



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	20 July 2022
Centre ID:	OSV-0008154
Fieldwork ID:	MON-0036788

About the designated centre

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

The centre is located within a small campus setting which contains six other designated centres operated by the provider. Cloghan provides full-time residential care and support to 3 residents. The designated centre comprises of a four bedded bungalow. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. Residents are supported by a staff team of both nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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 (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 20 July 2022	09:30hrs to 17:00hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor and review the arrangements the provider had put in place in relation to infection prevention and control (IPC). The inspection was completed over one day and during this time, the inspector met with residents and spoke with staff. In addition to discussions held, the inspector observed the daily interactions and the lived experiences of residents in this designated centre.

Cloghan was located within a small campus setting where there were six other designated centres operated by the same provider. Cloghan was an older building and different in design to the other centres on the campus. The campus was located in a residential area on the outskirts of a busy town. It was close to community amenities such as shops, leisure facilities and coffee shops.

This designated centre was a four bedroomed bungalow where care and support was provided to three residents. There was an entrance hall where a safety pause station was set up and a kitchen/dining room which was observed to be spacious and well equipped. All residents had their own bedrooms and these were observed to be comfortable and personally decorated. Each resident had arrangements in place for use of an en-suite bathroom or a communal bathroom for their personal use. There was one spare bedroom which was used to store equipment and for administrative tasks. Residents had a choice of two sitting rooms in this property which meant that they could choose to spend time together or apart. To the rear of the premises, there was a back door and the inspector noted that there was no hand hygiene station at this point of exit and entry. This led to a patio area where there was a small shed which was used for the storage of the washing machine and for the laundering of clothing and linens. Also, it was used for the storage of cleaning equipment such as mop heads, mop handles and mop buckets. The inspector found that although most areas of this designated centre were generally in a good state of repair there were other areas of the premises that required cleaning, maintenance and improvement. This will be expanded upon under the quality and safety section later in this report.

The inspector met with all three residents on the day of inspection. All residents used some words to communicate with the inspector although these interactions were short and discussions regarding infection prevention and control did not take place. One resident was sitting outside on a garden bench which waiting for the bus. They told the inspector that they were going to their day service. They were looking forward to this as there was a day trip planned. Another resident was spending time alone in the sitting room at the rear of the property. They were listening to a religious service on the television. The inspector noted family photographs displayed and the resident looked at these pictures with the staff and the inspector. The staff on duty told the inspector that they were planning a birthday celebration for this resident. The resident presented as content and interactions with staff members were noted to be respectful and cheerful. They had a plan to go to the town later

that morning. The third resident got up a little later. They moved around the premises and at times presented as unsettled for example, when wanting to watch television or go to get cake. The inspector found that the staff on duty were familiar with the resident's communication style and that they ensured that their wishes were responded to.

The person in charge told the inspector that all residents had regular contact with their families and their communities. Family contact was facilitated through visits to the designated centre, day trips to residents' homes and through telephone calls and video calls. There were no visiting restrictions in place in the designated centre on the day of inspection and this was in line with public health advice at that time.

The person in charge was on duty on the day of inspection, along with a staff nurse and a healthcare assistant. The person in charge told the inspector that they commenced employment as person in charge for Cloghan in December 2021. Since that time, they were on a period of leave and returned to duty in early June 2022. During their absence, staff members told the inspector that they reported to an acting person in charge initially and then to a second acting person in charge at a later stage. This meant that this designated centre had experienced a time of change in relation to the leadership and management arrangements in place and the inspector found that this had an impact on the oversight of the infection prevention and control measures in use.

In relation to these infection prevention and control measures, the inspector found that some were of a good standard and others required review. There was a safety pause which was carried out at the point of entry. The inspector saw that hand sanitiser was provided and there were boxes of both medical face masks and FFP2 masks for resident and staff use. A checklist was in use. However, the inspector found that this required review. For example; this review would ensure that the use of temperature checks was in line with current public health guidance for long term residential care facilities and to ensure that the checking of COVID-19 passports was a valid request. The inspector reviewed a sample of 10 completed checklists and found that four of these were not dated, therefore, it was not possible to know when people visited in order to complete contact tracing arrangements if required by the provider.

