



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

Issued by the Chief Inspector

Name of designated centre:	Lunula
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	21 July 2021
Centre ID:	OSV-0007900
Fieldwork ID:	MON-0033808

About the designated centre

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

This house a three bedroomed bungalow located between Callan and Windgap in Co. Kilkenny. The house is located on its own site; it has ample parking spaces and a secure garden. The house comprises of three bedrooms, one of which is en suite , a sitting room, kitchen/dining room, utility room and a visitors room. It provides a service to three residents who present with intellectual disabilities and complex needs. The house is staffed with a combination of nursing and health care assistants. This is a high support home, with a requirement for two staff during the day with a third to assist in accessing the community. The stated aim of the service is to develop services that are individualised, rights based, and empowering, that are person-centred, flexible and accountable; services that energetically promote relationship building and social inclusion - and which are in and of the communities where people supported live.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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
Wednesday 21 July 2021	10:30hrs to 16:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This inspection took place during the COVID 19 pandemic. As such the inspector followed public health guidance and HIQA enhanced COVID-19 inspection methodology at all times. The inspector carried out the inspection primarily from an office in the centre. From here, the inspector was able to observe much of the daily activity in the centre.

This centre is a newly built bungalow in a rural location. It has a spacious back garden and ample parking to the front. The house comprises a kitchen, a large living room, a bathroom, three bedrooms, one of which is en suite and an office which doubles up as a visitors room. The corridor is wide and the home is filled with light from the large windows. This, coupled with a low-arousal approach and staff who were familiar with the residents, created a calm and homely environment on the day of the inspection.

The three residents living in this centre lived in a large unit in a campus-based setting up to 2017. They lived in another designated centre before moving to what the staff referred to as their "forever home" in December 2020. Staff reported that all of the residents were extremely content with their new home and experienced increased well-being as a result of the move. For one resident, some behaviours had been significantly reduced and in another case, stopped completely. These improvements were thought by staff to be related to residents having more space to themselves and the ability to go up and down the hall without impeding others.

The inspector had the opportunity to briefly meet with each of the residents on the day of the inspection. On arrival to the centre, the inspector was greeted at the door by one of the residents and led by the hand to the kitchen area to get a drink. Another resident was walking about the house enjoying kicking his ball and going in and out of the garden in the sunshine. The resident was observed to enjoy music on their television in their bedroom. Staff reported that they enjoyed lying on their bed and looking out the window, which was new for this resident. Later in the morning, two residents went out to a park and for lunch afterwards and they returned later in the afternoon, appearing content. The third resident remained in the house during the day. They listened to Irish music and helped the staff prepare a meal for the evening time. The resident was observed to be chatting to the staff as they ate lunch and during meal preparation.

Two of the residents communicated non-verbally using a variety of means (for example, pulling a person by the hand to what they want, through body language, facial expressions and behaviours). This required staff to know each resident and their particular communication methods well. All of the residents had a communication passport in place in order to support staff in this regard. Interactions were noted to be positive and respectful with all of the residents over the course of the day.

It was evident that staff had worked hard to ensure residents were well supported in transitioning to their new home. Each resident had a transition plan which included a 'moving story' which outlined each step of the move with photographs. A transition diary was kept for each resident with details of their progress at each stage of the move.

Each of the residents had a tablet with photographs of them achieving their goals and doing different activities. During the pandemic, staff had purchased mobile phones for each resident. They had made contact with families using video calls and also created a family group on the phone. This meant that photographs and videos of residents were shared with families in real time. Staff were very positive about this and gave an example of a family member ringing when the resident was at the beach and staff subsequently sent some photographs of that resident to the family. Families were sending videos and photographs to residents and staff reported that one resident smiled and laughed each time they saw their sibling on the screen. This was a very important way to support both residents and families throughout the COVID-19 restrictions. At the time of the inspection, visits were beginning in the centre again in line with public health guidance.

Residents all had detailed personal plans. Residents had an annual 'Visioning ' meeting where their personal plans and progress were discussed. Family were invited to attend this meeting with the resident. The person in charge told the inspector about a visioning meeting which had taken place for a resident the previous week. A photo-based presentation was done by their key worker to ensure that they were central to the meeting. Family members were able to attend via video. Staff described the resident as 'lighting up' and really enjoying seeing both themselves and their family on the screen.

