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:	Tús Nua
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	29 July 2020
Centre ID:	OSV-0005698
Fieldwork ID:	MON-0029974

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of three adults. In its stated objectives the provider strives to enable people to live a good life, with supports and opportunities to become active, valued and inclusive members of their local community.
Residents present with a broad range of needs and the service aims to meet these physical, mobility and sensory requirements. The premises comprises of two houses. Houses are two storey and semi-detached. Both houses are equipped with all facilities that a comfortable modern home would have. Each resident has their own bedroom and two residents share communal, dining and bathroom facilities. The houses are located in a populated suburb of the city and a short commute from all services and amenities.
The centre is operated on a social model of care. The staff team is comprised of social care staff and care assistants. The team work under the guidance and direction of the person in charge. Ordinarily there are four staff on duty each day, three in one house and one in the other house. There are two waking night staff except on occasions when there are only two residents in the house at night, when one waking night staff suffices.

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
Wednesday 29 July 2020	11:00hrs to 16:40hrs	Margaret O'Regan	Lead

What residents told us and what inspectors observed

This inspection took place in the midst of the COVID-19 pandemic. Communication between inspectors, residents, staff and management took place from at least a two metre distance and was time limited in adherence with national guidance. The inspector had the opportunity to meet with all three residents on the day of inspection.

The residents lived in two separate houses. Two of the three residents communicated primarily in a non verbal manner. The third and newest resident to the centre, used verbal language skills, particularly when they were in the company of familiar staff or with persons they knew well. The inspector observed all three residents communicating through vocalisations, some words, through their behaviours and overall demeanor. The inspector noted that residents were comfortable in their homes and looked comfortable in the presence of staff. The provider had made efforts to ensure there was a regular cohort of staff assigned to each house. Plans were in place for the staff from one house to cross cover the other house should the need arise. In addition, the roster was changed to mostly 12 hour shifts. This reportedly helped to stabilise the atmosphere in both houses and provided a continuity of daily care that best suited the needs of the three residents.

One resident enjoyed listening to and watching music videos. The resident was clear in indicating who their favourite band was. The inspector saw that this music preference was played throughout the day.

The inspector was in one of the houses when a resident was preparing to go for a drive in the car. The resident choose which staff they wished to accompany them and this was facilitated. Another resident was seen to enjoy sitting in their favourite chair and staff spoke about the resident's achievements around horse riding, graduating from school and attending a hurling match in Croke Park. These were significant achievements. These achievements had build confidence in the resident, brought pleasure and promoted independence and community integration.

Capacity and capability

In the previous inspection, which took place in May 2018, it was identified that improvements were needed to ensure management systems within the centre were effective. A similar finding was found on this, July 2020, inspection. Such improvements were needed to ensure the service was appropriate to the residents' needs, was consistent and was effectively monitored. Since the May 2018 inspection, five different persons in charge and six different line managers to the person in charge, had roles in this centre. Such a turnover of key personnel

not only affected the quality and continuity of care afforded to residents, it also raised concerns about the provider's capacity to secure and maintain proper oversight of the centre.

The current person in charge was appointed in March 2020 and their current line manager was appointed in June 2020. Both these managers were experienced in working within the disability sector, both were aware of the challenges within the centre and both showed a commitment to addressing the matters identified by the inspector.

The inspector reviewed aspects of the service that promoted the welfare of residents. In particular, the inspector noted the sensitivity in assigning specific members of staff to work with specific residents to ensure the best support for the resident. However, the lack of consistent governance and management arrangements contributed to a blurring of accountability. The inspector was challenged to get clarity as to how, some of the more recent decisions were made. For example, it was unclear how the decision was made in March 2020 to remove a car to another centre, without putting in place alternative arrangements and without fully taking on board the impact this would have on a residents' access to the community. The control of this resource, the car, was not planned and managed to provide person centered effective support to the adult living in the centre. This, and other aspects affecting care, are discussed further, under quality and safety.

