Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St. Michael's Centre
Centre ID:	OSV-0003497
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Saint Patricks Centre (Kilkenny)
Provider Nominee:	David Kieran
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Paul Pearson
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	6

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 January 2017 10:00	19 January 2017 19:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to Inspection.
This inspection was unannounced and took place over one day. The purpose of the inspection was to assess ongoing compliance and the provider's governance and management arrangements. Previous inspections of this centre have found serious breaches of the Regulations in the areas of fire safety, healthcare management, management of medication and significant lack of staff training to meet the needs of residents.

In May 2016 a new board of management had been appointed to St. Patrick's Kilkenny. The board had been in place seven months at the time of the inspection. The provider had been required by HIQA to bring about substantial improvements within the service in order to demonstrate to the Chief Inspector their fitness to carry on their role as provider of the service.

The aim of this inspection was to follow-up on actions given in the previous inspection and to assess if the quality and safety of care had improved in the six month time frame the provider had been given.

How we Gathered Evidence.
Inspectors visited both residential units that made up the designated centre. As part of the inspection, inspectors met with residents and staff in each residential unit, the

newly appointed staff training coordinator, the quality and compliance manager, a newly appointed assistant director of services, the director of services and two clinical nurse managers.

Inspectors spoke with residents they met during the inspection taking guidance from staff as to the particular way in which residents liked to interact. In some instances residents did not enjoy meeting new people or the presence of unfamiliar people in their space and inspectors respected their wishes at all times. Inspectors observed residents' interactions with staff, their peers and their environment.

Inspectors also reviewed documentation such as personal plans, risk assessments, allied health professional assessments and reviews, assessment of needs, audits and training needs analysis for the centre.

Description of the Service.
The centre is part of St Patrick's Kilkenny, which provides a range of day and residential services to children and adults with an intellectual disability. This centre is located in a congregated setting and comprises of two residential units.

Previous inspections of this centre had found the premises to be in a poor state of repair and décor.

In the previous six months the provider had undertaken a significant suite of works to upgrade which had improved the overall aesthetic and home-like feel of the centre, the residents' home. The designated centre had been repainted throughout, new furniture had been purchased, and residents' bedrooms had been upgraded and personalised. Living room spaces had also improved with soft furnishings throughout and flat screen televisions installed. The centre was now warmer and windows in the centre had been replaced.

Overall Judgment of our Findings.
Inspectors did find improvements had occurred in all outcomes inspected. These improvements had been brought about by the appointment of key posts and ongoing governance meetings.

The provider had appointed two project coordinators, four transition coordinators and a staff training coordinator to drive improvements within the service.

There was improved focused auditing carried out across a wide range of areas, sub-committee teams and meetings occurred now and reported directly to the board of management.

Change management meetings, whose focus was to ensure system change was communicated to managers and staff within the service were now occurring weekly.

However, at the time of inspection there was no person in charge in post. The previous person in charge had left their post the week prior to the unannounced inspection. The provider was required to instate a person in charge of the centre as required in Regulation 14.

There were improvements in relation to the management of residents' healthcare since the previous inspection. The provider had also implemented an initiative to ensure all residents living in the centre had received a multi-disciplinary allied health professional assessment and this was evident in residents' personal plans. This was of particular importance given the significant and complicated healthcare needs of residents living in the centre. The provider also intended to recruit an additional general practitioner (GP) to meet the needs of residents in the centre.

However, there were still improvements required in relation to resident health and social care planning to ensure residents' care plans were up-to-date and reflected the most recent recommendations by allied health care professionals involved in their care.

Some nursing care plans and associated health risk assessments were not regularly implemented or completed in order to review and evaluate the quality of nursing care plans in place and assess if they were effective.

These findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
This inspection found there were improvements with regards to the assessment and identification of residents' social care needs. There was greater evidence of allied health professional input maintained in residents' personal plans. Planned supports would also be in place when residents transferred between services. Some improvements were required.

