Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Clarey Lodge
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	09 August 2022
Centre ID:	OSV-0003386
Fieldwork ID:	MON-0037595

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. There are three self-contained apartment ,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

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Tuesday 9 August 2022	10:00hrs to 16:20hrs	Gearoid Harrahill	Lead
Tuesday 9 August 2022	10:00hrs to 16:20hrs	Michael Keating	Support

What residents told us and what inspectors observed

During this unannounced inspection, inspectors had the opportunity to meet three of the four residents of this designated centre, with the fourth resident attending an appointment on the day of the visit. Inspectors also met with support staff and keyworkers who were supporting the residents with their activities and routines.

Examples were observed during the inspection of how resident choices and preferred activities led the structure of their day. Residents were observed to be in good form and were content and comfortable with their support team. Inspectors spoke with one person who had lived in the house for a long time who commented that they liked their home and their involvement in food preparation. Residents were supported to go on trips and outings in the local communities, go swimming and horse-riding. During the inspection one resident left to go on a walk through the woods, and another went to the cinema in the afternoon. One resident talked to inspectors about a recent trip to Dublin city which they enjoyed. Some residents were busy engaged in activities or enjoying their breakfast and were not interested in participating in the inspection and this was respected.

Each resident had a private single bedroom and access to multiple communal areas and garden spaces. Two residents lived in their own annexe with separate living areas and kitchen facilities, and these spaces were highly personalised with features based on their hobbies, or to ensure their safety. Some residents had access to features in their own space which they enjoyed, for example a large paddling pool, hot tub, and soundproofed studio space for one resident to play their large collection of vinyl records and work with their DJ equipment. One resident enjoyed street art and was facilitated with large blank walls and fences to practice on with paint, markers and chalk. Community activities were supported through the use of suitable vehicles of which the centre had exclusive use.

Residents had visual planners in place, setting out the routine and activities for a space of time that best suited each person. This included mealtimes, movie nights, activities in the house and local area, visits from family, and upcoming appointments. Staff showed inspectors some examples of communication tools which were beneficial for residents, such as a catalogue staff made with pictures of every movie the resident owned so they could easily make their choice, or just enjoy looking through the pictures.

Staff who spoke with inspectors on this visit evidenced a good, personal knowledge of each resident, their interests, hobbies, histories and assessed needs. Interactions between staff and residents were patient, friendly and reassuring. Staff were knowledgeable on residents' preferences, for example when preparing their breakfast options. Staff had a good personal knowledge of residents' support plans, and knew where to find information and guidance on these supports if required.

Inspectors reviewed audits on the quality and safety of support and found that the

auditor on these visits reflected on commentary from residents and what they were doing with their day as part of the assessment on service quality.

The next two sections of this 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

Inspectors conducted this unannounced inspection in response to solicited and unsolicited information received regarding serious safeguarding allegations and incidents in the service, and to verify how the provider was responding to alleged, suspected and reported adverse events and upward trends in restrictive practices. During the inspection, inspectors met with members of the centre management and the front-line team, as well as a manager of the registered provider. Inspectors also met with the residents and reviewed documentation related to quality audits, incidents reports and safeguarding investigations.

Inspectors found examples of suitable governance and management structures, with effective governance and reporting systems in place. Management were kept aware of incidents and ongoing risks through comprehensive reporting of adverse events and allegations made. The provider had identified where types or patterns of incidents, use of restrictive practices and safeguarding concerns had arisen, and what action was being taken to respond to same. Detailed audits on risks relevant to this designated centre had taken place, and where improvement to regulatory compliance or adherence to provider policy was identified, a time bound action plan was set out to improve or enhance the quality of service. The quality manager conducting these service reviews spoke with residents or observed their support delivery to reflect on their experiences and activities as part of their report. The provider also had systems in place for auditing and reviewing risk controls related to medicines, finances, and the use of restrictive practices.

The inspectors reviewed records related to the supervision and training of the front-line staff members in their roles supporting residents. Training needs were identified for this designated centre and staff were supported to stay up to date on their required competencies. Inspectors found examples of meaningful supervision discussions had with staff members, with adverse incidents being used as a means of supporting staff in their ongoing learning or where enhanced supervision may be required. Where determined as necessary, the provider had followed their protocols related to disciplinary processes or where additional training may be required.