Hand washing facilities were available throughout the property and hand soap was provided. If hand towel was not available, this was noted and it was replenished promptly. Foot operated bins were available throughout the centre but in some rooms these were not working correctly as the lids did not close. Staff were wearing face masks and were observed to be practicing good hand hygiene at appropriate intervals throughout the day. There were sufficient supplies of personal protective equipment (PPE) available in the centre, including gloves, aprons, and both medical grade and FFP2 masks.

Signage was displayed throughout the centre. Many of these posters were in easy-to-read format, for example, the handwashing posters displayed in the residents' bathrooms. However, the inspector noted that some of the signage displayed required updating and in some cases, it was old and torn. For example, the easy-to-

read poster displayed on the front door which referred to visiting arrangements required updating. Also, the signage on the sitting room doors which referred to the limitations on the number of people permitted to use the room at any one time.

In summary, Cloghan provided comfortable living accommodation for the residents where there were some systems and processes in place to prevent and control the spread of infection. This designated centre had experienced a time of change in management recently and it was found that this impacted on the governance, leadership and oversight of the infection prevention and control measures used.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

As previously referred to, the person in charge was present and at the time of inspection they told the inspector that they had responsibility for that designated centre only. However, they said that plan was subject to change in the future.

In terms of the structures in place, the person in charge said that they were supported by the director of nursing and that this was a very supportive relationship. A clinical nurse manager 1 (CNM1) was employed to support the daily work of the person in charge, however, they were not working in the designated centre at that time as it was reported that they were redeployed to cover another centre.

The person in charge had access to an IPC link nurse on site and recently to part-time clerical support which was reported as very helpful. There was an experienced staff nurse on duty on the day of inspection, along with an experienced healthcare assistant. The inspector met and spoke with both staff members. They told the inspector that the return of the person in charge was a positive development for the service, that progress was being made in relation to governance and reporting structures and that there was a sense of 'settling down'.

A lead worker representative for COVID-19 was nominated along with a COVID-19 response manager. However, the inspector found that there was some uncertainty in relation to the identity of the lead worker representative (LWR) as two names were provided. In addition, the person named in the health and safety statement did not align with the person named in the COVID-19 site specific contingency plan. This required review to ensure that clear information about the roles and responsibilities for IPC in the centre were known to all.

The staff roster was reviewed, and the inspector found that it was not accurate as the CNM1 was on the roster and as they were not working in the service; this required review. This was not a nurse-led service, however, nursing support was available on site if required. For example, the person in charge explained that the optimum level of night-time support was one staff nurse and one healthcare assistant. However, it was not always possible to have a staff nurse on duty and therefore two healthcare assistants provided care and support with a nurse available on site if required. During periods when replacement staff were required there was a tiered on call arrangement in place. The first step was to make contact with senior staff member on campus and then with external senior management if required. This was reported to work very well. Furthermore, the person in charge told the inspector that they had access to experienced agency staff and this ensured that consistency of care was provided.

The provider had systems in place to assess, monitor and review performance in relation to infection prevention and control, however, the inspector found that some of these required review. For example, the person in charge told the inspector that they had held an internal governance meeting with some of the staff team recently. The agenda was available and the minutes were pending. This was discussed with the staff on duty, however, they were not in attendance at this meeting. Therefore, it was not a meeting of the full team. Furthermore, the inspector reviewed the internal governance meeting folder and the minutes of previous staff meetings. This review found that one meeting had taken place so far this year. This was held in January 2022. Therefore there were limited opportunities for all staff to meet to review and discuss IPC arrangements in the centre.