In summary, based on what the inspector observed, what residents and staff communicated and reviewing documentation, it was evident that residents were receiving good quality care. They appeared content, comfortable and well cared for. However, there were some areas for improvement including policies and procedures, governance and management and residents finances. The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that there was good governance and management structures and systems in place to ensure that the service provided was safe and of good quality for the residents. However, improvements were required in ensuring that policies and procedures were up to date.

Good provider level oversight of the quality and safety of care was provided through annual reviews and six monthly reviews in line with the regulations. There were

clear lines of authority and accountability in the service. The person in charge reported to the Community Services Manager who in turn reported to the Director of Services. The person in charge had oversight of three other centres. The person in charge ensured day to day oversight through clear delegation of tasks and assigned responsibilities to staff members in each centre.

A number of audits were carried out locally by staff and overseen by the person in charge to ensure that residents were receiving a good quality service and that systems of documentation and recording reflected this.

The provider ensured that there was an appropriate level of staffing and skill mix to meet the assessed needs of the residents. Staff had completed training in mandatory areas and where they required refresher training, a date was provided to the inspector when this would occur. All staff were supervised on a regular basis by the person in charge. Team meetings occurred on a monthly basis.

The provider had prepared written policies and procedure in the matters as set out in Schedule 5 of the regulations. While there was evidence of the establishment of working groups and the review of policies, a number of policies required review such as the residents' finance policy, the policy on staff recruitment, the policy on health and safety and monitoring and documenting nutritional intake.

On the whole, the high levels of compliance on this inspection were reflective of good systems of governance and management and demonstrated the provider's capacity and capability to provide a quality and safe service to the residents living in this centre.

Regulation 14: Persons in charge

The provider had appointed a suitably qualified and experienced person in charge to manage the centre. The person in charge worked full-time and had responsibility for three other centres. One of the centres was a COVID-19 isolation unit which was vacant on the day of the inspection. The person in charge divided their time evenly between the three centres. The person in charge had good systems of oversight and monitoring in place and could clearly demonstrate these to the inspector. They provided some direct support hours in each of the centres each week. The person in charge had done a significant level of work to ensure that the residents transition to their new home went smoothly. It was evident they knew the residents and their needs very well.

Judgment: Compliant

Regulation 15: Staffing

The provider had a sufficient number of staff and an appropriate skill mix on duty each day to ensure residents received good quality care in line with their assessed needs. There were between two and three staff on duty by day and one at night time. The team was made up of a staff nurse, health care assistants and the person in charge. Planned and actual rosters were well maintained. Where needed, regular relief and staff from within the organisation who were already familiar with the residents were rostered in order to provide continuity of care to residents. A sample of staff files indicated that all required documentation required in Schedule 2 of the regulations were present.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training matrix. This indicated that all staff had completed mandatory training in fire safety, safeguarding, manual handling, PPE, hand hygiene, food safety and managing feeding, eating, drinking and swallowing difficulties. Where staff required refresher training (for example in Studio 3 and in First Aid), these were scheduled for dates in August. The person in charge told the inspector about a project he had set up to support staff in the centre to further develop their skills, competencies and confidence in specific areas relating to their roles. Staff were asked to identify areas which they wished to improve upon (for example, computer skills, doing personal plans). They were paired up with another staff member who had those skills and were willing to support their peer to further develop. This system was reported to be working well. All staff received supervision on a three monthly basis. These were called "Quality Conversations". There was a clear structure to these conversations which set out targets and training needs. The person in charge was supervised by the Community Services Manager regularly.

Judgment: Compliant

Regulation 19: Directory of residents

The provider maintained a directory of residents which contained the information as required by Regulation 19.

Judgment: Compliant

Regulation 23: Governance and management

The provider had effective management structures and systems in place to ensure that residents were receiving safe and quality care. There were clear lines of authority and accountability. The person in charge reported into the Community Services Manager who in turn reported into the Director of Services. The person in charge had oversight of three centres. An annual review and six monthly review had been carried out , with clearly identified actions which were time bound. Family members were reportedly very happy with the move to the new centre and with the service received. Most of the identified actions had been completed on the day of the inspection.