There was evidence to indicate ongoing allied health professional assessments of residents were taking place. The inspector reviewed a sample of residents' personal plans. Of the plans reviewed there was evidence that an assessment of residents' social care needs was being implemented which was identifying residents' specific needs and providing comprehensive person centred detail. This was a significant improvement since the previous inspection.

Residents were also receiving allied health professional assessment of needs. Improvements in how this was being implemented had occurred also. Previously residents only received allied health professional assessment based on referral. This had not assured the inspector as there was a lack of social care assessment which in turn meant residents' social care needs were not being identified leading to referrals not being made. This was a significant improvement and was required to continue given the significant medical, physical and social care needs residents living in the centre presented with.

Previously inspectors had found that information and recommendations from allied

health professional reviews were not used in such a way as to update residents' support planning. To address an action from the previous inspection staff were to complete a medical or a non-medical information form for each resident's appointments with an allied health care professional.

Inspectors viewed copies of these forms in resident's files. The forms were filed with the normal multidisciplinary review files. However, there was no evidence that personal care plans were amended to reflect the changes recommended by allied health professionals. Therefore, while the action had been implemented it did not adequately address the non compliance previously found.

Previously residents' personal plan information was located in numerous folders and files. For example, each resident had a daily observation folder, medical file and personal plan file. Information pertaining to residents was difficult to retrieve and in some instances the information provided was not clear. There had been some improvement in that personal plans were now being filed in one file which contained all information relevant to the residents' health and social care needs. However, improvements were still required.

Inspectors found up-to-date information was filed along with information no longer in date which should have been archived. In other instances residents' personal files had multiple copies of support plans which had similar content but different dates. Therefore, it was not clear which support plan was in use or which one staff should follow. While some improvements had occurred there was still work to be done to ensure residents' personal plans accurately reflected their social care needs and support planning to meet those needs.

Audits of residents' personal plans had been carried out by the quality and compliance manager for the service. Not all plans had been audited, but of those that had inspectors noted the audits were detailed and comprehensive.

The director of services spoke with inspectors to inform them of how they planned to address their ongoing issues with personal planning for residents. During the course of the inspection the director of services showed an inspector a computer based system that the provider was intending to implement for the management for care plans and records for the designated centre. This system would provide a main record for each resident care where reviews by allied health professionals, daily notes and appointments could be maintained and organised.

The inspectors reviewed records relating to the providers practice development changes with regards to introducing improved social care outcomes for residents living in the centre. Some changes in institutional practice had been implemented. Staff now undertook a daily or weekly grocery shop as required rather than collecting some food supplies from a central kitchen on the campus. This provided social inclusion opportunities for residents when they accompanied staff on grocery shopping trips. This was a marked improvement since previous inspections of the centre whereby residents rarely if ever engaged in such activities.

Inspectors viewed a sample of the transition assessments. Of the sample reviewed

resident s had an identified transition coordinator and a secondary coordinator who would co-ordinate their transition planning. The transition assessment was structured so each resident would have information on their new community house and pictures of the bedrooms and other areas of the house, for example.

Judgment:
Substantially Compliant

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

Findings:
The systems to promote the health and safety of residents had improved since the previous inspection of the centre. The provider had also set out a plan to improve the documentation of incidents and accidents in the centre by installing an electronic system in early 2017. Fire safety training for staff had improved significantly since the previous inspection.

As was found on the previous inspection the provider's arrangements for the review of accidents and incidents and identification of personal risks to residents had improved.

Previously inspectors had noted that personal risk assessments in place for residents presented as a confusing document with most of its content instructions for how it was to be completed leaving the reader unclear as to the actual risk posed to the resident or the control measures in place to address the risk.

To address this the health and safety subcommittee for the service had drafted a new risk assessment template. This template was reviewed by an inspector during the course of the inspection which, when implemented, would adequately address the previous non compliance found. However, while the template had been drafted it was yet to be implemented in the designated centre.

