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:	JULA
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	21 February 2023
Centre ID:	OSV-0005694
Fieldwork ID:	MON-0038421

About the designated centre

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

Jula is a residential home located in Co.Kilkenny, catering for four adults with an intellectual disability over the age of 18 years. The service operates 24 hours, seven days a week. The property is a large bungalow which provides a homely environment for the residents. Each resident's private bedroom is decorated to their unique tastes. The person in charge works in a full time capacity with the support of the person participating in management and the staff team.

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 21 February 2023	09:30hrs to 16:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This announced, risk based inspection was completed following receipt of information of concern notified to the Chief Inspector of Social Services by the registered provider. The submitted information outlined an alleged safeguarding incident in the centre. On receipt of the information immediate assurances were sought from the provider that measures were put in place to ensure all residents in the centre were safe. The purpose of the inspection was to follow up on the immediate and provider identified ongoing actions that had been taken in relation to this alleged safeguarding concern. It was found that although immediate actions were taken to mitigate any potential risks to residents, follow-up actions, as identified by the provider, were not completed.

This centre provides full-time residential care for four individuals. Each resident in the home required full staff support across all their care and support needs. All residents in the home used a combination of non-verbal methods of communication, this included facial expressions and some vocalisations. To gather a sense of that it was like to live in the centre the inspector spent some time observing daily routines, speaking with staff and family members and reviewing documentation in relation to the residents' care and support needs.

The inspector met with all four residents who live in the centre on the day of inspection. On arrival at the centre residents were being supported with their morning routines. Three staff were present at this time. It was busy at this time of the day due to residents' specific care needs, however, there was a calm and relaxed atmosphere in the home. Some residents were in the kitchen being supported with their breakfast. Many residents in the home were on a specific texture-modified diet. Staff were patient and caring during this routine, and took their time to ensure residents were supported safely and appropriately. Following breakfast, residents were supported to relax in the kitchen or sitting room area. Music was playing or specific TV programmes were available to watch. Residents appeared very calm and relaxed. In the afternoon one resident went out on a family visit and and a second resident had a family visit in the home.

Staff members were observed to be kind and caring at all times. They had good knowledge of residents' specific care needs. They were respectful in their interactions and were seen to inform residents of what was happening at all times. Staff knocked on residents' doors before entering. When speaking about residents and their specific needs professional and person centred language was used.

On the walk around of the home it was observed that is was overall a well kept home. The residents lived in a detached bungalow in a rural area in Co. Kilkenny. There was a large garden surrounding the home. Each resident had their own individualised bedroom. Each bedroom was fitted with an overhead hoist to assist the residents when transferring from their beds to their wheelchairs. There was one large accessible bathroom. Residents also enjoyed the communal spaces such as the

sitting room, kitchen and sun room area. The garden area was overall well kept, and there was a swing set in the garden for family visits. Some residents had a young nieces and nephews and this had been added to the garden as they visited on a regular basis.

The person participating in management completed the walk around of the premises with the inspector. They were recruited to this role in the last few weeks. The person in charge was absent on the day of inspection. On the walk around it was noted that Infection Prevention Control (IPC) measures needed improvement. This included the cleaning of a laundry room, mop storage and replacement and cleaning of equipment. In addition, storage of oxygen within the premises required immediate review to ensure it was in line with fire safety requirements. This review was completed prior to the inspector leaving the home. As the current inspection was to specifically review safeguarding measures these areas of risk were addressed outside the inspection process and followed up through relevant regulatory processes.

Family members spoken with were happy with the service their family member received. They spoke about the person in charge and how they felt supported when engaging with the centre. They stated that communication with the centre was good. They spoke about actions that they wanted to happen on foot of the alleged safeguarding concern. This included being informed, in an appropriate manner, of the investigation process.

Overall residents were in receipt of care that met their assessed needs. Residents appeared comfortable and content in their home. However, continued focus was required in relation to safeguarding, specifically in relation to appropriate ongoing oversight. The next two sections of the report present the findings of this inspection in relation to the overall management of the centre in terms of safeguarding and these arrangements impacted on the safety of the service being delivered.

Capacity and capability

As stated previously, solicited information of concern was submitted to the Chief Inspector that pertained to a serious allegation of a safeguarding incident within the centre. This allegation had been submitted directly to the Health Service Executive's Safeguarding and Protection Team who in turn informed the registered provider.