Staff had access to infection prevention and control training as part of a programme of continuous professional development. Modules included; basics of infection prevention and control, hand hygiene, personal protective equipment (PPE), management of blood and body fluid spills and cleaning and disinfection training. The inspector found that of the 13 modules reviewed, seven refresher modules were either outstanding or completed, however some certification was not available on the day of inspection to verify what training was completed. In some cases, the person in charge was following up on how often this refresher training should be completed as there was a reported discrepancy between the guidance on the training matrix and the guidance on the providers training portal. For two further training modules, the person in charge was following up on the relevance of this training for their staff as this was uncertain. Four refresher modules were up-to-date, certificates were available and the matrix was updated. This showed uncertainty and inconsistency with regard to the IPC training provided and this required improvement.

This designated centre experienced a COVID-19 outbreak this year. A review of the documentation showed that outbreak meetings had taken place during this period with members of the management team. However, no post incident review had taken place. Staff spoken with were aware of how to monitor for signs and symptoms of infection, and of what to do if required to act promptly. They told the inspector that they would use enhanced PPE, put person centred isolation plans in place, report concerns promptly and seek support from the IPC link nurse and senior

management. They were aware of the how to safely manage risk waste and risk laundry, including the correct bagging, tagging and disposal of risk waste and the correct use of dissolvable laundry bags and the requirement to wash laundry at high temperatures. However, the inspector found that although staff demonstrated knowledge in relation to these measures, this was not supported by the guidance documentation in place. For example, the site specific contingency plan available on the day of inspection and for use by the staff was dated August 2021. This was found to require updating, as a number of public health measures had changed since that time. Furthermore and as previously referred to, it did not contain consistent information on the identity of the COVID-19 response manager and the lead worker representative. This meant that the information provided was not up-to-date and not clear.

The inspector found that the staff on duty had good knowledge in relation to their experience of the outbreak. For example, they discussed the process used for entry and exit of the designated centre during the outbreak and the procedures in place in relation to the donning and doffing facilities used. This showed that there were opportunities for shared learning and improvement from the outbreak experience. However, as mentioned previously, there was no evidence of a post outbreak review and therefore no opportunity to capture the learning gained from the experience. This required attention.

The provider had some audit systems in place to monitor and review its performance in relation to IPC. These included the HIQA self-assessment tool which was completed in April this year. The provider also had an environmental audit tool in place. The annual report on the quality and safety of care was completed two weeks previous and the twice per year provider-led audit was completed in May. Both were available for review on site. Actions identified in relation to infection prevention and control were monitored through the centre's quality improvement plan. However, the inspector found that while reviews were completed they did not fully capture the areas for improvement and the gaps identified on inspection. For example, the gaps in relation to the contingency plan and inconsistent information about the LWR and compliance lead for IPC in the centre was not identified. This showed that although the provider had systems in place to monitor IPC, these systems were not always effective, and this required improvements.

In summary, it was evident that the structures and systems in place to support staff discussion, to facilitate opportunities to assess and monitor performance and to enhance learning in relation to IPC were not effective and not sustained during the absence of the substantive person in charge.

The next section of this report explores how the governance and oversight arrangements outlined above affects the quality and safety of the service being provided.

Quality and safety

This section of the report will describe the care and support people received and if it was of good quality and if it ensured that people were safe.

The inspector found that most residents in Cloghan had good communication skills and were observed having short conversations with the staff on duty. They were observed to be supported to make decisions such as; their plans for the day, their decision to wear a coat, their wish to go and get cake and a drink. Residents meetings were taking place and an easy-to-read template was available for residents' use. However, of the sample of seven meeting minutes reviewed only one meeting reviewed information about infection prevention and control. This was under the health and safety heading and provided guidance on the importance of wearing masks while 'out and about'. There was no further evidence of discussion or decision making in relation to IPC at these resident meetings.