Inspectors were provided evidence to indicate that the registered provider had the capacity and resources to respond appropriately to serious allegations, adverse incidents and the complex support requirements of this designated centre. The provider had notified the Chief Inspector of incidents and ongoing practices in the

service. Part of the staff guidance on supporting residents during physical holds was identified as not being developed following its increased use and incidents identifying improper staff practices. However, in the main, inspectors found evidence how the reporting, investigation and response to adverse events was generally suitable to support residents and staff and identify aspects of the service which could be improved for future reference.

Regulation 16: Training and staff development

The provider had identified in writing the training and skills required by the support staff of this designated centre. The management had a means of identifying who had been in attendance at training and who was to be scheduled for refresher courses. Staff were up to date in their training related to safeguarding of vulnerable adults, moving and handling of people, supporting people with autism, and supporting people with assessed behavioural needs.

In a sample of incidents and investigations reviewed, inspectors found good examples of how the provider and line management supported and supervised staff members and identified opportunities for learning going forward. Where relevant, the provider had implemented their disciplinary process in accordance with their policy and procedures.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found evidence of how the registered provider maintained an effective oversight of the care and support delivery in this service. There were suitable management and reporting structures in effect, and the provider-level management was aware of the ongoing and incidental risks relevant to this centre, and how they were being addressed, investigated and mitigated.

Inspectors found good recent examples of auditing in the service to assess the quality and safety of resident support, trend and analysis adverse events, supervise staff, and ensure that resources and training was suitable for the needs of this designated centre. The provider's quality assurance team had conducted their six-monthly unannounced inspection of the designated centre, most recently reported in July 2022, and where areas were found in need of development, a time bound action plan was set out.

Judgment: Compliant

Regulation 31: Notification of incidents

The service provider had notified the Chief Inspector of practices and incidents occurring in the designated centre in accordance with the requirements of the regulation.

Judgment: Compliant

Quality and safety

Inspectors found that where serious incidents had occurred, or allegations had been made, in the designated centre, the provider had taken appropriate action to respond to the immediate risk to the resident, and conduct investigation into the matter in accordance with their policy and procedures. Inspectors reviewed detailed reporting by the person who initialled alleged or witnessed the event, and what action had been taken to keep the resident safe. The provider had notified their designated officer of all allegations made, and had evidence of their communication with other external authorities including An Garda Síochána and the Chief Inspector.

Inspectors reviewed investigations into allegations and found them to be comprehensive in determining the facts and engaging with relevant parties in coming to their conclusion. Where allegations had been substantiated, appropriate action had been taken. In instances in which no abuse was identified, but inappropriate practices were identified, this was also responded to in an appropriate manner for future learning. Whether substantiated or not, allegations and adverse incidents were found to be used as opportunities for individual or team learning going forward, or to develop or enhance risk controls measures.

The provider maintained good oversight of restrictive practices being used in the designated centre. A high level of environmental restrictive practice was in use in this designated centre, however there was evidence available to indicate how each measure was kept under ongoing assessment as being required in response to evidence-based risks. Inspectors found examples of where the provider had plans to reduce or remove some restrictions, where the associated risk had decreased.

Inspectors reviewed detailed, evidence-based support plans for residents who expressed anxiety or distress in a manner which posed a risk to themselves or others. Plans reviewed clearly identified the nature of the behaviour with functional analysis on causes, triggering factors and antecedent behaviours for each presentation. Staff were provided detailed and person-centred guidance for how to maintain a low stress environment, and how to support the residents in behaviour management and de-escalation. While proactive and reactive strategies were written in detail, there was limited detail guiding staff on effective procedures to follow

when physical intervention measures were used as a last resort measure.

Inspectors found suitable systems in effect for the management of resident medicines. Medicine practices were routinely audited to ensure that they were being recorded and stored appropriately, and administered in the manner prescribed. Where audits had identified areas requiring improvement or errors made, action plans and additional risk controls were communicated to the staff team for ongoing learning and precautions.

Regulation 12: Personal possessions

Residents were supported to purchase items, and to maintain an appropriate level of control over their property and belongings in their home. Residents' bedrooms and living spaces were personalised based on the preferences, hobbies and assessed safety needs of each resident.

