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:	St. John of God Kildare Services - DC7
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Short Notice Announced
Date of inspection:	12 July 2021
Centre ID:	OSV-0002944
Fieldwork ID:	MON-0033425

About the designated centre

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

DC 7, operated by St. John of God Community Services, is registered for 25 residents. Twenty-one of whom, both male and female, live across five terraced homes and one apartment backing onto a campus setting located in a large town in Co. Kildare. Since April 2020, the provider registered an additional building on campus as a dedicated isolation hub that could facilitate four residents, where required. Within the main buildings, each resident has their own bedroom and share common areas with other residents. Residents with an intellectual disability and mental health issues are supported by social care workers, nursing staff and a healthcare assistant. Some residents attend various day programmes provided by St. John of God Kildare services, and some residents are supported to participate in activities in their local community or stay at home on days that they choose. Residents have access through a referral system to the following multi-disciplinary supports psychology, psychiatry and social work. All other clinical support is accessed through community-based primary care with a referral from the individuals GP as the need arises.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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 - 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
Monday 12 July 2021	09:20hrs to 11:45hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This isolation unit was registered as a designated centre for the purposes of isolating residents from campus or community houses who would otherwise find it difficult to self isolate in their homes. This inspection report discusses the findings of an inspection of the isolation unit only.

There were no residents occupying the centre on the day of this inspection. Three residents had availed of the services of the isolation unit since it became operational. One resident in March 2020, one in January 2021 and the last resident was admitted on the 08 March 2021. All three residents had transferred from the main building of this designated centre, therefore the staff and management team were well known to residents. All three residents had spent a maximum of 14 days in the isolation unit either to isolate from other residents living in their regular centre following discharge from hospital, or following a confirmed or suspected case. These measures were taken as a precaution by the provider during the COVID-19 pandemic and took place with the consent of the resident.

The inspector of social services did not have an opportunity to speak with any of the residents that had stayed in the isolation unit. However, documentation pertaining to their stay in the centre was viewed by the inspector and this indicated that residents were content during their stay and their support needs were well catered for during that time. The provider had purchased new televisions for the four bedrooms that residents used during their stay. It was reported that one resident was particularly happy with the choice of DVDs that were available.

The provider had identified that if a resident did not wish to transfer to the isolation unit, but it was necessary to do so, this was viewed as restrictive intervention and should be referred to the provider's human rights committee. To date, this referral pathway did not have to be used as residents were consulted to ascertain their views on moving temporarily to the isolation unit.

The referral process also provided information to the person in charge regarding the residents' specific needs so that they could be assured their needs could be met in the centre, for example, mobility, equipment, communication supports and dietary requirements. From reviewing the daily notes of residents stay, the inspector was assured the needs of residents were met. To illustrate this, a resident requiring a physiotherapist assessment after a discharge from the hospital was assessed while in the isolation unit with the appropriate PPE precautions.

While the inspector was satisfied that the designated centre was suitable for residents as a short term arrangement during the COVID-19 pandemic, significant concerns were identified during this inspection that resulted in the provided being issued an urgent compliance plan to address urgent risks to residents.

The next two sections of the 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

The purpose of this risk-based inspection was to review the COVID-19 arrangements, premises and water treatment systems in place for the isolation unit, which formed part of the overall designated centre. The inspector announced the inspection to the person in charge 48 hours in advance of the inspection to determine whether there were any active or suspected cases of COVID-19 in the centre. This centre was registered in April 2020 following an application to register that was made in line with the specific COVID-19 arrangements the Chief Inspector of Social Services put in place in response to an anticipated need for isolation facilities for residents living in designated centres during the pandemic. The provider applied to register this isolation unit located on a campus setting and incorporate that unit into the footprint of an already registered centre called DC7.

In submitting this application, the provider gave written assurances to the Chief Inspector that this centre was fit for purpose and suitable for this intended use. During this inspection, the inspector identified significant deficits in the oversight of the water treatment systems, namely in the Legionella management procedures for the centre. This issue was first brought to the provider's attention in December 2020 during an inspection of another similar isolation unit located on the same campus. During that inspection, the inspector had requested to review the provider's Legionella management procedures as the premises had been unoccupied for a period of time. However, this was not available at the time of the inspection. As a result, the inspector requested the provider assess the water quality in the centre and provide further assurances that no resident would be admitted to the centre until a water test provided evidence that it was free from Legionella. Test results taken on 16 December indicated the presence of Legionella bacteria that required treatment before the admission of residents.