There was some ambiguity in the center's statement of purpose on how it dealt with emergency admissions. At one point it stated it "does not permit emergency admissions or respite at any time". Further on it stated that admissions for emergency respite or crisis care would be at the sole discretion of the operations manager, once a suitable place, satisfactory staffing levels and resources were available. In any regard, the inspector was not satisfied with the manner in which an emergency admission took place in March 2020. Nor was the inspector reassured about the manner in which a resident from the centre was discharged to another centre. These transfers occurred with less that 24hours notice. There was limited consideration of the needs of residents already in the centre and no evidence of consultation with them.

A six monthly unannounced visit, facilitated by the provider's auditor, took place on 10th January 2020. The visit lasted two hours and focused on one of the two houses that make up Tús Nua. There were findings of poor compliance with documentation, resulting in it not being possible for the auditor to triangulate between what happened in practice and what was recorded. It was identified in the January six monthly review that assistance was required with the documentation; however, the action plan at the end of the report did not identify specific actions that needed to be taken nor did it give time-lines for completion of any actions. On 17th June 2020 an annual review for Tús Nua was completed. Overall it was a comprehensive report and indications were that there had been improvements in the management of the centre and improvements in the documentation. It also identified that more needed to be done. Specific actions and time-lines were set out in this annual report and the inspector was satisfied that the person in charge and other key personnel were working towards these targets. Notwithstanding that footfall to the centre was being

curtailed due to COVID-19, the report showed minimal evidence of consultation with residents or input from their representatives.

The provider had made an application to renew the registration status of the centre. The provider had submitted documentation that is required as part of the renewal process. However, receipt of information confirming that the tenancy agreement for both houses would be in place for the duration of the next registration cycle was outstanding. Such confirmation is a requirement determined by the chief inspector.

The statement of purpose was reviewed regularly and contained the requirements set out in Schedule 1 of the Care and Welfare Regulations. However, more clarity around emergency admissions was warranted.

Registration Regulation 5: Application for registration or renewal of registration

Receipt of information confirming that the tenancy agreement would be in place for the duration of the next registration cycle was outstanding. Such confirmation is a requirement determined by the chief inspector.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was a full time employee and had the necessary skills to fulfil her role.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff numbers on duty day and night to support residents. The staff worked 12 hour shifts which were reported to support the stability of the house and the needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

A log was maintained of staff training. Staff were facilitated to avail of training relevant to the needs of residents who they were supporting.

Judgment: Compliant

Regulation 22: Insurance

The provider had submitted evidence of insurance cover as part of the documentation required for renewal of registration.

Judgment: Compliant

Regulation 23: Governance and management

Since the May 2018 inspection five different persons in charge and six different line managers to the person in charge, had roles in this centre. Such a turnover of key personnel not only affected the quality and continuity of care afforded to residents, it also raised concerns about the provider's capacity to secure and maintain proper oversight of the centre.

The control of a resource, the car, was not planned and managed to provide person centered effective support to an adult living in the centre

The six monthly report carried out in January 2020 did not set out a plan to address the concerns raised in the report.

The evidence was minimal that residents and/or their representatives had been consulted as part of the annual review.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed regularly and contained the requirements set out in Schedule 1 of the Care and Welfare Regulations. However, more clarity around emergency admissions was warranted.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector was satisfied that notifications were submitted to HIQA as required by regulations.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There was some ambiguity in the center's statement of purpose on how it dealt with emergency admissions. At one point it stated it "does not permit emergency admissions or respite at any time". Further on it stated that admissions for emergency respite or crisis care would be at the sole discretion of the operations manager, once a suitable place, satisfactory staffing levels and resources were available. In any regard, the inspector was not satisfied with the manner in which an emergency admission took place in March 2020. Nor was the inspector reassured about the manner in which a resident from the centre was discharged to another centre. These transfers occurred with less that 24hours notice. There was limited consideration of the needs of residents already in the centre and no evidence of consultation with them.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a lack of evidence that measures required for improvement in response to a complaint had been put in place

Judgment: Substantially compliant

Quality and safety

As outlined elsewhere in this report, Tús Nua comprised of two semi-detached two storey houses. One resident lived in one house and two residents lived in the other. These community houses were acquired approximately three years previously and were part of the organisations' move away from the provision of care that here to fore was delivered in a congregated setting. Overall, the community living

arrangements suited the residents. The inspector noted the calm atmosphere in the houses and the inspector was made aware of the positive steps residents had made since moving to the centre. This included an increase in vocabulary, a greater integration into community activities and a reduction in safeguarding concerns.

