

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005450
Centre county:	Kilkenny
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Aileen Colley
Lead inspector:	Gary Kiernan
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	28
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 25 February 2016 09:30 To: 25 February 2016 17:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This follow up inspection took place in order to assess regulatory compliance following the permanent granting of an order under Section 64 of the Health Act 2007 transferring responsibility for this designated centre from St Patrick Centre (Kilkenny) Ltd to the Health Service Executive (HSE) in October 2015. This centre had last been inspected in September 2015 following the temporary granting of this order in June 2015.

This inspection was carried out over the course of one day and as part of this inspection inspectors met with the Person in Charge, members of staff, residents and family members. Documents such as care plans, risks assessments, incident logs and staff training records were reviewed.

Although it was noted that staff numbers had increased and instances of peer to peer aggression had decreased, overall, inspectors were not satisfied that sufficient progress had been made since the permanent order was granted. Inspectors had significant concerns regarding the lack of suitable governance and management arrangements to oversee the quality and safety of care provided to residents. As a result there were direct negative outcomes for residents. Despite providing significant additional resources the HSE had not put sufficient arrangements in place

to ensure that outcomes for residents, in areas such as health care and social care needs, had improved to a sufficient degree. The physical environment was poor and did not meet the needs of residents.

Inspectors also had concerns regarding fire safety, the management of risk and arrangements for healthcare provision. These issues are discussed in greater detail in the body of the report.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors found that residents' social care needs were not consistently supported though a good quality assessment and an evidence-based approach in some cases.

An increase in staff numbers was resulting in increased activities for some residents which was a positive development. This was particularly true for residents who were assigned an individual personal assistant. During the afternoon of inspection residents were observed to leave the designated centre to visit a petting zoo. However from reviewing a sample of residents' personal plans it was apparent that some residents social care needs were not subject to a comprehensive assessment and as a result their social needs were not being adequately met.

Some of the residents' personal plan was spread across two folders, was difficult to retrieve and in some instances the information provided was not clear. Documents were observed to have some information roughly crossed out by hand and it appeared that this was done as part of the review process for such plans. Although some parts of the care plans seen were observed to be recently dated, these dates were not accompanied by a signature meaning that it was not possible to say who reviewed these plans. Therefore inspectors could not be assured that these plans were appropriately reviewed with multidisciplinary input as required despite inspectors being told that greater access to such input was now available.

Some residents had plans in place to meet their social care needs and support their development. These plans outlined various social goals for the residents to achieve. While some of the goals outlined were meaningful, some were basic in nature such as

decorating bedrooms. Some goals were marked as being achieved but the new goals put in place were not appropriately reviewed. For example one resident's personal plan contained a record of a meeting from 28 November 2014 where new goals were decided upon. However inspectors could find no evidence of whether these goals had been achieved or what progress had been made towards them.

Inspectors had concerns that the social care needs of some residents were not being met. For example, in the case of a resident, who had complex needs including visual impairment, the resident's assessment of social care need and care plan did not provide for a high level of support for this resident. The social care assessment was not based on multi-disciplinary input, in accordance with the requirements of the Regulations. The social care goals which had been developed for the resident were not sufficiently person-centred and did not take into account the need for support with visual impairment. For example, one of the goals related to support with a dietary need. The documentation showed that the social care goals previously set in 2014 had not been met. Inspectors reviewed the documentation in relation to outings for this resident in 2016 and found that while the resident had access to sensory therapy and went on a number of walks with staff, the resident had limited opportunity to access the community and access activities off the campus where the centre was located.

Some plans were inadequate to support the development of residents. In the case of a resident with high support needs, social care goals had been set at a meeting in May 2015 with an action for a follow up meeting to be held in November 2015. At the time of inspection this follow up meeting had not taken place despite the documentation showing that the plan was no longer relevant or fit for purpose. The daily logs indicated that one of the goals set out had been achieved while it was noted in the resident's personal plan in October 2015 that another of the previously identified interests no longer appealed to them. Inspectors were not satisfied that this resident's personal plan was reflective of the person or support their development.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:

The premises was not meeting the needs of a number of residents.

