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:	Le Cheile
Name of provider:	Health Service Executive
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	28 July 2022
Centre ID:	OSV-0005457
Fieldwork ID:	MON-0028456

About the designated centre

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

The designated centre is a detached bungalow with spacious landscaped gardens, situated on the outskirts of the local village. The house can accommodate five residents, and is wheelchair accessible throughout. There are various communal living areas, and each resident has their own personal room, two of which are en-suite. The provider describes the service as offering support to adults with intellectual disability and autism. The house is staffed full time, including waking night staff, and has 24 hour nursing support.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 28 July 2022	10:30hrs to 18:00hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This was an announced inspection conducted in order to monitor compliance with the regulations, and to inform the registration renewal of registration.

The centre was a clean and spacious home for five residents, and there were various communal areas so that residents could choose to spend time together, or to have time to themselves in small living areas. On arrival at the centre, the inspector observed residents utilising different areas of their home. Some residents were enjoying morning coffee in a pleasant landscaped outdoor area, and some were engaged in their preferred activities indoors. Others had already gone out to enjoy their chosen activities with the support of staff.

The layout of the centre supported the variety of preferences of residents, for example, there was a small living room which was mainly used by a resident who preferred to have their own space. There was also a large living room that was enjoyed by those residents who preferred the company of others.

Each resident had their own personal bedroom, and all these rooms were nicely decorated in accordance with their preferences, and personal effects were evident throughout.

While residents did not have verbal conversations with the inspector, they were observed to be comfortable. They were supported by a staff team who knew them well, and who understood their various ways of communicating. Throughout the inspection the inspector observed residents enjoying various activities, and saw that their home allowed for both joint and individual activities. Some residents had particular hobbies, and they were supported by staff to enjoy these hobbies. Some people were involved in their local community, and staff were seen to facilitate this engagement.

Some people had more interest in sensory activities, and there were examples of support for this preference throughout the centre, including music and sensory lighting. The local library had a sensory room, and residents were supported to avail of this facility. One of the residents was in the process of developing a sensory garden which was already nicely laid out with flowers and garden ornaments.

Discussion with staff and review of documentation showed that all efforts had been made to ensure that residents continued to have meaningful activities during recent community restrictions. In particular, staff members had been specifically assigned to those residents whose activation needs were not easily identified. For some people this meant simply having company and listening to music of their choice.

As this was an announced inspection, residents and their families had the opportunity to fill out questionnaires in relation to their experience of life in this designated centre. Several questionnaires had been completed by family members,

and other families had requested that staff support their relative to complete them. All of the responses were positive, and some families were very complimentary about the service offered to their relatives. Comments included reference to 'wonderful care' and to staff having the best interests of residents as paramount. There was reference to the positive way that staff had managed the recent pandemic to ensure the comfort and safety of residents. There was also acknowledgment for the activities offered to residents.

Communication and information sharing with residents was prioritised, and in particular in relation to public health guidelines. There was accessible information throughout, and all efforts had been made to ensure that residents were informed. Accessible information about activities, staff on duty and menu plans was readily available.

Overall, the provider had ensured that residents had a comfortable quality of life, and while some areas for improvement were identified as further discussed in this report, multiple examples of person centred practice were evident.

Capacity and capability

There was a clearly defined management structure in place with clear lines of accountability. The provider had made arrangements to ensure that key management and leadership roles were appropriately filled. There was a person in charge in position at the time of the inspection who was appropriately skilled, experienced and qualified. They were knowledgeable about the needs of residents, showed clear oversight of the centre and demonstrated an understanding of the importance of quality of care and support.

There was a staff team in place who were appropriately skilled and supported. The number and skill mix of staff was appropriate to meet the needs of residents. There was a core team of staff, all of whom were familiar to residents, and where agency staff were used, they were also familiar to the residents. There was a nurse on duty at all times, and staffing numbers were sufficient on a daily basis to meet the needs of residents. Both a planned and actual roster was maintained.

Staff were in receipt of regular training which was found to be current and relevant, with clear oversight by the person in charge. Staff had received all mandatory training, and some additional training had been made available in relation to the assessed needs of residents.

A sample of staff files was reviewed, and the files contained all the information required by the regulations. Formal staff supervisions were undertaken every six months and records of supervision conversations were maintained. Staff were knowledgeable in relation to the needs of residents and were observed to be providing care and support in accordance with the identified needs of residents.

Staff team meetings were held every two months for the most part, with a clear rationale for any missed meetings. Records of these meetings indicated a meaningful discussion and sharing of information.

The provider had completed various reviews and reports focusing on the quality and safety of care provided in the centre in accordance with the regulations. An annual review of quality and safety of care and support in the centre had been completed in accordance with the regulations, and any required actions identified in this review had been completed. Six monthly unannounced visits on behalf of the provider had also taken place, however not all the required actions identified in the report had been completed. A process of audits of practice had been established by the provider, but not all of these had been completed.

There was a complaints procedure in place which was readily available to residents and their representatives, and an audit of any complaints had been conducted. There were no outstanding complaints at the time of the inspection.

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.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

An annual review had been prepared, and six monthly unannounced visits on behalf of the provider had been conducted. However, actions relating to the development of meaningful goals for residents had not been completed. In addition, the suite of audits required by the provider to ensure oversight of the care and support of residents had not all been completed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. A complaints log was maintained, and complaints and complements were recorded and acted on appropriately.

