



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

## Issued by the Chief Inspector

Name of designated centre:	Cluain Farm
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	20 August 2019
Centre ID:	OSV-0005455
Fieldwork ID:	MON-0023280

## About the designated centre

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

Cluain Farm provides full time residential care and support to adults with a disabilities. The designated centre is a large rural two storey house, divided into two separate houses and one apartment. Residents living at the centre have access to communal facilities such as sitting rooms, kitchen/dining rooms, and spacious grounds. Each resident has their own bedroom which are decorated to their individual style and preference. The centre is located in a rural area, and has three vehicles to support access to the local community. The provider describes the service as one for adults with autism and people with disabilities. Residents are supported by a staff team on a 24/7 basis with sufficient numbers and skills mix to meet the residents assessed needs.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	7
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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 - 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
20 August 2019	10:00hrs to 18:00hrs	Julie Pryce	Lead
20 August 2019	10:00hrs to 18:00hrs	Sarah Barry	Support

## What residents told us and what inspectors observed

There were seven residents on the day of the inspection, and the inspectors met and spent some time with all of them. Not all residents communicated verbally, and some greeted the inspectors in their own way using their own preferred style of communication. Some residents showed the inspectors around their home, and were happy to have speak with the inspectors. Residents told the inspectors who they would go to if they had a problem, what they would do in the event of an emergency and which aspects of their daily lives were important to them.

Residents who did not communicate verbally were observed to be content in the company of staff, and there were various ways in which staff ensured that their voices were heard. It was clear that residents were consistently consulted with about the running of the centre, and that their choices were elicited and facilitated. All residents appeared to be comfortable and at home in the centre and each had their own room which was personalised to their own personal taste and preference. They also specific areas in the house that they preferred to spend time in.

Families of residents were involved in the running of the centre, and a system of person centred planning meetings involving residents and their families had been introduced.

## Capacity and capability

There were management and governance processes in place however, while the Health Services Executive (HSE) were the current providers of the service, the service was in effect being managed by a third party organisation by way of an agreement with the HSE. This arrangement was put in place as an interim arrangement pending the processing of an application from the third party organisation to register the centre. While the HSE were engaged in the management of the service and had some systems in place to oversee the management arrangement, overall governance of the centre required improvement. In addition, while there were some processes in place in relation to the operational oversight of the centre, they were not consistently effective in ensuring robust oversight of the centre.

Governance systems included audits of some aspects of care and support by the HSE, oversight of any accidents and incidents occurring in the centre and team meetings. However, not all actions arising form these processes had been implemented It was also observed that some actions had no completion dates meaning that monitoring of their implementation was inconsistent. In addition the monitoring systems had not identified some of the failings as found in this

inspection, for example parts of the premises required updating and modernisation.

While team meetings were held on a regular basis, there was no system in place of ensuring that all staff were aware of the discussions and decisions made at these meetings and not all decisions were transferred into guidance. For example some decisions made regarding the welfare of some residents were not being recorded in their personal plans. This meant that staff did not have the up to date information on some of the assessed needs of the residents.

There was an appropriately skilled and qualified person in charge at the time of the inspection, who provided evidence of leadership and support to the staff team. There was also a support management function in place which was effective throughout the centre. Therefore, while the provider had ensured that key roles within the centre were appropriately filled, other management structures and systems required regularisation such as systems of auditing and recording information.

There was a consistent team in place in the centre. The number and skills mix of staff was appropriate to meet the needs of residents. Staff were in receipt of training, and all engaged by the inspectors were knowledgeable about the support needs of residents. Staff supervision took place regularly and it was apparent that staff were supported in the provision of care to residents in accordance with their needs and preferences.

There was a clear complaints procedure in place which was readily available to residents, and residents knew who to address their complaints to. Residents reported to inspectors that any complaints they had made had been addresses to their satisfaction.

Therefore the inspector found that while there were some systems of oversight of the centre, that issues were not always addressed in a timely manner and that the management structure in the centre had not been regularised.

### Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre. The person in charge outlined various plans for ongoing quality improvement in an enthusiastic and person centred manner.

Judgment: Compliant

### Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents. There was continuity of staff, all of whom were known to residents, and all demonstrated an in depth knowledge of the support needs of residents.