The inspector discovered during this inspection that residents were admitted to the centre in January 2021 after the provider was made aware of the presence of Legionella in the first isolation unit and prior to testing the water samples in this isolation unit. The inspector found that the provider failed to undertake a risk assessment to assess the impact on residents' safety in admission to a centre in the absence of appropriate water testing when the risk of Legionella was known and being treated elsewhere on campus. Consequently, water testing carried out on 20 April 2021 returned a presence of Legionella bacteria. Moreover, the inspector identified that the management and communication procedures regarding the risks of Legionella were inadequate. For example, the person in charge was not given oversight of the water laboratory reports until requested by the inspector, and the

current status of Legionella during the inspection was unknown.

Due to the significant concerns identified on this inspection, the inspector issued an urgent compliance plan under three regulations relating to governance and management, risk management and infection prevention to the provider on the day of inspection. In addition, in light of the subsequent findings of Legionella and the significant risk to the welfare of residents, the provider was requested to provide assurances to the Chief Inspector for all designated centres on the campus. These failings are discussed in greater detail under the relevant regulations.

A statement of purpose had been submitted to the office of the Chief Inspector in respect of this centre at the time of its registration. The inspector found this document accurately reflected the intended use of the centre, and admissions were in line with the admission policy. All three residents admitted to the centre required either self-isolation from a hospital stay, or they were suspected of having COVID-19 or had confirmed COVID-19. Also, additional criteria were met in these instances; residents were unable or did not want to self-isolate in their own homes, and their needs could be supported in this centre.

The provider had made arrangements to appoint a person in charge of the residential unit. The person in charge's management remit encompassed two designated centres, including DC7. The additional isolation unit was situated adjacent to DC7 on the campus. The location of the isolation unit meant that this was an appropriate arrangement that could allow the person in charge to access and oversee the support of residents during their stay in the unit.

During the inspection, the inspector met with the person in charge and the social care leader from DC7. The inspector found that local management maintained strong contact with staff who worked alongside residents while in the isolation unit. The social care leader was also rostered during one of the isolation stays to support a resident. Records showed that topics discussed with staff members included personal protective equipment (PPE) stocks, arrangements for the resident's care, and access to on-call support.
There was evidence that the person in charge was present in the centre on a weekly basis when it was not in use to carry out safety checks and to ensure it was maintained to a good standard. These checks included fire checks and PPE stock audits.

The provider had produced a governance document dated 16 December 2020 for the operation of its three isolation units. This clearly stated the arrangements in place for the transfer of residents, the persons responsible and the staffing arrangements. The isolation unit was not staffed, and the document clearly stated that the centre's management the resident is moving from would organise staffing for the duration of the isolation period. In the case of the three residents who used the isolation unit, they had transferred from within the same designated centre; therefore, the social care leader and person in charge were responsible for organising the appropriate staffing levels. The inspector reviewed rosters from this time frame and found residents were supported by a staff team who were familiar

with their care and support needs.

Regulation 14: Persons in charge

The provider had appointed a person in charge to oversee the support and care of residents during their stay in the isolation unit. The person in charge worked full time, they had a remit over this designated centre and one other centre. They were also found to be aware of their legal remit to the Regulations and were responsive to the inspection process. Additionally, it was noted that there were clear systems in operation to facilitate the person in charge's current regulatory responsibilities for two designated centres. The person in charge demonstrated a good knowledge of COVID-19 related healthcare management and had experience supporting and managing a designated centre during the COVID-19 pandemic.

Judgment: Compliant

Regulation 15: Staffing

The statement of purpose also set out the staffing requirements in the centre. This stated that the centre would be staffed by a minimum of three staff as registered for four residents. The inspector viewed the staff roster in place in respect of when a resident had occupied the centre. This indicated that only one staff member had been on duty at all times. The inspector was satisfied that this level of staffing was appropriate to meet the individual's assessed needs, as at no time were more than one resident present in the centre. Staffing arrangements for the unit were based on a case-by-case basis, and arrangements were in place whereby staff would transfer with residents and support them during their stay in the isolation unit.

Judgment: Compliant

Regulation 19: Directory of residents

The person in charge had created a directory of residents to record admissions and discharge dates of residents who had transferred into the isolation unit and record other relevant details as required by Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

An urgent compliance plan was issued under this regulation.

The provider had failed to ensure that the service provided is safe and effectively monitored for all areas of service provision. Likewise, there were additional failures in implementing shared learning from a previous inspection's findings and executing corrective actions quickly.

