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:	Ceol
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	18 November 2020
Centre ID:	OSV-0007747
Fieldwork ID:	MON-0030469

About the designated centre

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

Ceol is a residential home located in Co. Kilkenny. The service can provide supports to four female residents over the age of eighteen years with an intellectual disability. The service operates on a 24 hour 7 day a week basis, with staffing levels in place based on the assessed needs of the residents. Ceol aims to develop services that are individualised, rights based, and empowering; that are person centred, flexible and accountable. The services supports and facilitates residents to participate in their local community and participate in activities which are meaningful to the individuals.

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 - 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 18 November 2020	10:00hrs to 16:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and observe the interactions of the four residents currently residing within Ceol. Residents were observed going about their daily routine such as going for a walk to the local shop to top up on supplies or going for a spin to Kilkenny city to run errands for the house. Activities were based on the individual preferences of the resident for example one resident chose relaxing and calming activities whilst others preferred to be out and about.

Staff supported the residents to communicate in accordance with their individual needs. All interactions were observed to be respectful and positive in nature. One resident who was not feeling the best on the day of inspection was supported by the staff team in accordance with their wishes and medical interventions were facilitated as per medical guidance.

Capacity and capability

This was the first inspection of this centre since it became operational in April 2020. The inspector reviewed the capacity and capability of the provider to provide safe and effective service to the residents currently residing in the centre and overall a good level of compliance was evident. Some improvements were required to ensure ongoing compliance with regulations including notification of incidents.

A clear governance structure had been allocated to the centre by the registered provider. The appointed person in charge was suitably qualified and experienced to fulfil their governance role. They had a direct reporting clear to the appointed person participating in management role. Within the governance structure there were clear lines of accountability with evidence of ongoing communication within the structure through quality conversations and regular meetings. There was also evidence of learning from peers with ongoing "cluster" and governance meetings recorded. These were an opportunity to learn from peer experiences and expertise.

A report of the most recent six monthly unannounced visit to the centre was reviewed by the inspector. This had been completed by a delegated person in October 2020. The report was currently under review by the person in charge to ensure factual inaccuracies were addressed in the final report. The actions identified in this report were being addressed in conjunction will service level identified actions to drive service improvement within the centre.

A number of auditing systems had been delegated to assigned members of the staff team. These included daily fire checks, mediation management and hygiene audits. Some improvements were required to ensure that any identified issues were

addressed effectively in a timely manner. For example, a review of incidents and accident showed a high level of minor medication errors since the centre became operational. This issue was only now being addressed following a full review but required action at an earlier date to prevent potential escalation of issue.

The registered provider was in the process of reviewing the current skill mix of staffing within the designated centre to ensure this reflected the assessed needs of residents. This included the potential need of 24/7 nursing care and additional staffing supports to facilitate prompt medication administration. At present due to staffing vacancies an interim arrangement was in place for nursing support to be obtained for other designated centres, this prevented a consistent approach to supports for residents.

The person in charge had the delegated duty to complete the formal supervision of the staff team within Ceol. Since the centre had become operational they had completed at least one quality conversation with all members of the staff team. The person in charge did acknowledge that these conversations had not occurred six weekly as set out within the organisational policy. However, the person in charge was actively present within the centre to afford supports to staff and residents as required. An emergency on call system was also available for staff to avail of additional supports outside of office working hours. Regular staff team meetings and information briefing sessions were completed by the person in charge and person participating in management to ensure that all staff were aware of the changing needs of residents and the supports plans to adhere to.

Overall, the person in charge had ensured all staff members were facilitated and supported to attend mandatory training including refresher training. The records of training maintained were unclear as to the due date for required training or when training had been completed. This required review. The person in charge had ensured that the training provided to staff was reflective to the current service provision needs. For example, a palliative course module was to be completed by all staff by the end of the month.

The inspector reviewed the notifications which had been submitted to the authority in respect to the designated centre. A number of notifiable incidents however had not been notified in accordance with the regulatory requirements. These were retrospectively submitted by the person in charge after the inspection.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. They held a role goverance role in two designated centres.

Judgment: Compliant

Regulation 15: Staffing

The registered provider was in the process of reviewing the current skill mix of staffing within the designated centre to ensure this reflected the assessed needs of residents. This included the need of 24/7 nursing care at present this was not in place due to staffing vacancies.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Overall, the person in charge has ensured that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Whilst staff were supervised by the person in charge this was not completed in accordance with organisational policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured 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.

Some improvements were required to ensure all management systems in place ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not given the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre.

Judgment: Not compliant

Quality and safety

The inspector reviewed the quality and safety of the service provided within Ceol. The resident's transitioned to this centre in April 2020 and in this time have adapted well to their new environment. With the support of the staff team and in accordance with national guidance they have explored their environment and local community. Resident's are consulted in the day to day operations of the centre and the person in charge has ensured the centre is operated in a manner that is respectful to the resident's rights.

The person in charge had ensured the development of an individualised personal plan for all residents currently residing within the centre.These were found to be holistic in nature and reflected the current needs of the residents. A number of goals had to be postponed or amended due to the national restrictions for COVID 19. Organisationally a new format of plan had been introduced to promote a social role valorisation approach to goal planning. The initial stage of this was the implementation of a visioning meeting. These were yet to occur for the residents of Ceol with appointments made for the coming weeks. Since transitioning to the centre in April 2020 residents had been supported to explore their new home and community,

The registered provider had recognised the importance of protecting residents from all forms of abuse. Where an allegation of abuse arose this was investigated appropriately with effective supports in place for staff to adhere to. Staff were confident to raise concerns to the governance team whom discussed any concern raised. As required concerns were escalated to appropriate members of the safeguarding team including the appointed designated officer. further investigation was completed in the appropriate manner be it through Trust in Care or safeguarding. All staff had received up to date training to safeguard vulnerable adults from abuse. All active safeguarding plans were reviewed by the inspector.