Judgment: Compliant

### Regulation 16: Training and staff development

Staff were in receipt of all mandatory training, had been supported in aspects of e-learning and were appropriately supervised.

Judgment: Compliant

### Regulation 23: Governance and management

While there had been significant improvements in the management structure since the previous inspection, and there were clear lines of accountability, not all expected management functions were fully in place. There were some systems of oversight of the service, however, issues were not always addressed in a timely manner and the management structure in the centre had not been regularised. Auditing and the processes in relation to staff meetings did not clearly outline required actions.

Judgment: Not compliant

### Regulation 31: Notification of incidents

Not all required notifications had been submitted to HIQA as required. There were no quarterly notifications outlining any restrictive practices.

Judgment: Not compliant

### Quality and safety

The provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having as required access to appropriate healthcare. Their rights were also upheld and individual choices respected. However, there were

significant gaps identified in supporting and informing documentation.

The layout of premises were suitable to meet the needs of residents, although not all areas were personalised or homely. Each resident had their own room, which was furnished and decorated in accordance with their preferences. There were various living areas both inside and outside the premises. The communal areas in one of the houses was homely with appropriate soft furnishings and furniture, decorated with personal items belonging to the residents throughout. The other house however, was in need of maintenance in several areas, including the bathrooms and living rooms. The furniture and soft furnishings were also in need of repair or replacement. There was signage throughout the house which related to instruction for staff rather than assistance for residents. The premises had not been maintained in a manner which supported the rights of residents to a homely environment.

While each resident had a personal plan in place, the information in them was not always accurate or up to date. Healthcare needs were however supported, including access to allied healthcare professionals in accordance with individual needs. Staff on duty were knowledgeable about required interventions and the recommendations following any consultations. However the information in the personal plans did not reflect this and plans had not been updated following changes in assessed healthcare needs.

Overall the requirement to support residents to maximise their potential was not consistently met. There were no detailed assessments of social care needs and several residents did not have any goals identified to support their personal development. Where some goals were set for residents, they were not always meaningful. However, some residents could identify their social goals and discuss the progress they had made in achieving them.

Communication was prioritised in the centre and various strategies were in place to ensure effective communication with residents. Staff had received training in augmentative forms of communication and there was clear evidence throughout the centre of the implementation of these systems. Residents' meetings were held regularly and various forms of communication were utilised to ensure that their voices were heard.

Where restrictive interventions were required to manage risk for residents, these interventions were documented and a rationale for their use was in place. However, the implementation of the interventions was not recorded on each occasion as required.

A risk register template was available however, it had not been populated. While the person in charge and staff could describe precautions throughout the centre in relation to the mitigation of risk, no risk assessments were available in the centre on the day of the inspection. Therefore there was no evidence of oversight and insufficient evidence of the mitigation of risk throughout the centre.

There were systems and processes in place in relation to fire safety. All required fire safety equipment was in place and appropriately maintained. There was a personal evacuation plan in place for each resident and residents could describe the actions



they would take in the event of an emergency. Inspectors saw evidence that a competent person raised some concerns pertaining to fire containment issues in the attic space of the centre. This issue remained on-going at the time of this inspection and the inspector sought assurances and information from the registered provider representative as to how this issue would be addressed. It was evident from the responses received that this matter was being addressed by the provider.

Improvements had been made in the management of residents' personal moneys. Each resident had their own bank account and received the level of support they required to manage their money. However the system in place to record the withdrawal of money from these accounts required review so as to ensure the adequate safeguarding of personal finances.

There were however, robust systems in place in relation to all other aspects of safeguarding of residents. All staff had had appropriate safeguarding training and there was a policy in place to guide staff. Staff and the person in charge were aware of their roles in relation to safeguarding of residents.

Overall the provider had systems in place to ensure that residents enjoyed a good quality of life, but there were significant gaps in supporting documentation to ensure consistent and meaningful review of the care and support provided.

### Regulation 10: Communication

Systems were in place to ensure effective communication with residents.

Judgment: Compliant

### Regulation 17: Premises

While the layout of the premises was appropriate to meet the needs of residents, not all areas were personalised, well maintained or homely.

Judgment: Substantially compliant

### Regulation 26: Risk management procedures

The risk register was not complete, and risk assessments were not available in the centre.