In March 2020, a decision was made to transfer one resident (from the house in which two people lived) to another centre. In tandem with this, a new resident moved into the vacated place due to an emergency that arose with the incoming resident. The inspector was made aware that the move had to be within the organisations' supply of community houses, as a decision had been made as part of the organisation's de-congregation plan, that no admission was to be accommodated on campus. While there was no doubt that a situation had arisen in another centre which required immediate attention, the inspector concluded that the decision around how to address it and the impact on the residents of Tús Nua had not been adequately considered. For example, residents and front-line staff of Tús Nua had less than 24 hours' notice of the transfers. The risk that the new resident would abscond was poorly communicated resulting in the new resident climbing over a wall into a neighbour's garden. Fortunately, no physical harm occurred and to minimise a re-occurrence, a wire mesh fence, approximately three meters high, was erected on three sides of the rear garden. No other episode of absconsion had occurred since. However, that was as likely to be from staff's increased awareness of the risk and the high staffing levels in place, as much as the fence being a deterrent. The wire fence was visually displeasing. It appeared to have been erected with little or no consultation or regard to the dignity and rights of the resident who had lived in the house prior to the new resident moving in. It was also questionable if the fence was the most dignified way to address the safety situation for the resident, for whom it was erected.

With the changes to the living arrangements, also came changes in the staff that worked in the house. These changes were sudden with little consultation. It was difficult to accurately assess the level of impact the changes had on the resident who had lived in the house for a number of years. The inspector concluded this resident did miss at least one of their regular staff, albeit the resident also appeared to have adjusted to the new staffing arrangements. The lack of preparedness for this change was largely reflective of shortcomings in the governance and management arrangements as opposed to this being an inappropriate placement.

Another consequent of the transfers, was that the resident who lived in the next door house, now had infrequent access to a car. Prior to March, a car was available to this resident on a daily basis. However, the car went with the resident who was transferred to another centre. The inspector was informed the other centre did not have a vehicle and one was necessary for the resident who transferred. No clear alternative transport arrangements were put in place. The resident who was impacted by this decision, was at a stage of life where their physical ability was limited. Transport was key to the resident achieving their daily and weekly goals, and for ensuring as meaningful a life as possible. It had been a significant achievement for the resident to secure the use of a car and the resident's quality of life had improved as a result. For example, the resident enjoyed visiting churches,

which were described as the resident's "happy place". The resident also liked to take flowers to their father's grave which was described as a meaningful activity for the resident. In addition, the resident really enjoyed driving to a local beach and enjoying the sea air. Notwithstanding that the COVID-19 pandemic would have impacted on these activities, the knock on effect of not having easy access to a vehicle was resulting in this resident spending most days indoors, even when the rest of the country was opening up to activity. Staff were aware of the impact this had on the resident and had made a written complaint to the provider on the resident's behalf. The resident clearly stated "I miss my car". The complaint was a good example of staff advocacy on behalf of the resident and the complaint had been investigated; however there was a lack of evidence that measures required for improvement in response to this complaint had been put in place. While some improvement to this situation appeared to have been made in the days prior to this inspection, the availability of a car and the frequency of that availability remained vague.

The car was a central part of the resident's emergency evacuation plan. To encourage the resident to evacuate the building at night the documented most effective measure was to offer the resident a "spin" in the car. This plan needed to be reviewed to confirm that the current strategy in the event of an emergency, was still valid.