Risk assessments were in place for the use of hoists for manual handling purposes. Inspectors observed staff following appropriate manual handling procedures during the inspection. Inspectors noted staff waited for the appropriate number of staff to carry out manual handling procedures before implementing them.

Priority fire safety works for the centre had been completed. For example, inspectors noted the presence of fire rated doors fitted at key compartmentalisation points in the building which improved the fire and smoke containment systems of the centre.

Since the previous inspection 25 staff from the centre had attended fire training. Ski pads or evacuation sheets were provided in residents' bedrooms if they were assessed as requiring them. Staff had received training in how to use this equipment since the previous inspection.

While there was evidence to indicate the provider had implemented a suite of fire safety measures in the centre an inspector identified a fire safety risk that required addressing before the close of the inspection. The lead inspector noted the presence of candles in various parts of the designated centre. While the candles were not lit at the time of the inspection they had been lit in the past.

The inspector directed the clinical nurse managers, working on the day of inspection, to remove all candles from the centre and assess if they were safe to use in this centre. The provider was required to ensure the use or prohibited use of candles was clearly reflected in the fire safety policy and procedures for the service.

As part of the providers practice development update in December 2016, a new hygiene and infection control checklist was introduced for the bathrooms in the centre. Inspectors noted improvement in the cleanliness of the centre since the previous inspection which demonstrated the new hygiene and infection control measures were working adequately.

Staff provided an inspector with a demonstration of the new electronic incident reporting system. Staff informed that inspector that the system would be rolled out to all of the centres operated by the provider in the first quarter of 2017. The new system is designed to send alerts to key people once an incident form is completed.

Judgment:
Non Compliant - Moderate

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

Findings:
There had been improvements in the training of staff in detection, management and response to allegations of abuse. There was also evidence of improvement in support planning and risk assessment of restrictive practices in the centre. However, some improvements were still required.

In December 2016 the provider introduced a new internal reporting form for alleged abuse of a vulnerable person. This internal reporting form was a more comprehensive document template than the previous one and encouraged the person completing it to follow the policy and procedures for reporting allegations of abuse in a more comprehensive way incorporating greater accountability for staff and the person receving the allegation report.

Most staff had now completed training in safeguarding vulnerable adults. More training was planned for 2017 with refresher training included in the training schedule. However, inspectors did not find adequate evidence that the training provided to staff ensured they understood the safeguarding reporting procedures for the service or the designated persons to report allegations to.

Inspectors spoke with staff working in the centre about their abilities to recognise and report abuse or suspicions of abuse. While staff spoken with were able to tell inspectors types of abuse and who they would report suspicions of abuse to, some were not familiar with all of the steps involved in the safeguarding procedure for the service.

One of the designated officers for the centre was no longer in post, however, signs were still displayed in the centre indicating this person was a designated person to report allegations of abuse to. Staff spoken with still named that person as the designated person and were unclear as to whom had taken their place. The provider was required to change the designated person information displayed in the centre and update staff on revised reporting procedures.

Some restrictive practices were in place in the centre. Inspectors assessed if a more comprehensive robust system was in place for their identification, management and review. Some examples of restrictive practice in place included an alarm on a resident bedroom door which alerted staff if the resident was out of bed and exiting their bedroom. A risk assessment for the use of this alarm was in place and a protocol for its use was also maintained which clearly set out the criteria for its use and when it was not to be used.

Bed rails were also in use for a number of residents living in the centre. An immediate action had been given on the previous inspection with regards to a risk to a resident posed by an ill fitting mattress on their bed. On this inspection inspectors noted the action had been satisfactorily addressed. The mattress had been changed and there was no longer a gap between the mattress and the bedrail. A risk assessment for the use of bed rails had also been completed for residents in order to mitigate risks associated with their use.