Judgment: Not compliant
Regulation 28: Fire precautions
Processes were in place in relation to fire safety.
Judgment: Compliant
Regulation 5: Individual assessment and personal plan
Personal plans were not up to date and did not include information about all aspects of residents' lives.
Judgment: Not compliant
Regulation 6: Health care
Residents' healthcare needs were met.
Judgment: Compliant
Regulation 8: Protection
Residents were safeguarded from abuse, although recording of withdrawals from personal bank accounts was not sufficiently robust.
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
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant

# Compliance Plan for Cluain Farm OSV-0005455

Inspection ID: MON-0023280

Date of inspection: 20/08/2019

## 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 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>All minutes within the service to have clear actions, timeframes and follow up on actions documented (completed 30.09.19)</p> <p>Monthly metrics and combined action log detailing all actions for the service as a result of monitoring and ongoing assessment and input from external professionals to be completed each month (completed for August 2019 and ongoing since then).</p> <p>At present the HSE is the Registered Provider for Cluain Farm. Once the lease arrangement has been agreed with the HSE and the Irish Society for Autism, Positive Futures will become the Registered Provider. The documentation to progress with lease have been finalised and will be brought before the next HSE Property Review Group meeting. It is anticipated that this application will be approved and the lease agreed and finalised by 31/12/19.</p> <p>Positive Futures are commencing internal audit process as and from 22/10/19 utilising HIQA audit tools.</p> <p>The Operational Manager will complete a workshop with Management Team regarding completion of HIQA auditing tools to ensure quality internal monitoring processes (to be completed by 31 November 2019)</p> <p>Governance and Monitoring Workshop scheduled for PIC/ Managers on 12 December 2019. This is a scheduled training for all Positive Futures staff across the country.</p>	

Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All notifications will be submitted within the required timelines (20/08/19).</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises: Priority schedule for interior maintenance/ décor to be completed for both houses and apartment. This has been completed on 21.08.19.</p> <p>Costings for above work to be received and work scheduled to occur. Work has commenced on the interior décor of the house that required personalisation. This will be completed by 30 November 2019.</p> <p>Extensive work is required to the 2 bathrooms within House 1. In line with national financial regulations three tenders required. To date one (n=1) costing has been received with another due by 31 October 2019. This work will be completed in line with the needs of the people living in the house in order to minimize the level of disruption to their daily lives. This work is due for completion by 31.01.20 due to consideration being allowed for Halloween and Christmas holidays of the contractors involved.</p>	
Regulation 26: Risk management procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All risk management documentation has been reviewed and completed / updated as required (21/08/19).</p> <p>All Person Centred Risk Assessments for each Individual to be reviewed so that clear, detailed and comprehensive Person Centred Risk Assessments are completed and filed within each individual's Reference Folder. This was completed by 30 August 2019.</p>	

Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:  Each individual to have a Person Centred Portfolio that is in line with Positive Futures Policy and Procedures. This includes:</p> <p>Updated Person Centred Risk Assessments (completed on 28 August 2019)  Updated Person Centred Restrictive Practice Agreements (completed on 28 August 2019)  Updated Finance Capacity Assessments (completed on 21 August 2019)  Updated Finance Agreements (completed on 21 August 2019)  Updated Support Agreements (completed on 21 August 2019)  Updated Personal and Intimate Care Guidelines (completed 13 September 2019)  Review and update outcomes and goals for all of the people we support (due for completion 30 November 2019)  Updated How best to support guidelines (Care Plan/ Portfolios)- There has been a comprehensive review completed of all Care Plans. All care plans now have up to date support guidelines in place. However, these require review again following outcomes and goal setting completion on 30 November 2019. Therefore, all Care Plans will be fully complete by 15 December 2019.</p>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:  A double signature column was added to the finance transaction folder to record after the bank withdrawal had occurred. This column was put in place on day of Inspection (20 August 2019) and from this date a double signature continues to be recorded following a bank withdrawal. Therefore action completed on 20 August 2019.</p>	

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2020
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.	Not Compliant	Orange	31/12/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	21/08/2019



	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	21/08/2019
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/10/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre,	Not Compliant	Orange	30/11/2019

	prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	14/12/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	20/08/2019