Immediate actions were taken by the provider to ensure that all residents were safe. As part of this, the provider formed an emergency safeguarding oversight committee with members of management and staff to manage the alleged incident in an appropriate manner. An Garda Síochána, family members, and staff were communicated with and informed of relevant information. Reporting occurred in line with both National and the provider's relevant policies and procedures and an investigation was instigated.

However, oversight from a provider level was limited following the initial response and initial actions that were implemented. The inspector found that sustained oversight and implementation of actions which had been identified as required subsequently failed to occur. To ensure the sustainability of safe services and the mitigation of risks around potential safeguarding incidents occurring, comprehensive and consistent provider oversight was required.

There was a staff team in place that consisted of nursing staff, social care worker and care assistants. There were a number of vacancies within the existing staff team. To ensure sufficient staffing was in place at all times a number of agency staff were utilised. The provider had identified the impact this had on continuity of care as a number of different agency staff were being used. Plans were in place to streamline this process to ensure continuity of care for all residents availing of the service. Staff spoken with and a sample of supervision notes reviewed indicated that staff found that the use of different agency staff put additional pressure on them to complete their roles effectively.

A training program was in place to ensure that staff had the required skills to support the residents appropriately. Part of the mandatory training requirements included completing training in relation to the safeguarding of vulnerable adults. On the day of inspection, two staff members had not completed refresher training in this area. One persons training had expired in July 2022.

Regulation 23: Governance and management

Appropriate and comprehensive management systems were not consistently in place to ensure that safeguarding risks were adequately reviewed and that identified control measures were completed as stated.

There was a defined management structure in place, with a full-time person in charge allocated to the centre. The person in charge reported directly into the community services manager. The community services manager was in the role for approximately six weeks at the time of the inspection. They commenced their role subsequent to the safeguarding allegation.

Although some appropriate provider actions were taken in response to the alleged safeguarding incident initially there were a number of areas of improvement identified as required. There was limited provider oversight across a number of key areas associated with safeguarding.

- Actions identified by the Provider in an interim safeguarding plan had not been implemented.
- There was limited evidence of additional supervision of staff following the allegation to ensure they were supported appropriately in their role.
- Team meeting notes from the time of the allegation were not available for review either by the staff team or when requested by the inspector.
- Although the training matrix identified that a small number of staff had not

completed safeguarding training this had not been rectified and no evidence provided that these were scheduled.
- While an 'Oversight Committee' was established at the point of the allegation being made, which had met on three occasions within that month, no additional oversight systems were put in place. For example, no audits specifically in relation to safeguarding had occurred.
- Risk assessments associated with safeguarding risks had not been updated or reviewed since 2020 .

Cumulatively, oversight was not demonstrated in a comprehensive manner considering the serious nature of the allegation.

Judgment: Not compliant

Quality and safety

Overall , the inspector found that the day-to-day practice within this centre ensured that residents were receiving care in line with their needs. Residents were seen to be treated with dignity and respect. However, safeguarding measures identified as required by the provider, had not been implemented. Although no immediate risks to residents' safety were identified, the provider was required to make a number of improvements to ensure safe care was central to all aspects of care provision.

Relevant plans and risk assessments had not been updated following the allegation, so it was not clear if the information presented in these documents was in line with best practice. The provider failed to put adequate arrangements in place to keep the residents safe from the risks identified by not ensuring these risk assessments had been reviewed. While there were documented interim safeguarding plans in place following this significant allegation, the follow through required by the provider to implement the safeguarding plans to further ensure the safety of the residents was inadequate.

Regulation 8: Protection

The registered provider notified the Chief Inspector that a potential serious safeguarding concern had occurred within the centre. On receipt of this information the provider took a number of appropriate steps to ensure residents were safe and completed an investigation in a thorough manner.

However, notwithstanding the outcome of the investigations the provider had identified a number of actions that were required to ensure residents' safety and

submitted these actions as part of their interim safeguarding plans. These actions included, reviewing a relevant policy and reviewing named care plans. The inspector requested a copy of all stated documents. The documents were found to have been reviewed prior to the allegation but there was no evidence to provide assurances that the provider had completed the stated reviews following the allegation.