Most health care matters were adequately addressed. However, one matter was left without timely follow up. It related to a medical matter identified over 12 months earlier, which remained unresolved. In the weeks prior to this inspection, this issue had received renewed attention and the current person in charge was actively engaged in resolving the issue. Each resident had a general practitioner and consultant medical support as and when needed. One resident recently changed their general practitioner and their specialist consultant. It was not clear why or if such changes were required. There was no issue with the actual support provided by the new medical team but again these decisions were taken "for" the resident rather than "with" the resident. This was a resident whose documented personal plan stated "I like to be treated as an adult and included in planning my daily life". Nursing advice was available to residents and medication reviews were conducted. It was noted a resident's medication had reduced following such reviews. This was attributed to their community living environment. Another resident had a reduction in the instances of infections. Staff attributed this to the staffing levels the resident now enjoyed and the comfortable home the resident lived in. Infections had been a regular health care issue for this resident in their previous accommodation.

The statement of purpose for this centre outlined its ethos of providing person centered care. A key mechanism used by the organisation to achieve this, was through a system called "Social Role Valorisation". This is a process that supports each individual to engage in activities, hobbies, interests which enhances the roles each has in society. For example, one resident's aptitude for art was facilitated. The attractive pieces of work that the resident created were appropriately displayed. This resident also painted a feature wall in the sitting room of their home. All this promoted a sense of value to the skills, talents and work that the resident had put

into these activities.

Another resident who, as an adult child, found it important to contact their elderly mother on a regular basis. This was particularly important during the COVID-19 pandemic and good phone contact was facilitated. Another important role for this resident was to take flowers to the grave of their father. These were key regular activities that mattered. However, taking flowers to their father's grave had become problematic as, aside from the COVID-19 situation, the resident no longer had easy access to a vehicle and was unable to walk to the graveyard. In another instance it was identified on 5th February 2020 that dog therapy was something one resident was likely to engage with and benefit from. However, the plan to examine this further as a meaningful activity appeared to get forgotten about.

Residents gained many positive benefits since moving to live in the two houses. However, the inspector concluded there were also missed opportunities to ensure the ethos of Social Role Valorisation, as set out in the centre's statement of purpose, was fully embedded in the culture of the organisation. The inspector was informed work was underway, including training sessions, to bring a sharper focus to the principle of person centred care.

Regulation 13: General welfare and development

Residents in this centre had benefited from many opportunities including, education, increased community involvement and involvement in artistic endeavours. It was inspiring to hear that since coming to live in their community house, one resident had increased their vocabulary, partook in horse riding and attended sporting events. The family of another resident recently stated that they never seen their family member so happy. However, the effect of not having easy access to a vehicle, which heretofore was available to a resident, was resulting in that resident spending most days indoors.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

The inspector was not assured that the transfer of residents was adequately planned, transparent and appropriately consultative.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents gained many positive benefits since moving to live in Tús Nua. However, the inspector concluded there were also missed opportunities to ensure the ethos of Social Role Valorisation, as set out in the centre's statement of purpose, was fully embedded in the culture of the organisation, in particular ensuring residents were actively participating in decisions that impacted on them.

Some aspects of the personal plan had not been reviewed to take account of changes in circumstances e.g access to a vehicle.

Judgment: Substantially compliant

Regulation 6: Health care

There was evidence that health care had an increased focus in the weeks prior to inspection. However, before that some health care matters were left without timely follow up.

One resident had their general practitioner and consultant changed with little or no discussion with the resident. Neither was it clear why such a change was deemed necessary.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Overall, the living arrangements suited the residents. The inspector noted the calm atmosphere in the houses and was made aware of the positive steps residents had made since moving to the centre. This included an increase in vocabulary, a greater integration into community activities and a reduction in safeguarding concerns.

Judgment: Compliant

Regulation 8: Protection

Staff had up to date training in safeguarding. Staff stated there were no barriers to raising concerns with the person in charge, if such a need arose.

Judgment: Compliant

Regulation 9: Residents' rights

There was a number of instances whereby limited participation was afforded to residents for changes that came about in their living arrangements. This included changes as to who they lived with, changes in who worked with them, changes to their garden, changes to their medical personnel and changes to transport access.