While this outcome was not reviewed in full, inspectors found that the premises did not meet the needs of a number of residents who lived in the main building which made up the designated centre. The building consisted of three units which were interlinked by means of connecting corridors. The building was not homely in nature and did not provide residents with a similar environment to that of their peers, although in some areas staff had endeavoured to add interesting features such as an imitation fire place which gave a focal point to one of the sitting rooms. Resident bedrooms were found to be small and did not provide space for assistive equipment and for personal belongings. Inspectors were concerned that the lack of space for assistive equipment could lead to unsafe moving and handling procedures and put residents at risk. A number of bedrooms and other rooms were in a poor state of maintenance and required upgrading.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The systems to promote the health and safety of residents were not satisfactory.

Some of the necessary fire safety works to be completed as identified at the previous inspection had not been completed and the time frames given for the completion of such works had passed. These works were significant in a number of cases. For example, they related to fire insulation of certain rooms and the provision of fire doors to a number of areas. In addition Inspectors were concerned regarding the centre's overview of risk and the failure to adopt a proactive approach towards identified risks.

All staff had undergone basic fire safety training however it was noted that some staff members had yet to receive training in some evacuation techniques that were in use for some residents within the designated centre. The Person in Charge informed inspectors that further training was scheduled in these areas.

All accidents and incidents for the designated centre were logged in an electronic system and inspectors reviewed a sample of such adverse events since the previous inspection. It was noted that the vast majority of incidents, which had occurred since the previous inspection, had not been closed off thus it was difficult to ascertain if any actions in response to such events had been completed or still needed to be implemented. In addition some of the actions described in the events logged were generic and short meaning it was not always clear what needed to be done, what had been done and who was responsible for carrying out such action.

When inspectors queried why so many events remained open the Person in Charge informed inspectors that she had not received training in this event recording system as evident in training records seen by inspectors. It was also stated to inspectors that there had been no review of accidents or incidents since the Person in Charge was appointed in November 2015. As a result no work had been carried out to identify trends within the designated centre or corrective actions which would have promoted improved safety.

Corrective actions in response to accidents and incidents were not always implemented in a timely way to ensure the safety of residents. While reviewing the incidents and accidents log inspectors noted two incidents, within two months of each other, where the same resident locked themselves into a room necessitating members of staff to force open the door on both occasions. The Person in Charge had added an action for the lock to be removed 21 days after the first incident had taken place. However this work was not carried out and after a further 37 days the same resident again locked themselves into this room. The Person in Charge informed inspectors that the locks had been removed/altered since the second event which was verified by inspectors.

Two more similar incidents also highlighted the need to respond to identified risks in a timely way. On one occasion while away from the centre accompanied by staff a resident was noted to have walked out in front of oncoming traffic requiring motorists to slow down. The actions stated in relation to the first incident were narrow and not specific enough to guide staff. Only after the second such similar incident, where the same resident narrowly avoided injury, were more definitive actions taken to ensure the safety of the resident. Following on from this event a new procedure was put in place which staff members spoken with were familiar with.

The person in Charge informed inspectors that unit specific risk registers were in the process of being developed. As a result, at the time of inspection individual risk assessments relating to specific residents were contained within residents' personal plans. While reviewing one resident's plan it was noted that a choking risk assessment for this resident contained an action relating to the proposed fire evacuation procedure of another resident. Also within this personal plan was a falls risk assessment for a third resident with the action stated again relating to the proposed fire evacuation procedure of another resident. Both of these risk assessments had been signed off as by being reviewed by the Person in Charge in the month before inspection. These inaccuracies were brought to the attention of the Person in Charge who undertook to address it.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Systems for the protection of vulnerable residents were in place, however, some improvements were required. Incidents of peer to peer abuse had reduced significantly in the designated centre. However improvement was needed to ensure that best practice was adhered to in relation to the use of chemical restraint while gaps were identified in relation to staff knowledge and training for behaviour support.

