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:	JULA
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	23 July 2020
Centre ID:	OSV-0005694
Fieldwork ID:	MON-0029583

About the designated centre

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

Jula is a residential home located in Co.Kilkenny, catering for four adults with an intellectual disability over the age of 18 years. The service operates 24 hours, seven days a week. The property is a large bungalow which provides a homely environment for the residents. Each resident's private bedroom is decorated to their unique tastes. The person in charge works in a full time capacity with the support of the person participating in management and the staff team. The whole time equivalent of staff, in accordance with the provider's Statement of Purpose document, which is a key governance document, is 13 staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 23 July 2020	10:20hrs to 16:10hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

This inspection took place in the backdrop of the COVID-19 pandemic. Communication between inspectors and residents, staff, and management took place in adherence with national guidance. At the time of this inspection there were four residents living in this designated centre, three of whom were present. One resident was in hospital and was due to return to the centre on the day of the inspection. The inspector had an opportunity to meet the three residents present and observed residents taking part in their activities of daily living at brief periods throughout the day.

All of the residents of this centre used wheelchairs for ambulation and required significant supports from staff to attend to activities of daily living. Residents did not communicate verbally and instead used a variety of methods to communicate their preferences to staff. Notwithstanding this, the inspector found on the day of this inspection, that the residents of this centre were leading full and meaningful lives and were afforded ample opportunities to partake in ordinary lived experiences and activities of their own choosing.

On arrival, residents were preparing for the day ahead in their respective rooms. One resident was preparing to go out to meet with family and the inspector heard another resident being offered pancakes for breakfast. Throughout the day, the inspector overheard and observed residents partaking in numerous activities such as preparing smoothies, assisting to bring in the post, having their nails done, having foot massages, using a foot spa and trying out some new sensory equipment that had been delivered to the centre that day. Residents were also offered opportunities to spend time out of the centre and one resident was observed leaving to meet with family, while another had plans to go for lunch with a friend. Plans were also discussed for a third resident to go out on the bus to a local shopping centre.

The inspector observed residents enjoying a home cooked lunch with sufficient staff support. Residents were offered an alternative if they chose not to eat what was provided in the first instance and the inspector observed choices being offered to residents on numerous occasions, with residents being given appropriate time to communicate their responses.

Staff working in the centre on the day of the inspection were observed to be responsive to residents needs and familiar with their individual communication methods and residents appeared comfortable and contented in their presence. Staff were noted to interact in a positive manner with residents and spoke respectfully about residents, their support requirements, and what the staff team would like to see happening for them in their lives.

Capacity and capability

Inspectors reviewed the capacity and capability of this centre to provide safe and effective services for the residents that lived there. The centre was previously inspected in May 2018 with positive findings on that inspection. There had been changes to the management of this centre in the two months prior to this inspection. However, the findings of this inspection remained positive with the centre found to be operating to a very high standard with effective governance and management systems in place.

A clear management structure was present that outlined lines of accountability. The person in charge, who had recently been appointed to this role in the centre, was present on the day of this inspection. She was suitably experienced and qualified and had remit over three centres in total. She told the inspector about the arrangements she had in place to maintain oversight of all three centres, and the inspector was satisfied that these were indeed adequate, and that this person maintained a strong presence in the centre. The person in charge spoke in depth about the residents of the centre and was knowledgeable about the their specific support needs. An on call management rota was in place to provide staff with additional support if required out of hours. Team meetings were taking place and and there was an appropriate audit schedule in situ that included, for example, medication management audits, personal plan audits and finance audits. The team leader, a staff member with additional responsibilities, also spoke to the inspector. She was found to be knowledgeable in her role and reported a supportive relationship with the management team of the centre.

An annual review of the quality and safety of care and support was in the process of being completed in respect of this centre and the previous review was made available to the inspector. A six monthly unannounced visit reviewing the safety and quality of care and support provided to residents had been completed as required. This document enabled the provider to self identify and action issues as appropriate, and there was evidence that this tool was being utilised effectively. For example, one of the findings in this report was that the use of the outdoor space such as the existing gazebo and polytunnel should be explored. Some work in relation to this action had already been undertaken and the person in charge outlined to the inspector further plans to continue to meet this objective. Formal staff supervision meetings were taking place on a regular basis. A sample of the records relating to these were viewed and they were seen to be appropriate for the purpose they set out to achieve. The person in charge also showed the inspector a folder that contained staff action plans used to delegate duties and ensure that these were then completed.

The centre was staffed by a mix of nursing staff, social care workers and healthcare assistants, with three staff on duty during the day and two staff at night. On the day of the inspection direct support was being offered to residents by one staff nurse and two healthcare assistants. This was found to be sufficient to meet the needs of the residents at this time. The person in charge reported that additional nursing

staff had been introduced in recent times to support an increased need for one resident with additional needs in this area.