As part of their process, the provider stated that the staff team were to be informed of the policies and care plans. There was limited evidence available that this had occurred. For example, on the back of a care plan there was only two staff signatures confirming they had read the care plans indicating that the rest of the staff team had not read them. When speaking with staff on the day of inspection they stated some practices had changed but they were unsure if this was in line with what was in care plans. In addition, not all staff had up-to-date training in safeguarding. Two permanent members of the staff team required refresher training in this area. One staff member had been out of date in this training since July 2022.

Although the allegation was investigated in line with National guidance and the provider's policies and an outcome reached, the provider had failed to ensure that relevant safeguards identified as required had been put in place nor that those already in place had been reviewed.

Judgment: Not 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 23: Governance and management	Not compliant
Quality and safety	
Regulation 8: Protection	Not compliant

Compliance Plan for JULA OSV-0005694

Inspection ID: MON-0038421

Date of inspection: 21/02/2023

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

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

The PIC and PPIM met after the inspection took place to discuss the identified concerns at the inspection. The PPIM, who commenced working in SPC/Aurora in January 2023 met with the staff team on the 24/02/2023 to start a full review of person supported's documentation and developed an action plan with the PIC and Jula team on identified areas of improvement.

All identified actions as per safeguarding plan are now completed, including full review and update of support plans and intimate care plans for the ladies supported. The review of risk register for Jula is still ongoing. PPIM is facilitating On the Job mentoring with the team to ensure a comprehensive review of all risk assessments in line with supports plans by latest 31/3/2023.

As part of the providers Safeguarding system the Community Service Managers have now been assigned to complete bimonthly reviews to oversee implementation of safeguarding plans and closure of actions. The PPIM for Jula has commenced the review of all safeguarding plans for the designated centre. The Assistant Director of Services (ADOS) is overseeing the completion of all Safeguarding relevant information and guiding the CSMs in their reviews. ADOS and PPIM for Jula are meeting for a further review on 20/3/2023 to evidence closure of actions for safeguarding plan.

Whilst the PPIM could not locate minutes of team meetings being held after the time of allegation in November 2022, the PPIM and PIC have since met with team members for a team meeting on 27/2/2023 and numerus On the Job mentoring. Director of Services and PPIM met for a Topic Specific Quality Conversation on the 28/02/2023 to discuss actions to be taken in Jula and assurance re Reg 23 and Reg 8.

As additional support for the PIC and team the PPIM is currently visiting Jula one to two days per week to follow up on agreed actions for completion.

Aurora provider audit system has been implemented in January 2023 and is now rolled out as per schedule. Besides bimonthly CSM Safeguarding reviews, next provider audits are scheduled for completion in Jula on April 2023 and August 2023.

Training specifically with regards to safeguarding, risk assessments, on the job, mentoring commenced 27/02/23 due for completion 01/04/23. All mandatory training has been booked with the training department.

Quality Conversations have been scheduled and commenced with the team members.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Following actions have been taken since the inspection took place to ensure protection for people supported and follow up on outstanding actions:

• All person supported plans have been reviewed. The PPIM has ensured that each team member has read and signed the plans. Through On the Job mentoring and visits to the house the PPIM has assured that the team is aware of following the plans.
• To ensure the team understands safeguarding pathway and systems the PPIM is carrying out regular visits and OJM in Jula to support the full review of designated centre and person's risk register, which will be completed by 31/3/2023.
• Mandatory Safeguarding training is now completed. One employee completed safeguarding training on 15/2/23 now uploaded to training matrix, second employee due to complete the training is on long term sick leave and will complete the training on return.
• All other mandatory training has been booked with the training department.
• Regular Quality Conversations have been scheduled and commenced with the team.
• As part of the providers Safeguarding system the Community Service Managers have now been assigned to complete bimonthly reviews to oversee implementation of safeguarding plans and closure of actions. The PPIM for Jula has commenced the review of all safeguarding plans for the designated centre. The Assistant Director of Services (ADOS) is overseeing the completion of all Safeguarding relevant information and guiding the CSMs in their reviews. ADOS and PPIM for Jula are meeting for a further review on 20/3/2023 to evidence closure of actions for safeguarding plan.
• Actions identified by provider have been completed, including full review of persons support plans.

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.	Not Compliant	Orange	01/04/2023
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Not Compliant	Orange	31/03/2023

Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	31/03/2023