Since the previous inspection the number of incidents of peer to peer abuse allegations had reduced and there had been no such incident in the month before inspection. Staff related this to a reduction in resident numbers and an increase in staffing at the time of inspection which was a positive development. From reviewing staff training records all staff had received safeguarding training while staff members spoken to were familiar about the procedure to be followed in the event of an allegation of abuse. Inspectors were also informed of work which was in progress to amend the designated centre's safeguarding policy to ensure compliance with National policy.

Inspectors reviewed a sample of behaviour supports plan for residents in the centre. Some of these plans had been updated in the months before this inspection and contained relevant information such as describing the behaviours of concerns for residents, predictors of such behaviours and the strategies to be adopted to respond to such behaviours. However some plans required updating and further information in order to provide appropriate guidance to staff.

While reviewing the positive behaviour support plan for one resident it was noted this the plan in place had not been reviewed since January 2015. This plan provided for the use of PRN (as required) psychotropic medication to respond to behaviours of concern for the resident. This plan provided some guidance on when to use this medication and staff demonstrated that they knew the contents of this plan. However it was noted the guidance provided for the use of this medication was broad and open to interpretation. This could increase the risk of inappropriate use of this medication and was not in line

with best practice.

Staff did not know the contents of behaviour support plans in all cases. Inspectors spoke to some staff members who were working specifically with one resident on the day of inspection. Neither staff member had read the behaviour support plan for this resident while one staff member, who worked exclusively with this resident, stated that she was unsure how she would react to behaviours of concern from this resident.

From reviewing training records it was also evident that not all staff members had receiving relevant training in the areas of de-escalation. During inspection the person in Charge outlined future plans for staff to receive additional training in responding to behaviours of concern.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

While reviewing a log of accidents and incidents it was noted that some minor injuries had not been notified to the Chief Inspector. For example one instance where a resident scalded one of their fingers had not been included in a quarterly notification previously submitted as required by the Regulations.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

It was not demonstrated that residents were consistently provided with appropriate healthcare.

Inspectors were concerned that there was a lack of assessment of residents' needs in order to inform clear plans of care with prescribed interventions. In some instances, where residents, had identified health issues, appropriate care was not provided. A sample of resident medical information and related documents was reviewed. It was observed that such documentation was poorly organised with information dating back several decades stored with more recent information.

Some annual health reviews had been carried out for residents by staff in the centre. Inspectors saw one such review which had last been carried out in October 2014. It identified some medical issues but there were no associated care plans in place although staff members informed inspectors that the issues identified were being treated. A number of residents had complex medical needs and co-morbidities however, there was no comprehensive nursing assessment carried out in order to facilitate clear and consistent care plans.

Inspectors read daily progress notes for a number of residents and noted that one resident was had a high risk of skin breakdown. While this resident had been seen by the general practitioner in relation to this matter, appropriate interventions had not been put in place overall to manage this resident's risk of skin break-down and an evidence-based approach was not followed. There was no skin assessment, no wound chart to monitor the size and presentation of the affected broken skin. There was no assessment and recording of contributing factors such as the continence and pain. There was no evidence of involvement or referral to other relevant multi-disciplinary professionals such as the tissue viability nurse (TVN) or the occupational therapist. The resident had been provided with a pressure relieving mattress, however, staff could not demonstrate that it was at the correct setting for this resident and the resident's seating arrangements had not been assessed with regard to the skin break-down. Inspectors were concerned that that there was a failure to proactively manage this condition and that as a result there was a high risk of negative outcomes for the resident. This matter was brought to the attention of the person in charge, who took immediate action during the course of the inspection to address this matter.