While it was clear that the person in charge maintained a good level of oversight in the day-to-day running of this centre, they were not informed of all of the findings from the water testing reports. Documented evidence could not be produced during the inspection regarding the chronology of events and time frames of actions taken to address the significant water quality concerns.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspector found that residents' admissions had been in line with the centre's current policy and procedures on access, discharge and transfers to and from an isolation unit. In addition, there was documentation in place to demonstrate that residents had been supported with clear information regarding their discharge and admission.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose reflected the service that would be provided in the isolation unit and supported the findings of the inspection.

Judgment: Compliant

Quality and safety

As referred to previously in this report, the isolation unit was located on a congregated campus setting operated by St. John of God Kildare Services. The

building previously accommodated residents full-time but was decommissioned in 2018 and remained empty until it was re-purposed as an isolation unit. The inspector issued two urgent compliance plans within this section pertaining to infection precautions and risk management procedures for return to the Chief Inspector within four working days.

The isolation unit was an old building comprised of two adjoining long, narrow bungalow buildings with an attached pre-fab extension. While the isolation unit appeared throughout as institutional in design and layout, it was noted as a suitable premise for the purposes of supporting residents with COVID-19 to self-isolate for a short stay. Also it was evident that the provider had committed to resourcing the centre in line with residents' assessed needs.The provider had fitted out four bedrooms with new beds, televisions and storage for residents' personal belongings. Four bathrooms were assigned for single resident use, including one accessible bathroom. Upgraded works had been completed to enhance the fire safety measures and laundry facilities installed. Each of the two bungalows had a large kitchen that had undergone refurbishment to ensure appropriate arrangements were in place for the refrigeration, storage, cooking and serving of food. The cupboards were stocked with dry food items and essential goods in the event of an emergency admission. The inspector identified some improvements were required in removing unused furniture, broken pieces of wood, and clutter identified during the walk-about. However, this did not present a high risk to residents as it was located in the linking corridor between the two buildings. The person in charge committed to a clear-out of this area after the inspection.

The inspector reviewed the COVID-19 contingency plans place and a local centre specific COVID-19 contingency plan. Localised cleaning schedules and procedures had been set out, and cleaning supplies were available. Staff were responsible for cleaning duties while staying with a resident in isolation, and checklists were maintained correctly. Housekeeping staff from the campus completed terminal or deep cleaning after the discharge of a resident. The person in charge also ensured that housekeeping staff carried out monthly cleaning checks to maintain the cleanliness of the building. Staff and residents received twice-daily temperature checks, and the provider had good arrangements for contacting and liaising with public health. There was a supply of PPE in the PPE storage room also in the event of an emergency admission to the isolation unit.

As previously highlighted at the beginning of this report, despite the efforts made by the provider to create a safe and suitable location for residents to self-isolate, it was negatively impacted upon by the findings relating to regulation 27 infection prevention. The inspector found that the centre did not adhere to National Standards and guidelines related to the controls, procedures, maintenance and management of water distribution systems and all uses of water within the building. The inspector also found the provider was non-compliant under regulation 26, risk management, as there was a failure or omission to undertake a risk assessment following the presence of Legionella bacteria in another isolation centre under the provider's remit. The inspector requested that no residents were admitted to the centre until further assurances were received through the urgent compliance plan.

Regulation 17: Premises

The premises had appropriate bathrooms, bedrooms, laundry facilities and living areas and to meet the specific objectives of the service and the needs of potential residents as identified in the statement of purpose in place on the day of the inspection.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge had ensured when a resident returned from another designated centre, hospital or other place, they took all reasonable actions to ensure that all relevant information about the resident is obtained in relation to their care, support and wellbeing. The person in charge had also ensured that the transition and discharge of residents was determined on the basis of transparent criteria in accordance with the statement of purpose.

Judgment: Compliant

Regulation 26: Risk management procedures

An urgent compliance plan was issued under this regulation.

The provider's systems in place did not ensure that all risks were appropriately identified, assessed and managed. For example, the provider had not adequately recognised or addressed the risks posed by the potential presence of Legionella bacteria to potential residents and staff members. Therefore the appropriate control measures were not identified and a risk management plan adopted.

Judgment: Not compliant

Regulation 27: Protection against infection

An urgent compliance plan was issued under this regulation.