The provider had systems in effect to routinely monitor and audit resident finances where they were supported or managed by staff. Inspectors found examples of where these systems had identified discrepancies, and how the provider had investigated to establish the reason behind same and respond accordingly.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider maintained a policy on the assessment and management of risk in the designated centre. Staff members had been trained in how to identify and establish risk control measures for hazards in the service. The inspectors reviewed detailed records of incidents reported in the centre and how these were used in investigations of events, and later in the trending and analysis of incidents.

There was a risk register for the designated centre as well as for risks specific to individual residents, in which there were measures outlined to mitigate the identified risk. The inspectors also found examples of how the outcome of investigations or the findings of audits had contributed to actions and controls for risk reduction.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found examples of appropriate medicines management and practices in

place. All medicines were stored securely and administered as prescribed. Medicine errors identified were responded to promptly and used as opportunities for learning or additional risk controls. Clear protocols were in effect to identify the circumstances under which PRN medicines (medicines only taken as the need arises) can be administered.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors reviewed a sample of positive behaviour support plans in place for service users. These were detailed, person-centred and reflective of actual experiences of the residents and staff. Plans were developed and reviewed regularly with input from the behavioural specialist and staff members advocating on behalf of service users.

Support plans outlined proactive and reactive strategies for maintaining low arousal environment and routines, recognising antecedent behaviour indicators, and how to respond in a manner which was safe for the residents and others. Where residents' behaviour necessitated physical intervention there was evidence of how staff had exhausted less restrictive options before doing so.

While positive behaviour support strategies were detailed overall, there was limited information guiding staff on the most appropriate and effective physical restraint measure to use for each behaviour for which it was prescribed. In light of the high frequency of use of these restraint measures, and instances in which improper restraint techniques had been identified, there was limited guidance to staff on safe and effective measures based on experience and evidence as was the case for the support plans as a whole.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had responded to allegations or suspicions of verbal, physical, institutional and financial abuse incidents in a manner which was in line with the regulations and provider policy and whose primary goals was ensure the safety and dignity of service users. Immediate measures had been taken to ensure that residents were safe while provider conducted their investigations. Inspectors reviewed investigation reports of allegations made in the service and found detailed accounting of the incident and the methods by which the provider established the facts and context for the events.

The provider had notified the appropriate parties such as their designated officer, the Chief Inspector, and An Garda Síochána, as well as the families and representatives of residents involved. Inspectors found records of how the safeguarding team was assured of the safety of residents and the actions taken on foot of allegations. Whether or not the allegation was substantiated in part or in full, incidents were used as opportunities for learning and development of support delivery in the future. Examples were found of how risk controls and precautionary measures were revised following events.

Residents' safety and dignity was also protected through support plans around financial safeguarding and intimate care. All staff were trained in recognising and reporting concerns related to the safety and wellbeing of vulnerable adults.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Clarey Lodge OSV-0003386

Inspection ID: MON-0037595

Date of inspection: 09/08/2022

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 7: Positive behavioural support	Substantially Compliant

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

1. The Behavioral Specialist, in conjunction with the Person in Charge (PIC), will conduct a review of the information guiding staff in on,

a) The most appropriate and effective physical restraint measure to be utilized when Service Users displaying behaviours of concern.

b) Ensuring plans implemented reflect, specific information guiding staff on the most effective way to reduce or discontinue the occasion of physical restraint during an incident in so far as safe practicable to do so.

Note: This is to ensure such physical restraint practices are applied, adopted, and recorded in the least restrictive manner for the shortest duration of time, in accordance with national policy and evidence-based practice.

2. In addition to the full review of physical restraints, Personal Plans will be reviewed in their entirety, to include Risk Assessments, SOP's and MEBSP's, to ensure that the information is accurate, that key risks are identified and managed, and that every effort is being made to identify and alleviate Challenging Behaviours prior to a physical restraint being utilized.

3. The PIC shall continue to monitor restrictive practices in conjunction with the Behavioral Specialist and in line with the Centre's Policy and Procedure on Restrictive Procedures [PL-C-005] to ensure such practices are applied, adopted, and recorded in the least restrictive manner for the shortest duration of time.

4. Following the review, the PIC shall update plans, as and where required, of Service User's Multi-Element Behaviour Support Plan (MEBSP) and or their proactive and reactive

strategies, Section 5 their Personal Plan.

5. The above points and updated plans will be communicated to the staff team and discussed at monthly staff team meeting.

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 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.	Substantially Compliant	Yellow	14/10/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	14/10/2022