When care plans were in place some interventions and measurements were not being carried out. In one instance another resident had a clear wound care plan which was updated in January 2016. The plan called for a daily wound assessment to be undertaken and recorded. However on reviewing this resident's information evidence of only one such assessment being carried out in February was provided. A satisfactory explanation as to why daily assessments had not been carried out as directed by the care plan was not provided.

A number of residents suffered from epilepsy. While these residents were regularly reviewed in relation to this condition, the care plans did not guide staff in sufficient detail should a resident experience seizure activity. It was also noted that, although, a member of the health care team had recommended that all staff receive training in the administration of rescue medication to control seizures this had not taken place for a significant number of staff at the time of inspection.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

While measures were in place to support safe administration of medication some improvements were required.

Inspectors were concerned regarding the review of and documentation in place for PRN "as required" medication. As discussed under Outcome 8 one resident's use of PRN psychotropic medication had not been reviewed in over a year. For some other PRNs it was also noted that the maximum dose to be administered in a 24 hour period was sometimes not stated on the prescription sheet or the protocol in place.

Some documentation errors were also observed to be present on administration and prescription records. For example discontinued medication were not signed for by a general practitioner and instead simply had a line drawn through the medication name. Such errors were identified in medication audits carried out within the designated centre but such audits did not identify any remedying action.

Medication within the centre was administered by nursing staff. However as will be addressed under Outcome 17 a recommendation had been made for all staff to received training in the administration of rescue medication for epilepsy related seizures but at the time of inspection this had not been provided.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The previous inspection in September 2015 found that systems of governance and management were not sufficient to ensure that residents received a safe service and quality care. On this follow up inspection, it was found that this continued to be the case.

The person in charge demonstrated that she understood the new reporting structure. She reported to the director of operations who in turn reported to the HSE provider nominee. It was stated that compliance with the Regulations was discussed at meetings which took place between the director of operations and the provider nominee.

The new governance structures, implemented since the transfer of the centre to the HSE, had resulted in some improvements. There were increased numbers of staff and this resulted in an increased level of one to one support for those residents assessed as requiring one to one support. This had a direct positive impact on the quality of life of some residents who were supported with individual activity programmes. The number of residents in the centre had been reduced through the provision of alternative accommodation and staff reported that this reduced peer to peer assaults in the centre. The carrying out of initial fire safety works had removed the immediate risks in relation to fire.

However, the new provider had not implemented adequate systems or procedures for monitoring the quality of care provided to residents. Systems were not in place to gather and analyse information which could be used to validate the quality and safety of care provided to residents. As a result, direct negative outcomes were observed for some residents, as outlined under outcome 11 (Healthcare) and Outcome 5 (Social Care). These outcomes had not been identified at the local level or at the provider level, despite resources, being available to address these issues.

Unannounced visits and audits by the provider, which are a requirement under Regulation 23, to gather information and assess the quality and safety of care were not carried out. Inspectors requested, documentation and evidence of unannounced visits to the centre by the provider, in accordance with Regulation 23, and were informed that

they had not yet taken place. In the case of health care, there was a system for residents to be reviewed by a multi-disciplinary team but this had either not yet taken place for some residents and in the case of others had not resulted in improved healthcare outcomes. Inspectors were informed that the services of the multi-disciplinary clinical team were accessible through an arrangement that had been put in place with the former provider and a separate third party provider. However, the systems to oversee and assess the effectiveness of this arrangement were not adequate in this centre.

Systems to assess the quality and safety of care at the centre level were not adequate. Systems for auditing and checking the quality of care had not been developed and implemented to a sufficient degree and where audits did occur they were not followed up. For example, on two separate occasions, in September 2015 and January 2016, an in-house audit of medication management, identified the need to state the maximum dose in 24 hours, for PRN "as required" medication on residents prescription documentation. As highlighted in Outcome 12 (Medication) this area continued to be an issue at the time of this inspection. There was no evidence of other audits. The person in charge stated that there were plans for other audits to be rolled out in the near future.