While there were improvements in place with regards to the risk assessment and management of restrictive practices in the centre some improvements were still

required. Where restrictive practices were used there was a lack of evidence that such practices were assessed and reviewed on a regular basis to ensure they were the least restrictive and in place for the least amount of time necessary, for example there was no restraint register for the centre. There was no evidence of restraint review meetings.

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:
Overall, inspectors found there had been significant improvements in the quality of medical and allied health professional assessment of residents' needs, ongoing review and timely intervention. There was evidence that improved health outcomes were being brought about from this significantly improved input. However, nurse care planning and evaluation of the effectiveness of the care plans required improvement.

Residents' personal plans provided evidence that residents were receiving regular assessment and review by allied health professionals as they required. Inspectors noted the quality of allied health professional assessment, review, evaluation and regular follow ups had improved for residents significantly. A relative of a resident spoken with during the course of the inspection also informed the inspectors that they had seen a significant improvement in the level of allied health professional input and was very pleased with these improvements.

Speech and language therapy (SALT) recommendations for residents were in place for all residents living in the centre requiring support with regards to modified consistency meals and management of compromised swallow which could lead to a risk of choking. Associated care plans had been drafted and were maintained in residents' personal plans which made reference to residents' SALT recommendations.

While all residents had received an annual medical review the provider had assessed that residents required more intensive medical assessment and review given the serious and complex medical needs and co-morbidities residents living in the centre presented with.

To address this the provider intended to increase GP provision to residents in the centre

and had decided to recruit a GP for a period of at least 6 months. At the time of inspection the provider had enlisted a recruitment agency to identify suitable candidates for the post and would carry out interviews starting the week following the inspection.

An inspector reviewed a sample of healthcare plans for residents in the centre. While plans were in place for residents' identified healthcare needs, they did require improvement. For example, care planning for residents at risk of developing pressure ulcers required improvement in the assessment and ongoing evaluation of care plans in place for residents.

Care plans had been drafted for residents however, ongoing completion of pressure ulcer risk assessments was not robust and the lead inspector noted that a pressure ulcer risk assessment had only been completed twice since October 2016 for a resident deemed at high risk of developing a pressure ulcer. Care plans in place for the prevention of pressure ulcers did not identify how often the risk should be assessed in order to evaluate the effectiveness of the plan.

Assessments of the effectiveness of nursing care plans were not carried out in a planned and documented way, Therefore, it was not clear how nurses in the centre evaluated the effectiveness of their prescribed care planning for residents to ensure their best possible health and manage their complex medical and healthcare needs.

Since the previous inspection, care plans had been drafted for all residents that required the use of oxygen as part of emergency management for respiratory distress or following an epileptic seizure. This was an improvement from the previous inspection. Clearer criteria had been documented to guide staff for when to use oxygen for residents.

Inspectors did also note there had been an increase in residents using emergency and on-call medical services which reflected improvements in emergency healthcare management of residents living in the centre.

Residents were supported to attend healthcare appointments and during the inspection a nurse, who had accompanied a resident on an appointment, described to the inspector the issues the resident had and the procedure the resident had undergone during their appointment. The nurse that accompanied the resident to the appointment had been scheduled to attend training on the day of inspection but the provider had facilitated them to attend the training on another date so the resident could meet attend their appointment. This demonstrated staff were involved and supportive of residents healthcare needs and also that the provider was facilitating residents to attend important medical appointments while also ensuring staff would meet their training requirements.

Residents' weights were recorded and their body mass index (BMI) was also recorded. There was ongoing input from residents' dietician and there was evidence to indicate enhanced dietetic input had brought about positive improvements for residents. For example, a resident assessed as underweight had been reviewed by a dietician in December 2016 whereby they made changes to the resident's dietary regimen. Following the change the resident had put 0.8kgs in one month which demonstrated an

improvement in the residents' health following recommendations and supports of the allied health professional.

Judgment:
Non Compliant - Moderate

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

Findings:
Since the previous inspection the provider had implemented a medication management improvement initiative which would bring about further improvements and ensure overall safety of medication management within St. Patrick's Centre, Kilkenny services.

