.

The PIC is also supported through monthly cluster meetings by the PPIM and other PICs within the cluster.
A new cluster administration support has commenced work in SPC. The cluster admin support is coordinating attendance of PPIM at team meetings, annual reviews and completion of Quality Conversations and cluster meetings to ensure oversight of needs for people supported and guidance for PICs and employees.

The PPIM attended the team meeting in Lolek on the 30/11/20 to discuss the outcomes from HIQA inspection and necessary actions to be taken.

The implementation of a new auditing system for annual and 6 monthly unannounced visits in SPC has commenced in October 2020. New templates for the completion of audits were implemented. Regular feedback and learning are discussed within the Operations Team and a feedback form is now available for PICs to ensure factual inaccuracies and feedback can be documented and processed by auditors.

To support PICs and their teams in their understanding of regulations and supporting them in achieving compliance, Quality Department has developed two Quality Improvement tools (Quality Zooms and Ways of working).

Quality Zooms in relation to Regulation 16 and 28 have been completed by the team in Lolek to ensure compliance in these areas. Ways of working in relation to Provision of Service documentation for people supported and the completion of annual reviews were sent to all designated centre. The PIC in Lolek will ensure that Zooms and Ways of working are discussed at team meetings to build capacity within the team.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC is currently planning with H & S department to move the office desk out of the sitting room. Necessary amendments need to be completed on wiring to ensure a safe set up of computer and internet in a different room in Lolek. PIC requested this to be completed by the end of January 2021 and is currently awaiting back confirmation for necessary works to be completed. As part of the PICs action plan contact has also been made with H & S department on the 29/12/2020 in relation to shelving for house folders in Lolek.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: An identified risk on the day in relation to staff training has been addressed immediately. A risk assessment for staff training being out of date has been developed. The PIC has reviewed the risk register and Standard Operating Procedures in Lolek to ensure all identified risks are adequately rated and reflecting current support needs.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The PIC addressed adherence to all COVID-19 related infection prevention and control	

measures as outlined in the SOP immediately after the inspection and at the team meeting on the 30/11/2020.
The observations of the inspector on the day were also discussed at SPC COVID-19 Task Force Meeting and a reminder was sent in the SPC weekly newsletter to all staff members in relation to taking breaks and wearing of PPE.

H & S department are providing regular updates and reminders in the SPC newsletter in relation to infection prevention & control measures.

The PIC has also completed the HIQA Assurance Framework for infection prevention and control for Lolek.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To ensure a holistic approach and supports for the gentlemen living in Lolek the new SPC Personal Plan Framework has now been fully implemented. Annual reviews for the two people supported were completed since the inspection took place. Progression of roles and goals are now documented within weekly progress sheets and are reviewed on a monthly basis.

The layout of new Personal Plan Framework ensures that all person's needs are discussed and necessary actions documented and followed through. Previous annual MDT reviews were included in the person's annual review and all necessary actions followed through.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
SPC acknowledges that a previous concern was not treated as a potential safeguarding concern. The PPIM and PIC at that time were acting upon the raised concerns from a behaviour support view and following actions had been taken at the time by the PPIM:

The PPIM and Team Leader at the time met with the Behaviour Support Specialist to discuss the behaviours of concern of a person supported in Lolek. The Behaviour Support Specialist gave guidance and support to the staff team and person supported. Additionally, a change of staff members was also agreed on managerial level.

The current PIC has now ensured that the Safeguarding policy and current safeguarding plans for both gentlemen are discussed at the monthly team meetings and annual reviews to build capacity and ensure adherence to policy and safeguarding plans.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	20/12/2020
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	30/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Not Compliant	Orange	22/12/2020

	supervised.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	20/12/2020
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.	Not Compliant	Orange	20/12/2020
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	20/12/2020
Regulation 26(2)	The registered	Substantially	Yellow	15/12/2020

	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.	Compliant		
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/11/2020
Regulation 05(6)(b)	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 be conducted in a manner that ensures the maximum	Not Compliant	Orange	20/12/2020

	participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
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.	Not Compliant	Orange	20/12/2020
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.	Not Compliant	Orange	20/12/2020
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation	Substantially Compliant	Yellow	30/12/2020

	or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			