As highlighted under Outcome 7 (Health and Safety) systems were not in place to review accidents and incident reports in order to improve safety arrangements for residents.

Staff cover for illness and unforeseen leave was provided for through an arrangement with the former service provider. Inspectors noted that this had been an effective resource for the centre on many occasions. However, effective systems were not in place to oversee this process. For example, there was no systems or policy in place to ensure that staff with the appropriate skills and training were allocated and the person in charge did not have input with regard to which staff were allocated to the centre. Inspectors found that this could result in inconsistent care for residents.

The service was led by a suitably qualified and experienced person in charge. The person in charge had commenced in her role in November 2015. She engaged positively with inspectors throughout the inspection process and it was observed that she had good rapport with staff and residents. During the inspection she demonstrated a good understanding of her roles and responsibilities as person in charge.

Judgment:
Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There had been an improvement in staff numbers but some training gaps remained while the supervision for staff required improvement.

The staff members present during this inspection were observed to be committed to their roles while having positive and caring interactions with residents. A family member spoken with during inspection also commented favourably on the staff working within the designated centre.

Since the previous inspection the staff to resident ratio had improved resulting in some residents having 1:1 support which was facilitating increased activities. There were now two clinical nurse managers (CNM) on the team. These were positive developments while measures had also been put in place to ensure a greater continuity of staff.

A staff supervision system had yet to be fully implemented at the time of inspection. Since the appointment of the current Person in Charge in November 2015 supervision meetings had yet to commence for longer term staff members. However the Person in Charge was conducting probation reviews for new staff which focused on elements such as a job knowledge and engagement with residents.

New staff members received an induction into the centre and the units in which they were to work in. Inspectors were informed that information and documents relevant to residents was made available to such staff as part of this induction. However no record of such inductions were made available to inspectors and as a highlighted under Outcome 8 two staff members had not read the positive behaviour support plan for a resident that they were working with.

Inspectors reviewed training records for staff working in the designated centre. As discussed elsewhere in this report gaps were identified in fire evacuation and de-escalation training for some staff. These have been actioned under Outcome 7 and 8 respectively. As mentioned under Outcome 12 a recommendation for all staff to receive training in the administration of rescue medication for epilepsy had not been facilitated at the time of inspection. Inspectors for that this was important training which would improve safety arrangements for residents particularly when they were away from the centre.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Gary Kiernan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd
Centre ID:	OSV-0003496
Date of Inspection:	25 February 2016
Date of response:	5 April 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents' goals had not been reviewed at annual intervals or to reflect changes in circumstances.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:

All personal plans will be reviewed and updated.

All care plans will be typed to ensure there are no areas that are crossed off.

Staff are aware that outcomes are to be purposeful and meaningful to the individual. Annual health checks are carried out for each resident by their GP.

Personal Plans developed to meet the social care needs of residents will be referred to relevant members of the MDT for their advice and input.

Proposed Timescale: 30/05/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some personal plan reviews did not have multidisciplinary input.

2. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

All personal plans will be reviewed to identify where multidisciplinary input is outstanding. All residents who are identified as requiring MDT input will be prioritised and have the required referrals and assessments completed. They will be tracked to ensure that the MDT input is actioned.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The effectiveness of personal plans were not adequately assessed.

3. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:

All personal plans are reviewed at a minimum of every three months (or sooner if there is changing needs), and all were updated in November 2015. The centre is introducing a new monitoring process which will see all personal plans and their reviews evaluated by the PIC, the resident and the relevant keyworker on a quarterly basis.

All personal / care plans will be typed and signed by staff, the resident (if appropriate) and/or an advocate on their behalf.

Proposed Timescale: 30/05/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some residents' personal plans were not reflective of the individual.

4. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:

Care plans will be reviewed to ensure same are person focused to reflect the needs and goals of the individual as indicated above.