A project leader for practice development of medication management practices had been appointed since the previous inspection. They had instigated a number of initiatives within the service and the designated centre discussed in this report. Previously inspectors had noted oxygen administered to residents was not prescribed. On this inspection inspectors noted this had been addressed. Each resident prescribed oxygen had an associated care plan in place to direct its use. This is further referred to in Outcome 11; Healthcare.

The quality and compliance manager and project leader had carried out medication management audits across a number of designated centres within St. Patrick's Centre, Kilkenny. These audits were thorough and detailed and had brought about a number of improvements and changes with regards to medication management systems within the designated centre referred to in this report.

One initiative implemented was the review of stored medications in the centre. Excess stock of medication in the designated centre was identified as a risk and all surplus and/or out-of-date medications were returned to the pharmacy as per the organisation's returns of medication policy and procedures.

A plan was in place for a local pharmacist to supply medications to the designated centre in a pre-packed medication dispensing system. This would reduce the amount of medications stocked in the centre and reduce the risk of medication errors. This change over process was underway at the time of the inspection and was co-ordinated by the medication management project manager. This change in dispensing of medication practice would also include a revised easier to use medication administration and

documentation chart for staff to complete.

The process of changing medication scripts from the medication administration charts in the centre to residents' GP records were underway but was a laborious task and was taking longer than had been expected. The provider was in the process of recruiting additional GP services in the centre to support this process. This is further discussed in Outcome 11.

The medication management policy for St. Patrick's Centre, Kilkenny had also been reviewed and changes made to ensure it reflected up-to-date safe medication management practices and procedures.

Some improvements in the policy included the revised management of medication errors and the documentation of such errors which included a root cause analysis which would be carried out by the person in charge, for example to ascertain why the error may have occurred and the systematic changes required to improve practice following an error made.

Judgment:
Compliant

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:
Previous inspections of the centre found systems of governance and management were not sufficient to ensure residents received a safe service and quality care. On this follow-up inspection, it was found the provider had instigated a significant suite of improvements across a wide range of areas. These improvements were identified by the inspector as pivotal in bringing about the significantly improved levels of compliance found on this inspection. The person in charge of the centre had ceased working in the centre the week previous to the inspection.

The provider had implemented significantly improved procedures for monitoring the

quality of care provided to residents. Systems were 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, improved outcomes were observed for residents, as outlined in Outcome 8; (Safeguarding and Safety), Outcome 11; Healthcare needs and Outcome 12 Medication Management, for example.

On the previous inspection, a person in charge had been recently appointed to manage the centre. However, on this follow-up inspection the person in charge had since ceased her post in the centre. Two persons participating in management were on duty in the centre the day of the inspection. The centre had two residential units each with an appointed clinical nurse manager 1 (person participating in management). There were deputising systems in place in the absence of the person in charge. The provider was required to appoint a person in charge of the centre as required in Regulation 14. The provider was aware the person in charge they would appoint would be required to meet the matters as set out in Regulation 14 (3) (a)(b).

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 had been carried out in September and October 2016 However, there were a number of auditing initiatives ongoing in the centre, for example extensive auditing was being carried out in the area of medication management, a full suite of audits of each residents' personal plan was underway, maintenance management audits had been carried out and a full audit of the transport vehicles allocated to the centre had also been implemented.

Systems to assess the quality and safety of care at the centre level had improved since the previous inspection with the appointment of a quality and compliance manager, the appointment of key project co-ordinators with responsibility for assessing and supporting the implementation of actions identified in audits carried out and another project co-ordinator in the area of medication management and healthcare improvements and practice development in the service.

Each project manager was required to report to the Board of Directors for St. Patrick's Centre, Kilkenny and update them on their progress in implementing improvements within the service. These updates were evidence in the minutes of the Board of Management meetings which were provided to the inspector for review during the inspection.