Residents had comprehensive support plans in place. A review of these documents provided evidence of residents' access to a general practitioner (GP) and members of the multi-disciplinary team. For example, the person in charge confirmed that a speech and language therapy assessment for one resident had been completed, from which a dysphagia report was provided and a review date agreed for the remaining two residents. Furthermore, there was evidence of support provided from occupational therapy, psychology and access to consultant-led services if required. This meant that a circle of care was in place for each resident which ensured their healthcare needs were attended to. There were no recent or regular admissions to hospital services and therefore there was no requirement for sharing of infection status on admission and discharge at the time of inspection.

As previously outlined the inspector found that the staff on duty had good knowledge of the standard precautions required to prevent and control the spread of infection and there were systems and processes in place to support the routine delivery of IPC. For example, staff were observed to be wearing face coverings and practicing hand hygiene on their return from lunch. Furthermore, the provider had a protocols in place in order to guide and assist staff in the completion of the tasks required. These included a daytime and night-time cleaning schedule and a weekly environmental audit which measured the risk presented and guided staff on how and when to carry out cleaning. However, although the systems were in place, the inspector found that these were not effective. For example, over a number of days, the daily cleaning schedule was not completed at 22:30 hours or at 06:30 hours as per the schedule in place. The person in charge and the staff on duty told the inspector that this was because there was no staff nurse on duty at night-time on the dates identified. The specific night-time cleaning tool referred to the cleaning of 'dinamap' which was used to measure the clinical observations such as blood pressure and temperature checks for all the residents. However, this cleaning was not taking place as planned, as this piece of equipment was visibly dusty and dirty and had a personal item of residents clothing hanging on it. Furthermore, there was no evidence provided that it was cleaned between use by residents. This meant that

it was not maintained effectively in order to minimise the risk of transmitting a healthcare associated infection to another resident.

The weekly environmental audit tool was reviewed and was also found to be ineffective. For example, a resident's bed frame was identified on the audit as a high risk area which was to be cleaned daily. However, the sample week reviewed, the inspector found that this was cleaned 3 out of 7 days and on the on the day of inspection it was visibly dirty. Furthermore, the folding shower screen doors which were in use were to be cleaned once weekly. They were found to have soap scum deposits, were stained and dirty and it was evident that the cleaning plan in place was not working.

There was a procedure in place in this designated centre for the scheduling of maintenance requirements. A walk around of the centre showed although the residents' home was generally clean there was evidence of wear and tear to the premises and cleaning, equipment organisation and maintenance improvements were required. For example, in the one of the bathrooms the floor covering was lifting from around the edge of the room and the storage unit and bin provided was stained and appeared dirty. There was an empty urine collection jug in the cupboard and an unused kidney dish on the window ledge. The storage of these items required review. The paint work on the corridor was marked and there was evidence of frequent touching by residents as they passed along the corridor. The paint work in a resident's bathroom was visibly soiled and required attention. The radiators in some areas had chipped paint and appeared to be rusting. In the larger sitting room, deterioration to the wooden floor covering was evident and this continued through the hallway and down towards the emergency exit door. There was evidence of damage from everyday use along with gaps in the floor covering in places which were patched with tape. This meant that it was not possible to effectively clean the floors in these areas. To the rear of the property, the shed used for storage of washing and drying machines and cleaning equipment had flaking paint which was coming away from the walls in place. Furthermore, the arrangements in place for the storage of mops and buckets required review. Although there were different coloured mop heads available, there were grouped together on a shelf and not separated. A used mop head was on the floor of the shed.

Overall, the inspector found that although governance structures were in place in this designated centre and that the service endeavoured to provide a good quality of care and support to the residents living there, improvements were required. These included the need to ensure that infection prevention and control systems and procedures in place were up-to-date, valid, consistently applied by all staff and effective. Furthermore, that in case of changes to the leadership and management arrangements in place, that these systems and process are embedded into routine service delivery and therefore effectively sustained despite changes that may occur.