A new Care Plan was introduced to the unit in late 2015. As part of the roll out of this new care plan there is ongoing staff training which includes individual care planning. All personal / care plans will be reviewed by the PIC with the resident and keyworker every three months.

All personal / care plans will be typed and signed by staff, the resident (if appropriate) and/or an advocate on their behalf.

Proposed Timescale: 30/05/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The premises did not meet the needs of a number of residents.

5. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:

While it not envisaged that the centre will be used in the longer term we do accept that more effort needs to be made to ensure the centre is more "homely" in nature. To that end we are currently costing the decorative work required and plan to complete the work in the coming weeks.

A schedule of basic decorative works will be prepared and a budget sought to address same.

Alternative interim residential arrangements will continue to be explored pending transfer of residents under the de-congregation programme.

Proposed Timescale: 30/05/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The premises required redecorating and upgrading in a number of areas.

6. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:

A schedule of basic decorative works will be prepared as part of the general maintenance budget.

Alternative interim residential arrangements will continue to be explored pending transfer of residents under the de-congregation programme.

There is a defined plan for the Centre to encompass an overall Organisational Plan which is running in parallel (accelerated de-congregated setting plan). Therefore some areas will be targeted for re-decoration with reference to the overall plan to move residents to decongregated settings.

Proposed Timescale: 30/05/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The ongoing review of risk was not being provided for. A review of accidents and incidents had not taken place to inform corrective actions.

7. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

Due to on-going difficulties with the current IT based incidents/accidents reporting system a decision has been taken to revert to a paper based system for the short to medium term.

The staff team conduct a risk identification process.

The PIC ensures a plan is in place to manage all identified risks.

All incidents/accident reports are now reviewed on a daily basis by the Health & Safety Officer and reported to the Senior Management Team on a weekly basis. Risk is an agenda item at the Management Team. This process facilitates the identification of trends etc and ensures senior management oversight and follow up to actions/recommendations arising from incidents/accidents.

The Registered Provider as part of the fortnightly meetings between the senior management of St Patricks and HSE will have as an agenda item Risk, Incidents/Accidents and notifications. This will be a standing agenda item at the governance meeting

A new Quality and Safety Committee is to be established which will have as a fixed agenda item risk and risk notifications.

Proposed Timescale: 30/04/2016**Theme: Effective Services****The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all staff had received appropriate training in some evacuation techniques prescribed for some residents.

8. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:

The 5 staff concerned are scheduled to attend mandatory training during the month of April.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Required fire safety works had not been completed in line with previous plan and timelines submitted to the Authority.

9. Action Required:

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:

All furnishings are now fire compliant. New mattresses for all residents are on order.

Discussions are on-going in conjunction with the de-congregated setting proposal. The Head of Estates for CHO 5 attends the HSE Governance fortnightly meetings held with the Senior management of St Patricks and the HSE Chief Officer. Fire Safety Works is an agenda item for that meeting and all fire issues have been risk rated. All priority A fire safety works for Our Ladys are now completed

Proposed Timescale: 30/04/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some staff members did not have knowledge of the contents of behavioural support plans which they were required to follow.

10. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:

A new Induction Process for all staff has been developed to ensure that all staff have knowledge and understanding of behaviour support plans in place.

All staff will be required to sign off, confirming that they have availed of training in the management of behaviours that challenge as presented by the residents.

Proposed Timescale: 09/03/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff members had undergone training in behaviour that challenges.

11. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:

Further training will be delivered to staff regarding Behaviour Support plans in their management of behaviours that challenge. All staff will be scheduled to attend training in the coming months. Centre staff member will commence Positive Behaviour Support "Train The Trainer" Programme in April 2016.

Proposed Timescale: 30/06/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The guidance provided for the use of a PRN psychotropic medication was open to interpretation and increased the risk of inconsistent care.

12. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

The PRN Care Plan in this case was reviewed and a more detailed and documented protocol re the use of PRN has been implemented.

