Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Clann Mór Residential 1
Name of provider:	Clann Mór Residential and Respite Company Limited by Guarantee
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	19 June 2018
Centre ID:	OSV-0004928
Fieldwork ID:	MON-0021380

About the designated centre

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

Clann Mor Residential 1 comprises of four houses which are located in close proximity to two large towns in Co. Meath. The centre supports both male and female adults some of whom live semi independently and others who require staff support on a 24 hours basis. The staff team is primarily made up of health care assistants. Community employment workers are also in place who work under the supervision of staff in the centre. All residents have access to a day service and are encouraged to be involved in their local community.

The following information outlines some additional data on this centre.

Current registration end date:	28/08/2020
Number of residents on the date of inspection:	13

How we inspect

To prepare for this inspection the inspector or 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
19 June 2018	08:30hrs to 18:10hrs	Anna Doyle	Lead
19 June 2018	08:30hrs to 18:10hrs	Erin Clarke	Support

Views of people who use the service

The inspectors spoke with 10 of the residents residing in the centre to discuss their views on the quality of services provided in the centre. All of the residents spoke positively about the centre. They found the staff very helpful and supportive including the management team.

They spoke about numerous ways in which they were supported to make choices and have autonomy over their lives. For example, one resident told an inspector that they did not like the day service they were attending and was now being supported to find alternatives that suited their individual preferences and talents. Another resident, who was a talented artist had been supported to hold an art exhibition in their local community.

Residents were observed to be involved in the day to day running of the centre. For example, they all prepared meals, did grocery shopping and were proud that they cleaned and maintained their own homes. Some residents had recently had their bedrooms decorated and had chosen the colours and interiors themselves.

They spoke about an advocacy service that was held in the wider organisation and gave an example of how this was affecting changes to their lives. For example, it had been raised that some residents wanted to go on holidays and were now being supported to do this.

One resident showed an inspector around their garden and spoke about the new plans in place to further develop this in order to grow vegetables.

Capacity and capability

The inspectors found the capacity and capability of the provider to deliver a safe quality service was impacted by the current operational management systems in the centre and that this was contributing to some of the failings identified at this inspection. However, it is acknowledged that this had been identified by the provider

who was taking steps to address and strengthen the governance structure in the centre at the time of this inspection.

For example, the person in charge arrangements was not effective at the time of the inspection as the person in charge had resigned. This had not been notified to HIQA appropriately and the interim arrangement in place found that the person appointed was also the person in charge for another designated centre and had overall responsibility for the provision of services in their role as the CEO of the organisation.

Some of the improvements being implemented by the provider included the appointment of a team leader who would be nominated as the person in charge of this centre. They were present for the inspection and were currently undertaking induction. It was envisaged that the person in charge would only be responsible for this designated centre going forward.

Improvements were also required in the management structures in place in the centre it to ensure clear lines of accountability. For example, community facilitators were in place in the centre that were responsible for some areas of practice. However, they reported to both the person in charge and the service manager.

In addition, while some informal auditing practices were being completed by community facilitators in the centre and there was some evidence to support these, they had not been recorded to assure that recommendations were effecting changes for residents or were being fully implemented. However, a schedule of audits had been drawn up to address this.

An unannounced six monthly review had been completed as required by the regulations. However, one of the recommendations from this had not been implemented in relation to one resident and staff were not aware of this recommendation. The inspectors were also informed that a member of the board of management would attend any future unannounced quality and safety of the centre to ensure effective oversight of these reviews.

There were adequate staff resources and a dedicated staff team working in this centre who demonstrated a good knowledge of the residents' needs in the centre. All staff felt supported in their role and said that they could raise concerns to senior managers in the centre. An on call out of hour's emergency facility was also in place which was facilitated by community facilitators and senior managers. Staff supervision although in place had not been completed for staff during recent months.

Additional staffing had also been put in place since the last inspection to ensure that residents' needs were being met in the centre. Staff had been provided with training in order to ensure they could meet the assessed needs of the residents; however inspectors found that community facilitators had not been provided with any supervisory training given the scope of their roles in the centre.

Improvements were also required in the records maintained in the centre and while

all residents' records were being reviewed at the time of the inspection, the information contained in residents' personal plans was conflicting and some of it had not been updated to reflect the changing needs of residents and was not dated.

Registration Regulation 7: Changes to information supplied for registration purposes

The provider had not notified the Authority that the person in charge had resigned from the centre.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge arrangements at the time of the inspection were not ensuring effective governance of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider had ensured that appropriate staff numbers were in place to meet the assessed needs of residents and continuity of care was provided in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Community facilitators had not been provided with any supervisory training given the scope of their roles in the centre.

