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Clarey Lodge, OSV-0003386, 05 March 2020

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

Issued by the Chief Inspector

Name of designated centre:	Clarey Lodge
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	05 March 2020
Centre ID:	OSV-0003386
Fieldwork ID:	MON-0024415

About the designated centre

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

Clarey Lodge provides 24 hour care and support for up to four adults both male and female with an intellectual disability. The centre is a detached bungalow which is subdivided into four separate areas, each with their own entrance. One area supports female residents and contains a kitchen dining area, two bedrooms, a bathroom and a sitting room. The second area is a common area and contains a kitchen dining area, a bathroom, a laundry area and an office. There are two self contained apartments which contains a sitting/dining area, a bedroom and a bathroom. One of these apartments has a sensory room and the other has an outside building for activities. Residents are support 24 hours a day by a staff team consisting of a person in charge, social care workers, health care assistants, a staff nurse and relief staff. There are a number of vehicles in the centre to assist residents to access community facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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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
Thursday 5 March 2020	09:30hrs to 17:40hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

The inspector of social services had the opportunity to meet and briefly engage with the four residents living in the centre at the time of the inspection. Throughout the day the inspector had the opportunity to observe residents interacting with staff and spending time at home engaging in activities of their choice, including some relating to the day-to-day upkeep of their home. In addition, a number of residents were observed leaving the centre supported by staff to take part in activities in their local community such as going to the shops.

Throughout the inspection, staff were observed to be very familiar with residents' communication needs and preferences and to offer residents choices in relation to activities and meals and snacks. Residents appeared comfortable in the presence of staff and with the levels of support offered to them.

A number of residents showed the inspector around their home including places where they liked to spend their time. These included an external building for one resident where they liked to spend time taking part in their preferred activities. In addition to this external building this resident and supporting staff described other activities they enjoyed taking part in such as attending day services twice per week, going for walks, horse riding and arts and crafts. They also had plans in place to take part in an educational programme and to grow seeds and plants in their garden in the coming months.

Two resident indicated using gestures and signs that they were happy, including one resident nodding when asked if they were happy in their home and another resident gave the inspector a thumbs up when asked if they were happy and enjoying the activity they were engaging in. Another resident told the inspector that they were happy and felt safe in their home. Staff were observed to be responsive to residents' requests for support. In addition, they were observed responding to residents' requests to spend time alone. Residents were observed seeking out staff support to go outside to spend time in their back garden, to go to the shops and to make a cup of coffee. One resident was enjoying a visit with their family during the inspection.

Capacity and capability

The provider and person in charge had systems in place to ensure residents were safe and in receipt of a good quality service. There were clearly defined management systems and structures that identified lines of authority and accountability and staff had clearly defined roles and responsibilities. There were systems in place to ensure staff were trained and supported to carry out their

roles and responsibilities to the best of their ability.

The person in charge and a director of operation (DOO) from within the organisation facilitated this inspection. They were both found to be knowledgeable in relation to residents likes, dislikes and preferences and motivated to ensure they were happy and engaging in meaningful activities. Through discussions with them and other members of the team, it was clear that the provider was identifying areas for improvement in line with the findings of this inspection and developing action plans to address these. They outlined the areas for improvements which had been identified during their audits and reviews. These included, the need to fill a number of staffing vacancies and the requirement to review practices relating to ensuring documentation was reviewed and completed fully. They had also identified that actions following their own audits needed to be followed up on and completed in a more timely fashion.

The provider's systems for monitoring the quality of care and support for residents included, the annual review and six monthly reviews, audits and regular management meetings. There was evidence that the majority of actions were being completed following these reviews and audits, and that these were positively impacting residents' experience of care and support in the centre. In addition, the person in charge was completing weekly and monthly reports and sending these to the DOO. The findings from these reports were shared with the executive management team and actions developed as required.

Staff meetings were held regularly and the agenda items were resident focused. There was evidence of the review of incidents and the sharing of learning across the team following these reviews. The provider had identified the need to spend more time at staff meetings discussing incidents and learning garnered following their review and plans were in place to ensure this was occurring. In addition to staff meetings there was a process in place for staff handover at the end of each shift. There was a template in place to ensure relevant topics were covered during handover including safeguarding and incident review. At shift handover, staff were assigned specific duties and areas of responsibilities for each shift. For example, it was clearly identified which staff were supporting residents both at home and during activities in their local community and the shift lead was identified.

There were three staffing vacancies at the time of this inspection. The provider had recognised the need to fill these vacancies and they were in the process of recruiting to fill these vacancies. The provider was ensuring that these vacancies were not impacting on continuity of care for residents by offering additional shifts to part-time staff in the centre and by covering a small number of shifts by regular relief staff.