Regulation 27: Protection against infection

The provider had not ensured that residents who may be at risk of a healthcare-associated infection were adequately protected by the processes and procedures in place in this designated centre.

Improvements were required to ensure that the IPC processes and procedures in place are strongly embedded into routine care delivery and that they would not be impacted on by changes in oversight should they occur. Staff were found to be experienced and knowledgeable. However, there were gaps in the systems and documentation available to guide and support staff. In other cases, the systems and documentation was in place but it was not effective. For example;

- the site specific COVID-19 response plan required review to ensure that it was up-to-date and in line with current public health guidance
- the process in place for staff governance meetings required review to ensure that they were taking place regularly and that all staff had opportunities to attend team meetings
- the roster required review to ensure that it was an accurate reflection those on duty and the lines of authority in place
- clearly documented arrangements for a compliance IPC lead were required to ensure effective monitoring of IPC systems and ensure that all staff grades were aware of their responsibilities in relation to the prevention and control of the spread of infection
- the training matrix required review to ensure that all staff had access to mandatory and refresher training in relation to IPC
- opportunities for shared learning and reflection were required post outbreak to ensure that improvement identified were included in the updated contingency planning
- the oversight of the maintenance schedule required improvement so that issues identified could be addressed promptly

Judgment: Not 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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Protection against infection	Not compliant

Compliance Plan for Cloghan OSV-0008154

Inspection ID: MON-0036788

Date of inspection: 20/07/2022

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 27: Protection against infection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>To ensure compliance with regulation 27 the following actions has been taken</p> <ul style="list-style-type: none"> • The Person in Charge has reviewed and updated the site specific COVID-19 response in line with current public health guidance. Completed: 27/07/2022 • The Person in Charge has completed a schedule for governance meetings to year end 2022. This schedule is arranged to ensure that all staff working in the centre have the opportunity to take part in regular meetings. Completed: 17/08/2022 • The Person in Charge ensures on a daily basis that the actual roster is up to date and reflects the lines of authority in place. Completed: 15/08/2022 • Arrangements for a compliance IPC lead have been identified in the site specific contingency plan. The Lead Worker Representative has completed the relevant training to fulfill the role. Staff have completed IPC modules on HSEland to ensure that they are aware of their role and responsibilities in relation to prevention and control of spread of infection. Completion date: 31/08/2022 • The Person in Charge has completed a review of the training matrix for the centre. All staff have been provided with a copy of the individual training needs analysis which includes all IPC modules to be completed. The Person in Charge will continue to monitor and review the training matrix to ensure all staff have access to and complete all mandatory and refresher training. Review completed 17/8/2022 • The Person in Charge will complete a review with all staff to reflect on the shared learning post outbreak to ensure any improvements are included in the site specific 	

contingency plan. The review will be completed at the next scheduled governance meeting. Completion date: 08/09/2022

- The Person in Charge in conjunction with all staff working in the centre will complete a review on a daily basis to ensure that all maintenance issues are responded to immediately. All issues will be reported via email to the maintenance department to ensure prompt attention. Completed: 18/08/2022
- All maintenance issues identified on date of inspection were reported immediately to the Maintenance department. Completed 20/7/2022
- Storage of cleaning equipment(mops and buckets) has been addressed. Baskets have been put in place to store different colours of mops separately. The mop buckets are stored in the laundry room. Completed 21/7/2022
- The Person in Charge in conjunction with an IPC link will complete the MEG audit each month as per the audit schedule also to ensure all issues are addressed promptly. Completion date 31/08/2022
- The Person in Charge will review all documentation in relation to cleaning records and IPC documents on a weekly basis to ensure that all records are maintained accurately and will address immediately if not completed fully. Completed 15/08/2022
- The Person in Charge will review the documentation for visitors to the centre to ensure that it is reflective of current Public Health Guidance. Completion date 22/08/2022.

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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	08/09/2022