Judgment: Not compliant

Regulation 28: Fire precautions

The personal emergency evacuation plan for one resident needed to be reviewed to confirm that the current strategy to exit in the event of an emergency, was still valid.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant
Regulation 28: Fire precautions	Substantially compliant

Compliance Plan for Tús Nua OSV-0005698

Inspection ID: MON-0029974

Date of inspection: 29/07/2020

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Tenancy agreements are in place for all people supported living in Tus Nua until 17/10/2022. As part of the application for re-registration, SPC requested an extension of the tenancy agreements to be completed by the landlord (Respond Housing Body) to ensure compliance with the duration of the next registration cycle. SPC housing department is in regular contact with SPC solicitors since the 26/04/2020 to request a variation to the current tenancy agreements for extension of the lease. SPC solicitors have yet not received the updated tenancy agreements from Respond Housing Body. SPC solicitors have contacted the landlord again on the 04/09/2020 to request a deed of variation to the current lease to be signed. SPC is currently awaiting to receive signed deed of variation, which will be made available to HIQA upon receipt.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: SPC acknowledges the governance and management issues related to a high turnover of key personnel in Tus Nua since May 2018.	

A new PIC has been assigned to Tus Nua in March 2020 and a new PPIM commenced work with SPC in June 2020, supporting the PIC and staff team in Tus Nua. A well established management system is now in place in Tus Nua and improvements have already been identified through the last provider audit and on the day of the inspection. The PIC and PPIM are meeting on a regular basis. SPC as a provider is committed in supporting the PPIM, PIC and staff team to ensure people living in Tus Nua are supported in the best possible way.

The Director of Service, PPIM, PIC and Quality Department have met on the 27/08/2020 and the 02/09/2020 to discuss the Tus Nua inspection report, necessary actions to be implemented to improve the service provided to people supported in Tus Nua and learning for SPC as a provider.

The following was discussed and actions agreed to be taken:
• Ensure that the PIC and PPIM are involved in all decision making as regards to the people supported in their designated centres. This will facilitate the PIC and staff team to communicate all relevant decisions to the people supported.
• Mitigate the risk of concerns regarding the quality and continuity of supports afforded to the people living in SPC.
• Ensure evidence of decision making on management level as regards to a person supported.
• Ensure evidence from minutes of meetings being held on management level as regards to a person supported.

The following actions have been taken since the inspection took place:

• The PIC has commenced with completing an action plan based on findings of the last HIQA inspection. Actions will be discussed and implemented with the staff team.

• A review of minutes of meetings and emails between February and May 2020 has taken place regarding the decision making process regarding the resource of a car and an emergency admission in Tus Nua.

SPC acknowledges that although meetings of relevant personnel had taken place and evidence is given in emails of supports provided to the people supported by PICs, clinicians and staff teams, this was not evident on the day of inspection in Tus Nua. Due to the changes of PICs and PPIM a lack of clear leadership in some decision making progresses was found. Quality Department is supporting the current PIC to ensure all relevant emails and minutes are being made available within Tus Nua and necessary follow up actions being taken.

• SPC has implemented a computer based shared library for each person supported. Senior management and all SPC departments are to ensure minutes of meetings or delegated duties via email as regards to a person supported are filed in soft copy in the relevant person supported's folder. Quality Department is coordinating the computer based library and PIC and PPIM have access to their relevant people supported. This will ensure that decision making processes from all management levels in regards to people supported is evident within SPC designated centres.

The computer based shared library is being introduced to all PICs and PPIMs at the Quality Assurance meeting on the 10/09/2020.

• A new Quality Improvement Policy has been developed and rolled out in SPC on the 28/08/2020. As part of the Quality Assurance and Improvement strategy SPC will be implementing 2 new tools (based on Regulations and Standards) at the next Quality Assurance meeting on the 10/09/20230. The new QI tools "Ways of Working" and "Quality Zooms" will support the PICs and staff teams going forward in a systematic way in improving the service delivered to the people living in SPC.

• A full review of SPC Admission, Transition & Discharge Policy is currently in process and will be completed by the 30/09/2020. The updated policy will include clear guidance regarding admissions externally and internally within SPC designated centres. It will also include guidance around mergency admissions.

• A full review of SPC transition documentation has taken place. The person supported's moving stories and transition booklets have been updated to support the staff teams and people supported in their transition process.