The registered provider had provided appropriate health care for each resident, having regard to that resident’s personal plan. Where medical treatment is

recommended and agreed by the resident such treatment was facilitated. Staff were supporting some residents with complex medical concerns at present with support from a range of multi-disciplinary agencies including occupational therapy and the palliative care team. Guidance for staff was clear and concise with all staff observed adhering this guidance on the day of inspection in a respectful and dignified manner. The person in charge had ensured that measures were in place for all residents to receive support of end of live which was holistic in nature and respectful to the wishes of the individual and their loved ones. This also took into account the impact on their friends currently residing in the centre. All residents were currently waiting psychology supports to assist them in comprehending the health needs of all.

The person in charge had ensured that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing and disposal of medicines. Some improvement was required to ensure all staff were aware of correct administration of medications for all residents in accordance with organisational policy and best practice. Where a resident could refuse medication directions for staff to adhere to ensure a consistent approach. Also as per organisational policy two staff were required to administer a controlled medication. This procedure could result in a resident waiting a period of time for the administration of the required treatment.

Overall, the systems in place in the designated centre for the assessment, management and ongoing review of risk were effective. Some improvements were required to ensure that the description of the risk reflected the changing needs of the centre. For example, whilst a lone working risk assessment had been completed this did not reflect the impact lone working have on the residents such as drug administration. The person in charge had completed a review of the risk register in April 2020 to reflect the current controls measures required due to the COVID 19 pandemic.

This inspection did occur during the pandemic and measures were taken to ensure all national guidelines were adhered to. This included social distancing and the use of appropriate PPE. All staff were observed adhering to these procedures with a clear contingency plan in place should any resident or staff display symptoms of COVID 19. The centre presented as a clean environment with disinfecting of regularly touched surfacing occurring throughout the day. Visits to the centre were occurring on compassionate grounds with measures in place to reduce the risk of transmission.

Regulation 26: Risk management procedures

Overall, the systems in place in the designated centre for the assessment, management and ongoing review of risk were effective. Some improvements were required to ensure that the description of the risk reflected the changing needs of

the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had ensured 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 and the current national guidance relating to COVID 19.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems are in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing and disposal of medicines. Some improvement was required to ensure all staff were aware of correct administration of medications for all residents in accordance with organisational policy and best practice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured the development of an individualised personal plan for all residents currently residing within the centre.These were found to be holistic in nature and reflected the current needs of the residents

Judgment: Compliant

Regulation 6: Health care

The registered provider had provided appropriate health care for each resident, having regard to that resident's personal plan. Where medical treatment is recommended and agreed by the resident such treatment was facilitated.

The person in charge had ensured that residents receive support at times of illness and at the end of their lives which met their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Judgment: Compliant

Regulation 8: Protection

The registered provider had recognised the importance of protecting residents from all forms of abuse. Where an allegation of abuse arose this was investigated appropriately with effective supports in place for staff to adhere to. Staff were confident to raise concerns to the governance team whom discussed any concern raised.

Judgment: Compliant

Regulation 9: Residents' rights

Resident's are consulted in the day to day operations of the centre and the person in charge has ensured the centre is operated in a manner that is respectful to the resident's rights.

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	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ceol OSV-0007747

Inspection ID: MON-0030469

Date of inspection: 18/11/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since the inspection took place a staff nurse was redeployed from Bramble House to Ceol to ensure nursing support in the designated centre throughout the day. During night time nursing support is currently facilitated through SPC night manager. A staff member returning from leave in January 2021 will be allocated to the staff team in Ceol to ensure 24/7 nursing staff in the designated centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has a schedule in place for completion of Quality Conversations and is providing supports to her staff team through QCs, Team Meetings and informal day to day support. At the policy working group meeting on 08/12/2020 the DOS and ADOS have agreed to review the Quality Conversations Policy in January 2021 to ensure adequate guidance and timeframes for managers in SPC in regards to completing Quality Conversations and ensure governance and oversight.	
Regulation 23: Governance and	Substantially Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A clear governance and management structure is in place for Ceol. The PIC and PPIM are meeting regularly through Quality Conversations, Cluster and QA meetings and as needed on a day to day basis. The PPIM is attending Team Meetings to ensure oversight and supports for the people living and working in Ceol.
Regular debrief meetings are facilitated in relation to one person supported's current needs in Ceol.

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 is 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.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
On the day of the inspection 2 notifiable events were identified as not being notified to the Chief Inspector. The relevant NF06 was submitted by the PIC and relevant NF07 by the PPIM immediately after the inspection took place. Notification of incidents were discussed between the PIC and PPIM.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC has reviewed the risk assessment in relation to medication administration and the impact of lone working staff on same. The risk rating has been amended to reflect the level or risk identified and necessary actions being taken and discussed between PIC, PPIM and staff team.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: A review of one person's medication administration plan has taken place since the inspection took place. The new medication administration plan includes all GP recommendations and was discussed with the staff team to ensure adherence to same.	

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	04/01/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	20/11/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/01/2021
Regulation 23(1)(c)	The registered provider shall	Substantially Compliant	Yellow	30/01/2021

	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.			
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	30/11/2020
Regulation 29(4)(b)	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 to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/11/2020
Regulation	The person in	Not Compliant	Orange	18/11/2020

31(1)(f)	charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff.	Not Compliant	Orange	18/11/2020