Staff had access to mandatory training in fire safety, first aid, manual handling, medication management, Safeguarding Vulnerable Adults, and management of actual or potential aggression. Staff were in receipt of regular formal staff supervision. During these meetings there was evidence of discussions relating to staff's strengths and contributions and relating to areas for further development.

The inspector found that due to the volume of documentation for each resident, it was difficult to source some information. Across a number of documents reviewed throughout the inspection, there were gaps in recording some information. Some of these gaps in documents related to residents' care and support needs and some related to day-to-day documentation in the centre. For example, documentation relating to health monitoring was not being consistently completed or fully completed. The provider had recognised the need to review some documentation in the centre in their own audits and had plans in place to complete the required actions. For example, they had identified that some documents such as incident reports required review to ensure they were factually accurate and using the correct terminology. Other gaps were identified in weekly water temperature checks, fridge temperatures and residents' health monitoring sheets.

Regulation 15: Staffing

There were a number of staffing vacancies in the centre and the provider was in the process of recruiting to fill these vacancies. In the interim, the provider was minimising the impact of these vacancies by offering additional shifts to part-time staff and by utilising regular relief staff to cover a small number of shifts.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of training and refreshers in line with the organisation's policies and they had also completed training in line with residents' assessed needs. They were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities.

Judgment: Compliant

Regulation 21: Records

There were gaps across a number of documents in the centre which required review. Some of these related to documentation regarding residents' care and support and some to other documentation relating to the day-to-day running of the designated centre. These were not contributing to any significant risk for residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were clearly defined management structures and systems. The provider was monitoring the quality and safety of care and support for residents in the centre by completing the annual and six monthly reviews and regular audits and meetings of the management team. Arrangements were in place to support and performance manage staff.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief inspector was notified in writing of all incidents occurring in the centre which required to be notified in line with the requirements of the regulations.

Judgment: Compliant

Quality and safety

Overall, residents were in receipt of a good quality service and that the provider and person in charge was making every effort to keep them safe. They were being supported to make choices in relation to how they wanted to spend their day. The provider and person in charge were recognising areas for improvement in line with the findings of this inspection and had plans to complete the required actions to make these improvements.

The premises were warm, comfortable and well maintained. It was designed and laid out to meet the needs of residents. Residents had access to adequate private and communal space within their home. Their bedrooms were decorated in line with their preferences and they had access to adequate storage for their personal belongings. Changes had been made to the design and layout of the house since the last inspection in line with a residents transition to the centre. This had resulted in this resident having their own self-contained apartment and separate garden space. It had also resulted in an additional communal space available for residents to spend time in, if they so wish, or for use by visitors if required. The apartment had been designed and decorated in line with this residents' needs and preferences. There were areas in the apartment in need of repair or decoration but the provider had plans in place to complete these required works. In addition to the internal works in

the house, works had been completed to the front garden area of the house in response to flooding in this area. The provider also had plans to make some improvements to the garden areas including painting fences, putting in some plants and putting down a patio area at the back of the premises. Plans were in place to complete the required works once the weather improved.

Each resident had an assessment of need completed and then their personal plan was developed. There was evidence of regular review and update of their personal plans in line with their changing needs. Each resident had access to the support of a keyworker. There was evidence that each resident was being supported to develop and achieve goals relating to both life skills and activities.

Residents were supported to enjoy best possible health. They had their healthcare needs assessed and had access to allied healthcare professionals in line with these assessed needs. The provider had recognised some inconsistency in relation to documentation relating to health monitoring in their audits and had discussed these at staff meetings and actions were developed to ensure they were kept under ongoing review. The provider was in the process of supporting a number of residents in relating to accessing national screening programmes in line with their age profiles.

There were a number of restrictive practices in place in the centre, there was a restrictive practice register and quarterly meetings were being held to review restrictions across the centre. There reviews included a review of the rationale for the restrictions and evidence that they were reviewed to ensure that the least restrictive practices were used for the shortest duration. There was evidence that a number of restrictions had been removed or reduced since the last inspection and plans were in place to further reduce and eliminate some restrictions. Residents had access to allied health professionals and had support plans developed as required to support them. These plans were clearly guiding staff to support residents in line with their assessed needs. There has been a significant decrease in the number of incidents and physical interventions in the centre and there was evidence that this related to the consistent implementation of residents' support plans.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Safeguarding plans were developed and safeguards put in place as required. Allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. Staff who spoke with the inspector were knowledgeable in relation to their responsibilities in the event of a suspicion or allegation of abuse. Residents had intimate care plans developed as required which clearly outlined their wishes and preferences. Safeguarding was discussed at handover, staff meetings and during staff supervision. The provider was aware of an increase in safeguarding concerns relating to a number of residents and they were meeting regularly to ensure they were monitoring this closely in relation to compatibility and the impact for residents.

Residents were protected by the risk management policies, procedures and practices in the centre. There was a risk register in place and general and individual risk assessments were developed as required. There were systems in place for

recording, investigating and learning from serious incidents and adverse events. There was an emergency plan which included where residents could relocate to in the event of an emergency.