Staff training records were viewed on the day of the inspection, including records relating to agency staff working in the centre. Staff had completed up to date training in required areas including fire safety, first aid, medication management and safeguarding, and the records viewed indicated that all mandatory training had been completed. A finding from the previous inspection was that staff in this centre required training in the area of dysphagia due to residents' specific support needs. While the majority of staff had completed this training on the day of this inspection, not all staff working in the centre had this necessary training completed. This had been identified by the person in charge prior to this inspection occurring and plans were in place to address this. The person in charge told the inspector that staff who did not have this training worked at night and would not be supporting residents with meals until this training had been completed.

The inspector had sight of a service provision agreement that was in place for a resident of the centre. This set out the fees and charges in place, including transport fees and how these are calculated. There was evidence that the provider had engaged an independent advocacy service to review this document on the residents behalf. There was an easy read version of this contract in place and this had been explained to the resident by their keyworker.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge of the designated centre. The person in charge had the required qualifications, skills and experience necessary for the role and demonstrated good oversight of the centre.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were satisfied that staff had the knowledge and skills required to support the residents of this centre. The number, qualifications and skill mix of staff was appropriate and there was a planned and actual staff rota in place.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that all staff had received mandatory training within the centre. Improvements were required in training to meet specific, individual needs of residents. Staff supervision was occurring as per the organisations policy and this was addressing pertinent issues as appropriate.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents within the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre with management systems in place to ensure that the service provided is safe, appropriate to resident's needs, consistent and effectively monitored. Appropriate arrangements were in place for the supervision of staff.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

A contract for the provision of services was in place that set out the fees and charges paid by residents.

Judgment: Compliant

Quality and safety

The inspector looked at the quality and safety of the service provided to individuals living in this centre, and was satisfied that the standard of care afforded to residents was very good. A person centred approach was evident in all aspects of care and support observed during this inspection. Some improvements were required in

relation to how fire precautions were being reviewed.

The centre was situated in the countryside and was found to be clean, homely and well presented throughout. Residents had access to ample gardens and outdoor space and the person in charge showed the inspector how efforts had been made to include residents in the decorating of this space. Some of the garden space was not yet accessible to wheelchair users but the person in charge had taken some steps to rectify this and outlined to the inspector further plans expand on this. Residents bedrooms were personalised and comfortable and found to be suitable for residents' needs. All bedrooms had ceiling hoists as did the main bathroom utilised by residents.

Residents in this centre had individualised plans in place that contained detailed information to guide staff in supporting them on an ongoing basis. These were found to be very comprehensive and presented a very positive overview of residents. Goals that were set with residents were found to be relevant and the documentation around these was being updated regularly. This documentation clearly demonstrated how goals were being achieved and what steps were being taken to address any issues identified that might compromise the successful completion of goals.

Residents had access to their own handheld tablet devices and these were seen to contain pictures of activities that residents took part in and communication applications to facilitate remote video contact with family members and friends. Communication assessments had been carried out that included significant input from the multidisciplinary team, and staff were seen to follow the recommendations contained in these documents. Efforts were being made to include residents in the running of the centre through regular resident meetings. These were designed to take account of residents particular communication needs, such as using objects of reference to communicate preferences, and using easy read and pictorial guides to communicate with residents about various topics.

There was evidence that residents had accessed numerous multidisciplinary supports as required, including appropriate medical input and occupational therapy supports. Support plans were in place for a resident that had recently had a percutaneous endoscopic gastrostomy (PEG), which is a procedure where a flexible feeding tube is inserted into the stomach. Staff training was taking place to allow all staff to support this resident with their nutrition and medication administration procedures. Plans were in place to support residents to transfer to acute service and on the day of the inspection the inspector saw that risk assessments and healthcare plans in relation to a resident who was planned to transfer back to the centre from hospital were being updated to reflect new information.

Residents at this centre were adequately supported to manage any behaviours of concern and had access to appropriate supports, including the behaviour support team and psychology input. This centre had in place a low level of restrictive practices. An assessment tool was in place to identify any restrictions in residents' lives and there was a clear rationale for any restrictions in place. Restrictive practice logs were in place in the centre and restrictive practices, including restrictions

relating to the ongoing COVID-19 pandemic were being identified.

Infection control procedures in place in this centre were found to be in line with national guidance during the COVID-19 pandemic. The premises was visibly clean and appropriate hand washing and hand sanitisation facilities were available. An enhanced cleaning schedule was in place and staff demonstrated an awareness of infection control measures to take to protect residents, staff and visitors to the centre, including appropriate use of personal protective equipment (PPE). Staff had undertaken training in recent months on infection control measures including training about hand hygiene and the appropriate donning and doffing of PPE. There was a support plan in place for a resident that required extra precautions to be taken due to susceptibility to vanconycin resistant enterococci (VRE).