The inspector found a lack of adequate water management systems in place by the provider to prevent the risk of healthcare-associated infections. The issue of water

stagnation leading to potential Legionella growth had not been addressed, assessed or treated prior to the admission of residents. The person in charge had implemented a weekly water flushing programme in October 2020 to prevent Legionella growth. While this was a good initiative taken by the person in charge, this was not an effective measure for contaminated water.

Judgment: Not compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which was regularly serviced. There were suitable fire containment measures in place, including fire doors and door closures where required.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had created an assessment pathway for residents on their admission to the centre, ensuring their health and personal needs were supported during their stay.

The inspector found that all residents had a pre-admission assessment prior to them coming to live in the designated centre. This helped to ensure that the centre could meet the resident's needs and that any specialist equipment could be organised prior to their admission.

Care plans were kept up to date and included each resident's preferences for care and daily routines. In addition, care plans included the health promotion of residents such as nutrition, hydration and emotional wellbeing. Care plans also clearly stated the emergency procedures if there were an escalation of symptoms.

Judgment: Compliant

Regulation 9: Residents' rights

The admission criteria and referral pathway for residents admitted to this centre had a focus on a rights based approach. There was documentary evidence to show that the resident who had spent time in this centre was supported to exercise choice and

control while staying in the isolated centre.
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 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St. John of God Kildare Services - DC7 OSV-0002944

Inspection ID: MON-0033425

Date of inspection: 12/07/2021

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Remedial works (duck chlorination system and new water storage tanks and pipe system installed and shower heads replaced) have taken place in March & April 2021 in relation to water systems in isolation unit DC7.
2. Testing took place on the 13th of July 2021, Results received 27th July 'Legionella not detected'.

3. There will be no admissions to the isolation unit at DC7 should Legionella be detected at quarterly testing.

4. Risk assessment completed re Hazard of Legionella in water systems with control measures identified. 15/07/2021 (Completed). Going forward will be reviewed on a quarterly basis.

5. Risk management: Hazard identification updated for DC7 to include the risk of Legionella in water systems as part of the Risk Management Policy. 15/07/2021 (Completed and in place). Going forward this hazard identification will be reviewed annually or sooner as required.

6. Standard Operating Procedure for the management of water systems will be developed with reporting structure /communication, monitoring, responsibilities & emergency response to the risk of Legionella. By 23/07/2021 (Completed and in Place). In line with Standards for the prevention and control of Healthcare Associated Infections and St. John of God Infection Prevention and Control Policy.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. SJOG Risk Management Policy in place and will be adhered to with immediate effect.

2. Risk management Hazard identification updated for DC7 to include the risk of Legionella in water systems. This hazard will be reviewed as part of the Risk Management Policy under Hazard Identification on an annual basis or sooner if required.

3. Risk assessment completed re Hazard of Legionella in water systems with control measures identified. 15/07/2021 (completed). Risk assessment will be reviewed quarterly in line with testing of water systems and receipt of results.

4. Standard Operating Procedure for the management of water systems will be developed with reporting structure, monitoring, responsibilities & emergency response to the risk of Legionella. By 23/07/2021, (completed and in place). In line with Standards for the prevention and control of Healthcare Associated Infections and St. John of God Infection Prevention and Control Policy.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Remedial works (duck chlorination system and new water storage tanks and pipe system installed and shower heads replaced) have taken place in March & April 2021 in relation to water systems in isolation unit DC7.

2. Testing took place on the 13th of July 2021, results received on the 27th July 2021, not detected for Legionella.

3. There will be no admissions to the isolation unit DC7 should Legionella be detected at quarterly testing.

4. In line with Standard Operating Procedure there will be robust monitoring of quarterly testing of water systems at Isolation Unit DC7; along with weekly safety checks from 23rd July 2021.

5. Risk assessment completed re Hazard of Legionella in water systems with control

measures identified. 15/07/2021. (Complete)

6. Risk management 'Hazard Identification' updated for DC7 all identified to include the hazard and risk of Legionella in water systems. 16/07/2021 (completed and in place).

7. Standard Operating Procedure for the management of water systems will be developed with reporting structure, monitoring, responsibilities & emergency response to the risk of Legionella. By 23/07/2021, (completed and in place) . In line with Standards for the prevention and control of Healthcare Associated Infections and St. John of God Infection Prevention and Control Policy.

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	Red	16/07/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Red	16/07/2021
Regulation 27	The registered provider shall ensure that residents who may	Not Compliant	Red	23/07/2021

	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 published by the Authority.			