The centre had appropriate systems in relation to the detection, containment and extinguishing of fires. There was a fire alarm system, emergency lighting and fire fighting equipment, which were regularly checked by staff and serviced by an external company. Fire doors were in place throughout the centre and clear signage was on display indicating fire evacuation routes and the fire assembly point. Fire exits were marked by lit signage. Fire safety training was provided to staff. Each resident had a personal emergency evacuation plan in place. There were regular fire drills held including day and night time drills. In response to a recent fire related incident in the centre, risk management plans and residents' personal emergency evacuation plans had been updated. In addition, the Fire Marshall had attended the centre and made a number of recommendations. There was evidence that these recommendations had been followed up on.

One resident had transitioned to the centre since the last inspection. The inspector reviewed records and spoke to staff and it was evident that the resident's admission was completed in a planned and safe manner. The resident had a transition plan in place which was detailed in nature and there was evidence that the transition was completed at a pace suitable to them. Appropriate information was transferred between services.

Residents were protected by the policies, procedures and practices in place relating to medication management. Staff had completed training to support them to carry out their roles and responsibilities including the administration of rescue medications. Staff described the procedures in place for ordering, receipt, storing and administration of medicines. Audits including stock control audits were being completed regularly. There was evidence that medication related errors or omissions were reviewed and that learning following these reviews was shared with the team. These included documentation errors in drug recording sheets. Staff described procedures in place for stock control and returning medicines to the local pharmacy. There was a separate secure storage area separate from other medicinal products, to store out of date medicines or those for return to the pharmacy. The inspector reviewed a sample of residents' kardex and drug recording sheets and found that they contained the required information. There were protocols in place for as required medicines which clearly guided staff.

Regulation 17: Premises

Overall, the premises was warm, clean and well maintained. The provider had identified areas for improvement in their own review and plans were in place to complete works to the gardens and to one of the apartments.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Transitions and discharges were planned and completed in a safe manner. Detailed transition plans were developed and these detailed the steps involved in supporting residents to transition into and from the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy and a risk register in place. General and individual risk assessments were developed and reviewed as required. Incidents were reviewed regularly in the centre and these reviews were leading to the review and update of risk assessments and management plans. There was an emergency plan in place which was reviewed regularly.

Judgment: Compliant

Regulation 28: Fire precautions

Residents were protected by the arrangements in place to detect, contain and extinguish fires in the centre. There was evidence of maintenance and regular servicing of equipment. Residents had personal emergency evacuation procedures in place which clearly guided staff in relation to supports they required to safely evacuate in the event of an emergency. There was evidence of regular fire drills and that the relevant documentation was reviewed and updated following learning garnered from incidents and drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by the policies, procedures and practices relating to medication management in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had an assessment of need and personal plans which clearly guided staff to support them. There was evidence that these documents were reviewed and updated regularly. In addition, residents had access to a keyworker to support them with their personal plans and to set and achieve their goals.

Judgment: Compliant

Regulation 6: Health care

Residents were being supported to enjoy best possible health. They were being supported to access allied health professionals in line with their assessed needs. Support plans were developed as required and reviewed and updated regularly.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices in the centre were reviewed regularly to ensure that the least restrictive measures were used for the shortest duration. A number of restrictive practices had been reduced or removed since the last inspection and plans were in place to reduce or remove others. Plans and guidelines were developed as required to support residents. They were detailed and clearly guiding staff to support residents.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Allegations and suspicions of abuse were reported and escalated in line with the organisation's and national policy. Safeguarding plans were developed and implemented as required. Staff were in receipt of training and refreshers to support them to carry out their roles and

responsibilities.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Clarey Lodge OSV-0003386

Inspection ID: MON-0024415

Date of inspection: 05/03/2020

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records: PIC to ensure that systems are in place for the correct maintenance of records in line with Regulatory requirements and ensure that any gaps in documentation are flagged and followed on up as required.</p> <ul style="list-style-type: none">• PIC to ensure that all health monitoring information is recorded correctly as per Health Professional guidelines and any irregularities are followed up with accordingly and flagged with relevant Health Professional for review and follow up as required, this in place and ongoing• PIC to ensure that any issues with Quality checks are followed up on, that all actions have a responsible person and a set time frame for completion. This in place and ongoing.• PIC to ensure that Personal Plans are maintained correctly and that they focus on Residents' specific needs and are developed by the resident with required supports from Professionals and relevant stakeholders. Personal Plans are to demonstrate continuity throughout. This in place and ongoing.• PIC to discuss maintenance of documentation at team meeting and review learnings with team. Due to current COVID 19 protocol on gatherings, team meeting to be held by group conference call and completed by 01/05/2020.	

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 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.	Substantially Compliant	Yellow	04/05/2020