As was identified on the previous inspection improved systems in place to review accidents and incident reports in order to improve safety arrangements for residents were ongoing. Incidents/accidents and risk were now a fixed agenda item on the newly established quality and safety committee.

Another sub-committee that reported to the Board of Management for the service was the quality and compliance committee. They met at least monthly to discuss actions set from the previous meetings, review current system changes that had been implemented and revise if required and provide a report for the Board of Management following each meeting.

Board of Management meetings occurred at least monthly and the inspector noted an

urgent Board of Management meeting had taken place following a meeting the deputy chairperson and provider nominee had attended in the Health Information and Quality Authority (HIQA) Dublin office in October 2016. The Board of Management meeting had discussed plans to address HIQA's concerns with regards to the provider's progress in demonstrating improvements within the six month timeframe which had been set by the Authority and was due to cease the end of November 2016. The Board of Management meeting set specific actions which included the appointment of key stakeholders with responsibilities for driving improvements within the service.

Overall, the inspector found significant improvements had occurred and these improvements had been brought about by the appointment of these key stakeholders and governance meetings. These included the appointment of project co-ordinators, community connectors, the appointment of a staff training co-ordinator, improved focused auditing, sub-committee teams and meetings and the regular change management meetings whose focus was to ensure system change was communicated to managers within the service supporting them to implement system changes on the ground which would ultimately improve outcomes for residents.

The inspector was assured the provider had implemented significant improvements and demonstrated a more compliant, comprehensive and robust management of the service focused on improvements in quality and compliance across a wide range of areas which in turn would bring about improved outcomes for residents which were already evident on the day of inspection.

The provider was required to continue with these improvements.

Judgment:
Non Compliant - Moderate

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:
Inspectors found there had been a number of improvements implemented by the provider to ensure staff were appropriately trained to support residents needs. Systems for supervision of staff had improved also. A key worker system had been implemented

since the previous inspection which the inspector noted had brought about a number of positive outcomes for residents.

Since the previous inspection the provider had appointed a staff training co-ordinator for St. Patrick's Centre, Kilkenny. Prior to their appointment there had been no person specifically appointed with this remit. This had resulted in an uncoordinated system of staff training and non compliances found on a number of inspection reports for St. Patrick's Centre, Kilkenny with regards to inadequate training of staff to meet residents' assessed needs.

Inspectors met with the newly appointed staff training co-ordinator. They had started their role in July 2016 and had audited staff training for all designated centres comprising St. Patrick's Centre, Kilkenny services. They had also compiled a training needs analysis for staff working within the designated centre and also for each residential unit that comprised the designated centre. From this training needs analysis the staff training co-ordinator had established a comprehensive staff training scheduled with a schedule devised for 2017.

Staff training records for the designated centre were now easily retrievable by the person in charge. There were identified gaps in training that the co-ordinator had identified and had scheduled training dates for staff to attend. The person in charge was responsible for ensuring staff attended the training dates scheduled by arranging staff rosters accordingly and communicating with staff with regards to the training.

As part of the new staff training initiative for the service it had been decided that a number of staff would be identified as persons who would be trained up in a specific healthcare/social care support need and become trainers to other staff within the service.

Training was planned for the introduction of a new computer based care management system. Inspectors were informed that the provider had set up an IT training room to provide staff with the necessary skills to use the system effectively.

The provider had implemented a training initiative for staff since the previous October 2016 inspection. Training records evidenced the following:

21 staff had received key-worker training, five staff had received manual and patient handling training, 11 staff, infection control training, five staff, percutaneous endoscopic gastrostomy (PEG) pump feed training and eight staff had received nutritional risk assessment training.

Other training received by staff included safeguarding vulnerable adults training, management of dysphagia and fire safety, this is further elaborated on in outcomes, outcomes 7, 8 and 11 of this report.