• Quality Department and Community Service Managers have scheduled a full review of provider audits for the 25/09/2020. SPC is aiming to develop a template for provider audits based on the regulations, suitable for the service.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose has been updated. As part of actions resulting from the inspection in Tus Nua, SPC has reviewed the Admissions, Transition & Discharge Policy and in line with the policy updated the Statement of Purpose regarding admissions to the designated centre.

The updated Statement of Purpose is now available in Tus Nua and has also been sent to HIQA registration on the 07/09/2020.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
A full review of the SPC Admission, Transition & Discharge Policy has commenced since the inspection in Tus Nua took place. The updated policy will be completed by the 30/09/2020 and is clearly outlining the criteria for admissions from external to SPC, SPC internal admissions & discharges between designated centres and also emergency admissions.

The Statement of Purpose for Tus Nua was updated in line with the policy.

A full review of minutes of meetings and emails between February and May 2020 has taken place regarding an incident resulting in the decision of an emergency move of a person supported to Tus Nua.

SPC acknowledges that although meetings of relevant personnel have taken place and evidence is given in emails of supports provided to the people supported by PICs, clinicians and staff teams, this was not evident on the day of inspection in Tus Nua. Due to the changes of PICs and PPIM a lack of clear leadership in some decision making progresses was found and documentation was not evident within Tus Nua or people supported's files.

From the review of emails it was evident that:
• Safeguarding plan, Feeling safe guidelines and Behaviour Support Guidelines were developed after the incident.
• The PICs involved at the time of the emergency move informed some people supported in Tus Nua and Damara. It is not evident that all people supported living in other areas of Damara and Tus Nua were informed of the move.
• The Social Worker, Clinical Supervision Specialist and Behaviour Support Specialist were providing supports to the people supported involved in the move.
• Service Design meeting for person supported was held on the 18/02/2020 after the move to discuss necessary actions regarding. A review meeting took place on the 12/03/2020.
• Review meeting with Psychologist took place on 24/02/2020 for person supported.
• SOPs and risk assessments had been developed.
• Review of restrictive practices for person supported.

SPC acknowledges that although meetings have taken place and supports were given it is was not documented at the time how all people supported living in Tus Nua and other designated centre were involved and how the emergency move impacted on each person.

The PIC and staff team have now created a homely atmosphere with the people living in Tus Nua and especially both gentlemen have settled well in their home.

To ensure all documentation in relation to the emergency admission is available within Tus Nua, Quality Department is supporting the current PIC to ensure all relevant emails and minutes are uploaded on the newly developed computer based library.

Going forward the updated Policy and transition documentation will support SPC in their

planning and documentation of admissions and discharges – planned or in emergency case.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The decision making process regarding a person supported's availability of a car was reviewed as part of the response for the compliance plan. The provider's decision was communicated via email to the previous PIC at that time. The idea of carpooling as identified in the providers directive was not consistently followed through during the outbreak of COVID-19 pandemic, as the relevant person supported was cocooning at that time.

A staff member completed the complaint on behalf of the person supported in April 2020. The complaint was discussed at the person's MDT review meeting on the 02/06/2020. And carpooling has commenced with other SPC houses in close proximity since COVID-19 restrictions had been lifted.
The current PIC has now developed a monthly plan for carpooling with 2 designated centres to ensure the person supported can avail of transport and staff is aware of the allocated times. Additionally the staff team is also exploring the usage of public city transport for the people supported in Tus Nua. Kilkenny is offering a very valuable city bus, which is an interesting opportunity of transport for two young people supported in Tus Nua.
The PIC and PPIM are currently in discussion with the finance department to support the person exploring purchasing her own vehicle. Quality Department and the PPIM have linked with finance department to develop a guidance pathway for SPC in regards to purchasing private vehicles.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Since the changes of occupancy and management in Tus Nua in early 2020 the PIC and staff team have settled very well and are providing a homely environment for the three people supported living in Tus Nua. All people supported are enjoying their daily routine. The PIC and staff team have implemented all learning from previous incidents, which have been reduced significantly.

A lot of exciting and positive activities have happened in Tus Nua during the start of COVID-19 to ensure people are supported to have meaningful days. Since restrictions had been eased family visits have re-commenced successfully.