Judgment: Substantially compliant

Regulation 21: Records

The records in relation to each resident as specified under Schedule 3 were under review at time of inspection and contained conflicting information.

Judgment: Not compliant

Regulation 23: Governance and management

Improvements were required in the management structures in place in the centre to ensure clear lines of accountability and that the services provided were effectively monitored. Supervision had not been completed with staff in recent months.

Judgment: Not compliant

Regulation 31: Notification of incidents

A sample of incidents were reviewed by the inspectors and all incidents were notified to the Authority as required.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had notified the Authority in the event of the person in charge being absent from the centre for more that 28 days. However as already stated earlier in the report they had not notified the Authority that the person in charge had resigned.

Judgment: Compliant

Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent

The provider had arrangements in place to for the management of the centre in the event of the person in charge being absent from the centre for more than 28 days.

Judgment: Compliant

Quality and safety

Overall inspectors found that residents said they enjoyed a good quality of life in this centre, identified the centre as their home, felt safe and outlined the range of activities that where available to them. However, the inspectors reviewed the quality and safety of the services provided to the residents and found that significant improvements were required in order to meet the requirements of the regulations. Improvements included residents' personal plans, positive behaviour support, fire safety, risk management and food and nutrition.

The inspectors found that the assessments of residents' health and social needs were not completed or updated as residents needs changed; for example personal care plans and risk assessments were in place for epilepsy which not been updated or reviewed to reflect changes in need. The inspectors recognise that the provider had recently completed an audit of the health and social needs of the residents and had committed to reviewing all risk assessments and individual needs of the residents.

A review of personal plans and conversations with the residents indicated that residents were supported to achieve goals which reflected their personalities and interests for example holding an art exhibition, going on holidays, joining a badminton team and redecorating bedrooms.

Residents were supported to prepare meals in the centre and individual preferences were taken into consideration. Residents said that they were happy with the food provided in the centre. However, from a sample of plans viewed inspectors found that two residents who had been recommended specialised diets had no plans in place to guide staff practice and to demonstrate the residents' wishes about these specialised diets.

Since the last inspection fire doors had been installed in three of the four houses and the provider had plans in place to install fire doors in the fourth house. In addition, significant improvements were also required to ensure that adequate emergency lighting was in place in each house and to demonstrate that all fire equipment and fire alarms were being serviced appropriately. Inspectors acknowledge that there were plans in place to address this. Fire drills had taken place in the centre to ensure a planned safe evacuation of residents.

The risk management policy in the centre did not include some of the requirements of the regulations. Some of the risk management systems in the centre also required review. For example, the risk register had not been updated or reviewed. There were no records of risk assessments for operational risks in the centre. Risk assessments which were currently under review by the staff team were not appropriately risk assessed and did not include all of the controls in place to

mitigate identified risks.

All incidents that occurred in the centre were reported to senior personnel and a register of incidents was maintained in the centre. While some incidents were followed up effectively others were not. For example a resident who had been identified as being at risk of falls had been provided with equipment to reduce the likelihood of a recurrence. However, some recommendations from a review of medication errors occurring in the centre had not been implemented.

All staff had completed training in the provision of positive behaviour support to residents. Staff were knowledgeable around residents needs in this area. However, a number of improvements were required to ensure that each resident had a positive behaviour support plan to guide staff practice and that residents had access to allied health professionals in regard to this.

While a restrictive free environment was promoted in the centre, there were some restrictions in place due an identified risk. Inspectors found that improvements were required to ensure that they were reviewed, used for the least duration and discussed with residents who may be impacted by their implementation.

Regulation 13: General welfare and development

Residents had access to facilities for occupation and recreation and which considered their wishes and preferences.

Judgment: Compliant

Regulation 18: Food and nutrition

Two residents who had been recommended specialised diets had no plans in place to guide staff practice and to demonstrate the residents' wishes about this specialised diet.

Judgment: Not compliant

Regulation 26: Risk management procedures

The risk management policy in the centre did not include some of the requirements of the regulations. The risk register had not been updated or reviewed and some of the information was inaccurate or no longer applicable. There were no risk assessments for operational risks in the centre. Risk assessments were not appropriately risk assessed and did not include all of the controls in place to mitigate identified risks. Some recommendations from a review of incidents in the centre had not been implemented.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire doors had not been installed in one house in the centre. Significant improvements were also required to ensure that adequate emergency lighting was in place in each house and to demonstrate that all fire equipment and fire alarms were being serviced appropriately.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Improvements were required to ensure that the assessment of need in place for residents was inclusive of all their identified needs and that this assessment was updated to reflect the changing needs of residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Some residents had no behaviour support plans in place to guide practice and there had no access to allied health professionals with regard to the development and review of these plans. Some improvements were also required to ensure that some environmental restrictions in place were reviewed, used for the least duration and discussed with the individuals who may be impacted by their implementation.