Risk management procedures were found to be good in this centre. A risk register was in place and was being updated to reflect any change in circumstance. Individualised risk registers were in place for residents and reviewed regularly and as required. There was an appropriate Health, Safety and Risk Management policy in place. A log of incidents and accidents was viewed and there was evidence that these were being reviewed and actioned as appropriate by the person in charge. Practices in place in this centre indicated that attempts were made on an ongoing basis to ensure that risk control measures in place were proportional to the risk identified, and that the residents quality of life was considered prior to the implementation of control measures. For example, the use of bedrails had been reduced in the centre by introducing a crash mat system that would allow residents to safely lower themselves to the floor if they so wished, thus providing a greater level of independence to residents while also ensuring their safety.

Overall, the fire precautions in place in this centre were found to be good. There was appropriate firefighting equipment such as fire extinguishers and fire blankets and this was being regularly serviced by a competent professional in this area. Fire containment and detection measures including fire doors and an appropriate alarm system were in place. Appropriate plans were in place to provide for the safe evacuation of residents, staff and visitors in the event of a outbreak of fire in the centre. There was emergency lighting in place and regular fire drills were occurring, including night time simulation drills. However, the inspector noted that some fire checks completed by staff in the centre were not recorded accurately. For example, a staff member had signed to say that oxygen was stored securely despite there being no oxygen stored in the centre on the day that this check was completed. Having had sight of some of these records, the inspector was not fully assured that these checks were occurring on a daily basis as required.

There was a locked cabinet in the centre for the storage of medications. Medication administration records were in place and were being completed appropriately by staff. All staff had received training in medication administration and management. Where medications were being crushed, this was clearly recorded on the medication administration record. PRN protocols were in place and there was a designated area for the storage of out of date or no longer required medications.

Regulation 10: Communication

The communication needs of residents had been assessed and were being met. Individual communication guidelines and communication support plans were in place and provided a good level of detail to guide staff. There were communication tools, such as picture exchange and object of interest in place, to assist residents make choices and participate in a meaningful way throughout the day.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were observed to be relaxed and comfortable in their home and in the company of the staff that supported them. Residents were provided with ample opportunities for recreation and meaningful activities.

Judgment: Compliant

Regulation 17: Premises

The premises was suitable to meet the needs of the residents. Resident bedrooms were decorated in a manner that reflected the individual preferences of residents. The designated centre was clean, adequately maintained, and there was adequate cooking and bathroom factilities and a pleasant outdoor space available to residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Arrangements were in place to assess, manage and review risk on an ongoing basis in the centre. Risk control measures were proportional to the risk identified, and any adverse impact on the resident's quality of life was considered.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had in place infection control measures that were in line with public health guidance and guidance published by HIQA.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems were in place including fire detection and containment measures. Equipment was regularly serviced and plans were in place for the safe evacuation of the centre in the event of an outbreak of fire. Some improvements were required in relation to fire checks in the centre to ensure that all staff were completing these appropriately.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines. Medication was stored securely including out of date or returned medications. Medication administration records were in place. All staff had received training in medication administration and management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Individualised plans were in place for all residents that reflected their assessed needs. These were available in an accessible format and were regularly reviewed to take into account changing circumstances and new developments.

Judgment: Compliant

Regulation 6: Health care

Appropriate health care was provided for each resident. The person in charge had ensured that residents had access to an appropriate medical practitioner and recommended medical treatment was facilitated. Residents had access to health and social care professionals as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up to date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. Restrictive practices in place were appropriately identified, documented and reviewed and a clear rationale was provided for any restrictions in place.

Judgment: Compliant

Regulation 8: Protection

Residents were found to be adequately protected from abuse on the day of this inspection. Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with appropriately in this centre through a variety of means. Residents were supported to exercise choice and control over their daily lives and participate in meaningful activities. Staff were observed to speak to and interact respectfully with 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	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	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	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for JULA OSV-0005694

Inspection ID: MON-0029583

Date of inspection: 23/07/2020

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 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The PIC and Team Leader followed through with the staff team on the completion of fire checklists immediately after the inspection. Quality Conversations were completed to address same and a team meeting is scheduled for the 21/08/2020. At the team meeting completion of fire documentation will be discussed with all staff members to ensure accurate checks being completed. The Team Leader will ensure correct completion of fire checklists through weekly audits and inform PIC of same. Quality Department and the Community Service Managers have further developed SPC Quality Improvement process to ensure learning from HIQA inspections and completed audits. Going forward standardised "Quality Zooms" and "Ways of working" will support PICs and staff teams additional to the current "Quality Assurance" meetings to develop areas of improvement. Learning from the inspection in JULA will be discussed at the next QA meeting on the 10/09/2020 a Quality Zoom as regards to Regulation 28 has been developed for all PICs and staff teams.	

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 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	21/08/2020