The planning of access to a car for one person supported in Tus Nua has been further progressed by the PIC and staff team. A monthly carpool planner is now in place to support the person in accessing transport.

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
As outlined under Regulation 24 a full review of the SPC Admission, Discharge & Transition process has commenced. This review includes the update of relevant policy and transition documentation, which will be completed by the 30/09/2020.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
SPC has developed a Personal Plan Policy and Pathway to ensure clear guidance for all staff members on personal planning and the use of documentation to evidence:
• Assessment processes – to assess all support needs for the people supported.
• Annual and monthly reviews – to identify roles and goals and create actions and steps to progress same.
• Weekly progress – to evidence progress on roles and goals.

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

The Personal Plan Policy and Pathway was rolled out by the CSMs and Quality Department at cluster meeting on the 05/08/2020. All PICs, Team Leaders and identified staff members have attended to ensure rollout within all designated centres in SPC. Training for all staff teams has commenced since the 05/08/2020 and will be completed

by the 11/09/2020.

Additional support and guidance will be given to all staff teams through mentoring by CSMs, Quality Department and Practice Development Lead by attending annual review meetings and providing video based training via SPC Q drive.

As part of the roll out of the new Personal Plan Framework each person living in Tus Nua will be supported to complete an annual review of their personal plan by 30/10/2020. This will ensure all person's relevant roles and goals have been identified and reviewed and each person is supported in achieving same.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
One person supported is currently awaiting a date for a medical procedure. Supported by the GP and SPC clinicians, the PIC and staff team have ensured adequate preparation with the person supported, including the development of a pathway.

Another person supported was informed about the change of consultant and medication supported by the team and social worker. A social story was used to facilitate the communication with the person supported. The person was also supported to attend a Zoom meeting with the consultant on the 26/06/2020, which he choose not to attend. The person supported was informed and supported to attend a review meeting via ZOOM on the 07/09/2020 with the consultant.
Within the new Personal Plan Framework, annual and monthly reviews have to be completed as part of each person's role and necessary actions. Health & Wellbeing is one important part of the Personal Plan Framework and the PIC and staff team will ensure the people living in Tus Nua are involved in their reviews and all necessary actions communicated appropriately.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
SPC acknowledges that a number of decisions have been made in relation to people supported in Tus Nua, which were not communicated in a timely manner to the people living in Tus Nua.
Following the inspection communication between relevant personnel and minutes of meetings were reviewed which evidenced that supports were given to people supported during decision making by e.g. the social worker, clinical supervision specialist, etc.

Evidence of these supports were not documented sufficient enough to provide assurance to the HIQA inspector on the day of the inspection.

SPC management is committed to ensure the PIC and CSM is included in all relevant decisions as regards to the people supported living in SPC. The PIC will ensure that all relevant decisions, affecting people's lives will be communicated with them in e.g. residents meetings using adequate communication tools (e.g. social stories). All people supported in Tus Nua use verbal language and can express their wishes and dislikes.

A referral for one person supported regarding an independent advocate has been completed. The PIC and person supported are awaiting a date to meet with the advocate.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The PEEP for one person supported has been reviewed and updated on the 06/09/2020 since the inspection took place. This change was necessary to reflect the change of assembly point in the event of a necessary evacuation. The PIC and staff team have discussed the updated PEEP and communicated this change also with the person supported.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	30/09/2020
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	11/09/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in	Substantially Compliant	Yellow	03/09/2020

	accordance with the statement of purpose.			
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	10/09/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	10/09/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any	Substantially Compliant	Yellow	10/09/2020

	concerns regarding the standard of care and support.			
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Yellow	30/09/2020
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Not Compliant	Orange	30/09/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	06/09/2020
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	03/09/2020
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a	Substantially Compliant	Yellow	15/09/2020

	complaint are put in place.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/10/2020
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/10/2020
Regulation 06(2)(a)	The person in charge shall ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available to the resident.	Not Compliant	Yellow	10/09/2020
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is	Substantially Compliant	Yellow	10/09/2020

	facilitated.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Yellow	20/09/2020