Judgment: Not compliant

Regulation 8: Protection

Staff were knowledgeable about the different types of abuse and the reporting procedures in place in such an event. Two new staff had not completed training in safeguarding vulnerable adults. However, the service manager had a plan in place to complete this in the coming weeks.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Clann Mór Residential 1 OSV-0004928

Inspection ID: MON-0021380

Date of inspection: 19/06/2018

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 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: To meet Regulation 7, going forward Clann Mór Residential & Respite CLG will notify HIQA appropriately within the timeframe required regarding resignation/s of person in charge The CEO (Director of Services) upheld the positon of PIC for Clann Mór 1 short term. The Service Manager is now the PIC for Clann Mór 1 while awaiting a new PIC - 12.10.18	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Community Based Support Staff in Clann Mór 1 report to the Team Leader. The Team Leader reports to the Service Manager. On a day to day basis the Community Based Support Staff can dialogue with both the Service Manager and the Team Leader. The Service Manager and Team Leader dialogue daily to review issues. The reporting structure will be reaffirmed to all staff at the next staff training on 20.09.18. An additional Team Leader post has been formally sanctioned by our funder. This position will be filled by 12.10.18.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Community Facilitators will be provided with additional training to cover the scope of their role with training in the area of coaching and mentoring peer staff. This initial	

training will be completed by 17.10.18 and will form part of their continuous personal development.

Staff supervision takes place twice a year, which will be completed by 31.12.18.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

A new audit schedule for Clann Mór CLG has been introduced on 29.05.18. This auditing will formally commence by PIC and Team Leader on 07.08.18. In addition this auditing will also be carried out by Community Facilitators from 30.08.18.

All personal plans will be reviewed to reflect changing needs of residents. All documentation will be signed and dated. Annual PCP reviews will be completed by 30.09.18.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Management ensure that a six monthly unannounced inspection, annual review, and regular auditing takes place.

All recommendations from a six monthly unannounced inspections will form part of Staff quarterly training. The next training will take place on 20.09.18

Staff supervision takes place twice a year, which will be completed by 31.12.18.

An additional Team Leader post has been formally sanctioned by our funder. This position will be filled by 12.10.18

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

Residents are supported to complete a food menu on a weekly basis. Residents who have a health related dietary requirement, will be supported to follow the recommendations. Staff in houses will support this. Special diets will form part of staff house team meetings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The Risk Register for Clann Mór will be reviewed to include operational risks.
The Risk Management Policy will be reviewed to include the risk of aggression/violence.
Individual risk assessments will be reviewed and recommendations followed as part of the PCP review.
Audit of individual risk assessments takes place on a quarterly basis

Clann Mór have a policy for responding to emergencies. This policy will be reviewed. The Emergency Response team includes all members of the Management team and On-call.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Fire doors are to be installed in final Clann Mór 1 house on 19.10.18

Emergency lighting has been reviewed, new emergency lighting has been installed as appropriate.
Fire equipment and fire alarms have been serviced

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:

Assessment of need/Critical Information forms were reviewed and all residents took part in completing form and signing same.

These Assessment of need/Critical Information forms will be updated every six months.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

In May 2018 enhanced Positive Behavioral Support plans were put in place for residents as appropriate. These plans will be reviewed every six months.

A senior psychologist met with key staff and supported the development and implementation of these Positive Behavioral Support plans.

There is a positive behavioral support training manual in place to guide best practice, which was devised by the senior psychologist for staff.

Effective from September 2018, the senior psychologist will act as a consultant to support these plans.

Restrictive practice has been reviewed in Clann Mór 1, appropriate to the needs of the residents.

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 7(2)(a)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event notify the chief inspector in writing, within 10 days of this occurring, where the person in charge of a designated centre has ceased to be in charge.	Not Compliant	Orange	07 August 2018
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	12 October 2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	17 October 2018

Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Not Compliant	Orange	17 August 2018
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30 September 18
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	20 September 2018
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	07 August 2018
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31 December 2018

Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Substantially Compliant	Yellow	08 August 2018
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	30 September 2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	30 September 2018
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30 July 2018
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	31 July 2018
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape,	Not Compliant	Orange	31 July 2018

	including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	19 October 2018
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30 September 2018
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30 September 2018
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	07 August 2018
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's	Substantially Compliant	Yellow	30 September 2018

	challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	20 July 2018
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	17 September 2018