The provider had effective emergency governance arrangements in place for night time and weekend cover. In order to ensure day to day oversight of the centre, there was a team lead on duty to support the person in charge. In addition, the person in charge had delegated duties to staff such as health and safety , menu planning and personal plan audits. The person in charge signed off on all audits carried out with the staff member and these were discussed as part of the staff members' "quality conversations" in supervision sessions. Team meetings took place on a monthly basis and were clearly structured.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre had a Statement of Purpose which contained all of the information required in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had prepared written policies and procedure in the matters as set out in Schedule 5 of the regulations. While there was evidence of the establishment of working groups and the review of policies, a number of policies were out of date and required review such as the residents' finance policy, the policy on staff recruitment, the policy on health and safety and monitoring and documenting nutritional intake.

Judgment: Not compliant

Quality and safety

On the whole, residents were found to be receiving good quality care which was person-centred and well suited to their assessed needs in this centre. However, there were two areas which required improvement - fire safety and access to personal possessions.

All residents had personal plans in place and staff had supported residents in their transition to the centre in an accessible and person-centred manner. Assessments of residents' needs were up to date and had corresponding support plans which were detailed in line with the residents' preferences. Residents had communication passports and profiles in place to support staff in their interactions with the residents. Residents were supported to enjoy the best possible health and had access to a range of health and social care professionals in line with their assessed support needs. There was a clear documentation system in place to ensure all health care needs were appropriately monitored.

The provider had appropriate measures in place to ensure the safety of residents and to identify, assess and manage risks both at centre and individual level. There were appropriate measures in place regarding infection prevention and control in the centre, in particular those relating to COVID-19.

The provider had suitable fire safety equipment in place with regular maintenance carried out, staff training was in place and personal evacuation plans were completed for each resident. Fire drills needed further work. No night time drill or simulated night time drill had been carried out in order to assure the provider that safe and timely evacuation with minimal staffing was achievable for the residents.

While residents were supported to purchase and retain their personal possessions in line with their interests, they did not have full access to their finances. Residents did not have their own bank account and were required to request money from their accounts held in the organisation on a weekly basis.

In summary, residents were found to be content and comfortable in their new home and enjoying a good quality of life in line with their assessed preferences and needs.

Regulation 12: Personal possessions

The person in charge had a system in place to ensure that residents had control over their clothes, with large wardrobes provided to store them. The residents had all purchased furniture for their own bedrooms. There were systems in place to manage residents' finances. However, improvement was required to ensure that residents were supported to manage their own financial affairs. For example, it was not evident that no assessments of financial support needs had taken place. Residents did not have their own bank account and were required to request money from their accounts held in the organisation on a weekly basis. There were systems in place to ensure residents had access to funds in a timely manner as well

as keeping a detailed record of any monies spent.

Judgment: Not compliant

Regulation 17: Premises

This is a newly built bungalow which is fully accessible. The premises had ample space for residents and this was well suited to their assessed needs. There was good heat, light and ventilation and a large garden to the rear. There was suitable arrangements for the safe disposal of clinical waste and adequate facilities for laundry. Each of the residents rooms were tastefully decorated with family photographs and done in line with their interests.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector found a robust approach to risk management in the centre. The centre had a safety statement, risk management policy and very clear centre specific risk management procedures in practice. Individual risk assessments were kept on file and were clearly correlated with relevant support plans and assessed needs. The accident and incident logs and the risk register were reviewed and were found to be updated and reviewed by the person in charge regularly. The inspector spoke with staff about identified risks in the centre and how these risks were being managed. The vehicle used for the centre had a maintenance log, weekly checks carried out and documented and it was appropriately insured.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. The inspector found the centre to be very clean. There was adequate supplies of PPE for staff and a suitable number of areas to sanitise and wash hands. There were temperature logs kept for staff twice daily. All up to date HSE guidance and HPSC guidance was available for staff to read. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. Staff had worked hard to ensure that all residents were able to successfully receive the COVID-19 vaccine with minimal distress.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was a maintenance log kept which was up to date and all equipment was tested regularly. Each resident had a personal emergency evacuation plan in place and there was a grab bag by the door with required items to support residents in the event of a fire. The person in charge had liaised with the local fire brigade in relation to evacuation procedures at night. There were records available of fire drills. However, all of these took place during the day. No night time drill or simulated night time drill had been carried out in order to assure the provider that safe and timely evacuation with minimal staffing was achievable.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector viewed each of the residents personal plans. All of the residents had up to date assessments carried out, most recently to plan for the move and identify current levels of need and supports required. There were corresponding support plans developed in line with assessed needs. Personal plans contained a detailed profile and biography of each resident. Visioning meetings took place annually and in order to make these accessible to residents, photographs and video were used.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve and maintain best possible health. All annual medical reviews had been completed prior to the move to support the transition process. Residents attended a local GP. Residents had access to health and social care professionals as required in line with their needs. There were clear records of access to health and social care professionals on residents' files such as psychiatry and occupational therapy.