Judgment: Compliant

Regulation 4: Written policies and procedures

Whilst all policies required by the regulations under Schedule 5 were in place, there was no policy in place to guide staff in the event of there being a 'Do not attempt resuscitation' (DNAR) order in place.

Judgment: Substantially compliant

Quality and safety

There were personal plans in place for each resident, and accessible versions of these plans had been made available to them. However person centred plans did not include goals for residents. While staff could describe some of the activities that they hoped to involve residents in, the person centre plans comprised only photographs of past activities. There was insufficient evidence of the requirement in the regulations to maximise the potential of each resident, such as aspirational goals. This was an issue identified as requiring attention in the six monthly unannounced visits which had not been acted on.

However, there were detailed communication passports in place, which outlined each resident's preferred way of communicating, and these included detail of both expressive and receptive communication preferences. These plans included referrals to the speech and language therapist and associated guidelines for each of the residents. These plans also included an assessment of the ways in which each resident communicates distress of various levels, and staff were knowledgeable about the content of these plans.

Infection prevention and control (IPC) had been well managed in this centre. Public health guidelines had been followed throughout, and when there was an outbreak of COVID-19 this was also managed in accordance with best practice. There was a detailed contingency plan which had been followed, which referred both to public health guidance and to plans to ensure on-going activities for residents. There was an identified COVID-19 lead person identified. Following the outbreak there was a detailed post outbreak review which detailed the steps taken. It was clear from this document, and from discussion with staff members that all appropriate precautions had been taken. Where residents had to self-isolate, there were facilities within the centre that ensured the safety of others.

Current guidelines were observed by the inspector to be in place both at the start of the inspection, and throughout. Facilities and equipment to support good practice were available, however, some items which might be needed in the event of an infection control incident were out of date.

Healthcare was well managed for the most part. There were detailed healthcare plans which were informed by the recommendations of various members of the multi-disciplinary team. Appropriate health screening had been offered to residents. A 'hospital passport' had been developed for each resident to inform staff of a receiving healthcare facility of the needs and preferences of resident in the event of an admission to acute services. Changing healthcare needs were responded to swiftly and appropriately,

However, there was a 'Do Not Attempt Resuscitation' (DNAR) order in place for one

of the residents, in the absence of sufficient detail to inform this decision. A review of the documentation and discussion with staff and the person in charge did not demonstrate a clear rationale for this significant order to be in place. The information provided to the inspector on the day of the inspection was not adequate to ensure the best interests of the resident. There was insufficient guidance as to the circumstances under which staff should or should not attempt resuscitation, and there was no organisational policy to guide staff in the interpretation of a DNAR order.

Medication was safely managed. There was secure storage of medications, and robust stock control practices. Administration practice was observed by the inspector, and found to be in compliance with best practice. Protocols were in place for 'as required' medications, and clear records of the administration of these medications was maintained.

There was a risk register in place which identified both local and individual risks, each of which was appropriately risk rated and included an appropriate risk management plan. There was a process whereby identified risks were overseen, and escalated as required.

Effective fire safety precautions were in place, including fire detection and containment arrangements, fire safety equipment and fire doors. Staff and residents had all been involved in fire drills. These fire drills took place regularly, and included night time drills and unannounced drills. The documentation of these fire drills, together with discussion with staff members, demonstrated that all residents could be effectively evacuated in a timely fashion in the event of an emergency.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

Judgment: Compliant

Regulation 17: Premises

The design and layout to the premises was appropriate to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Appropriate processes were in place to assess and mitigate identified risks.

Judgment: Compliant

Regulation 27: Protection against infection

Infection prevention and control was well managed for the most part, however spills kits for use in the event of blood spills were out of date.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Structures and procedures were in place to ensure the safe management of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Whilst personal plans were in place for each resident, they did not include goals or plans for the maximisation of the potential of each person.

Judgment: Substantially compliant

Regulation 6: Health care

Whilst the healthcare needs of each resident were addressed and well managed for the most part, there was a DNAR order in place for one of the residents with insufficient evidence to support this decision, and insufficient guidance for staff in relation to the implementation of the order.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to ensure that residents were protected from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were upheld, and the privacy and dignity of residents was respected.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Le Cheile OSV-0005457

Inspection ID: MON-0028456

Date of inspection: 28/07/2022

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PCP meetings have been scheduled and all will have taken place by 16/09/2022. Staff have been working closely with residents to identify meaningful, aspirational goals which will be agreed at residents PCP meetings. A new template has also been implemented to support the delivery of goals. All audits are now up to date.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Policy review group is meeting on the 21.09.2022 and will agree on a process to develop a DNR policy. It is envisaged that the DNR policy will be finalised and implemented by 31.12.2022	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection	

against infection: Spills kit has been replaced and a system for monitoring the dates on cleaning products has been developed.

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: PCP meetings have been scheduled and all will have taken place by 16/09/2022. Staff have been working closely with residents to identify meaningful, aspirational goals which will be agreed at residents PCP meetings to maximise the potential of each resident. A new template has also been implemented to support the delivery of goals.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Care plan has been developed for the resident with the DNR in place. The, PIC has consulted with family, GP and as per care plan meeting arranged for formal review to be completed by 16.09.2022. An interdisciplinary review of the DNR will be completed to uphold the validity of the clinical decision making to ensure it remains in the best interest of the residents in accordance with their care plan.

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 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.	Substantially Compliant	Yellow	16/09/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	31/08/2022

	published by the Authority.			
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/12/2022
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.	Substantially Compliant	Yellow	16/09/2022
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.	Not Compliant	Orange	16/09/2022