All clients who have epilepsy have a specific individual care plan which addresses their specific requirements.

All residents prescribed PRN medications will have this reviewed and specific protocol documented for its use.

Proposed Timescale: 29/04/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all minor injuries had been notified to the Authority.

13. Action Required:

Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

Please state the actions you have taken or are planning to take:

All injuries will be notified to the Authority within the appropriate timeframe.

As part of the governance meetings with the HSE all risks/notifications/incidents will be discussed as an agenda item.

A Quality and Safety Committee will be established at which the quarterly report will be discussed and actioned

Proposed Timescale: 30/04/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Appropriate healthcare was not provided for some residents with acute healthcare needs.

14. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:

All residents with acute healthcare needs will be reviewed and a management plan for same documented in consultation with GP who visits the centre weekly.

Proposed Timescale: 15/04/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A resident with acute healthcare needs did not have access to the required multi-disciplinary professionals.

15. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:

All residents have access to multi-disciplinary supports through the Centre MDT and/or through the Primary Health Care System. The MDT team has recently been augmented to add to the existing Play Therapist/Psychotherapist and behaviour management therapist to include a physiotherapist, dietician, occupational therapist, psychologist and Speech and Language Therapist. Referral to these therapies is through the Clinical Nurse Manager on the ward and is specifically for the residents in St Patricks including Our Ladys Unit.* (clarification to report).

All service users will be referred to the MDT as required.

Proposed Timescale: 26/02/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Some PRN medication required review. The maximum dose of PRN medication to be administered in a 24 hour period was not always stated. Errors were observed in administration and prescription records.

16. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:

Full medication audit completed and actioned. All PRN Guidelines currently being reviewed and updated as required.

Where PRN medications are prescribed, the maximum dose in 24 hours will be included on the prescription / administration documentation.

Proposed Timescale: 29/04/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Management systems were not in place to oversee the quality and safety of care and to ensure that care was sufficiently monitored.

17. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

St Patrick's is currently recruiting for a Quality Assurance Officer (Closing date for applications 13/04/16).

St Patricks including Our Ladys Unit will establish a Quality and Safety Committee which will oversee the quality agenda for the unit including risk notification, incidents, trend analysis, quality, and training all as standing agenda items. The Quality Assurance Officer is currently a shared post between St Patricks and another organisation. The filling of this post will allow for a dedicated post holder specifically for St Patricks.

Proposed Timescale: 30/05/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Unannounced visits were not carried out to monitor the quality and safety of care.

18. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:

The Operations Manager who represents the registered provider (HSE) will conduct periodic unannounced visits of the centre.

The HSE Disability Manager meets regularly on site with the Operations Manager and Senior Management Group. The Chief Officer and future Head of Social Care will complete periodic unannounced visits.

The Chief Officer carried out an unannounced inspection of Our Ladys Unit on Tuesday 12th April 2016 accompanied by the person in charge. Future unannounced visits will be carried out and are evidenced in the sign in book on each unit.

Proposed Timescale: 12/04/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff had received training in the administration of buccal midazolam as recommended.

19. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

All staff will be scheduled to attend training in the administration of buccal midazolam during the calendar year. Three staff scheduled for training on Tuesday 19th April 2016

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Appropriate supervision arrangements were not yet in place for all staff members.

20. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

Recently a "formal supervision" process has been introduced for Our Ladys Unit as part of St Patricks and this staff appraisal system known as staff supervision will take place every 6 months. All staff will have commenced the formal supervision process on or before 30/06/2016. Day to day supervision in the unit is managed through the CNM2 and the two CNM1s who provide daily supervision for the staff working in the unit including household staff, healthcare assistants, nursing staff and personal assistants. They all report to the Clinical Nurse Manager. Completion of Probation forms for new staff is completed every three months. The PIC carries out a minimum of two ward rounds daily and this is evidenced in the staff sign in book in each unit/house.

Proposed Timescale: 30/06/2016