Medical data sheets were kept by key workers in order to ensure that all residents were supported and monitored to ensure best possible health. All residents had been supported to receive their COVID-19 vaccinations. Each resident had a hospital passport in place to ensure that key information about the person was shared as

appropriate in an emergency.

Judgment: Compliant

Regulation 8: Protection

Residents were found to be safe and well protected in this centre. Inspectors reviewed the centres policies and procedures on safeguarding and found that they were in place, up to date and clearly understood by staff. A sample of intimate care plans reviewed indicated very detailed and clear guidance for staff including their preferences for the gender of staff to provide support. Staff were aware of how to report any concerns relating to the safety and welfare of residents. A log of safeguarding plans was kept and audited by the Social Worker for the provider. Residents presented as being very well cared for and appeared to be content in their home.

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 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	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lunula OSV-0007900

Inspection ID: MON-0033808

Date of inspection: 21/07/2021

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 4: Written policies and procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <p>SPC has started a comprehensive review of old Schedule 5 policies in 2019/2020. Progression of this review had been delayed due to the outbreak of COVID-19 pandemic in March 2020.</p> <p>SPC policy working group is further progressing the review and updating of relevant Schedule 5 policies as follows:-</p> <ul style="list-style-type: none"> • A review meeting for the Missing Person Policy was held in May 2021 and final amendments to the policy will be discussed at the next meeting on the 26/08/2021 and sent to all relevant groups (QA, SMT and Unions) for agreement and signing off. • The drafted policy Managing People's Money and Property is currently under review by Finance and Quality Manager to necessary assessments and person centred planning is integrated in the procedures. The policy review will be finalised by 30/09/2021. • SPC has adopted the HSE Food, Nutrition & Hydration Policy, a preamble has been added to the HSE document to acknowledge same. The policy has been signed off and rolled out in SPC as a Practice Development to all employees on 12/08/2021. • HR is further progressing the review and updating of SPC Staff recruitment, selection and Garda Vetting Policy and have set a date for final sign off by latest 30/08/2021. • The Health & Safety and also SPC staff training policy are currently being reviewed and updated by relevant department and SMT and will be circulated to Quality Assurance Group and Unions as per SPC Pathway in September 2021 for final review and signed off after completed review. • The File retention policy is scheduled to be finalised by the 30/08/2021. 	

Regulation 12: Personal possessions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 12: Personal possessions:</p> <p>As part of a full review of SPC Policy in relation to managing person's finances and property a new finance pathway has been implemented across the service as a practice development on the 23/06/2021.</p> <p>SPC acknowledges that the inspector found additional improvements and guidance was required in relation to person's finances. SPC Finance and Quality Manager are currently developing the new policy, which will be based on a person centre approach, including the SPC Personal Planning Framework and also individual assessments for people supported.</p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>A night time fire drill has now been completed since the inspection took place and learning and evaluation of fire drills is being discussed at team meetings between PIC and staff team. The PIC will ensure that regular night time/simulated night time drills are completed and documented in Lunula.</p>	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	08/09/2021
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	24/08/2021
Regulation 04(3)	The registered	Not Compliant	Orange	30/10/2021

	<p>provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.</p>			
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