Judgment:
Compliant

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:

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Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Saint Patricks Centre (Kilkenny)
Centre ID:	OSV-0003497
Date of Inspection:	19 January 2017
Date of response:	17 February 2017

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:
There was no evidence that personal care plans were amended to reflect the changes recommended by allied health professionals.

1. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

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:
• Personal Plans will be reviewed monthly and/or when updates are required following GP, MDT etc recommendations. Once personal/support plans are updated the old plan will be archived immediately.
• In house, Clinical Pathway meetings will be conducted monthly which will serve to identify MDT input required.
• Personal plans are now filed in one file containing all information relevant to the residents' health and social care needs.

Proposed Timescale: 17/03/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While some improvements had occurred improvement was needed to ensure residents' personal plans accurately reflected their social care needs and support planning to meet those needs.

2. 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:
• All files will be audited to ensure that only up to date and relevant information is present. Any information that is no longer in date will be archived immediately.
• All files will be audited to ensure that only "live" support plans are present. Any support plans no longer in date will be archived immediately.
• All files will be audited to ensure that personal plans accurately reflect residents social care needs and support plans are in place to meet those needs.
• The centre have a number of measures to support and monitor staff performance: such as training and development, supervision, an appraisal system to be developed, and performance management processes and when necessary evoking the disciplinary policy. Staff accountability is paramount. For example, staff responsible for files found not to meet the required standards may be subject to disciplinary measures.

Proposed Timescale: 31/03/2017

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:
While a revised risk assessment template had been drafted it was yet to be implemented in the designated centre

3. 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:
• Risk Management Policy has recently been reviewed and updated and now reflects matters as set out in Regulation 26 (e).

• The new Risk Assessment Template is now in place. All new risk assessments will be conducted using the new format and when all existing centre specific and individual risk assessments are reviewed they will be updated using the new template.

• New Electronic Incident Reporting System will be piloted in the centre in the coming weeks and expected to be fully operational by the end of March.

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was required to risk assess the use of candles in the centre and ensure safety arrangements were reflected in the fire safety policy and procedures for the service.

4. 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 candles have been removed from the unit and across the centre.
• A recent practice development update informed staff in all centres across the organisation that candles and plug in air fresheners are forbidden.

Proposed Timescale: Completed 17/2/17

Proposed Timescale: 17/02/2017

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:
Where restrictive practices were used there was a lack of evidence that such practices were assessed and reviewed on a regular basis to ensure they were the least restrictive and in place for the least amount of time necessary.

5. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
• In-house Clinical reviews acting as a pathway are underway on a monthly basis. Attended by staff nurses and HCA/Keyworkers the purpose is to review needs and behaviours of residents and develop preventative and reactive strategies. All restrictive practices will be reviewed at this monthly forum with a view to ensuring that they are the least restrictive options and in place for the least amount of time necessary.
• These Monthly Clinical reviews are scheduled to ensure all residents have their clinical needs assessed on a regular basis. Particular emphasis will focus on OT, SALT, Behaviour Support and Dietitian referrals. The outcomes of these reviews will determine referrals to relevant allied health professionals. Recommendations from allied health professionals will in turn inform the in-house clinical reviews.
• A newly established Restrictive Practice committee will review all restrictive practices across the centre in the coming months.
• All residents requiring a Behaviour Support Plan will have that plan reviewed and updated to reflect recommendations from all relevant allied health professionals.

Proposed Timescale: 30/04/2017
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors did not find adequate evidence that the training provided to staff ensured they understood the safeguarding reporting procedures for the service or the designated persons to report allegations to.

One of the designated officers for the centre was no longer in post, however, signs were still displayed in the centre indicating this person was a designated person to report allegations of abuse to.

6. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
• Safeguarding and the reporting of allegations will be added to the agenda of every staff meeting to reinforce the learning from the training provided.
• "Reference" cards to remind all staff of the protocols and guidelines concerning safeguarding and the reporting of allegations have been developed and are located in the centre.
• The sign with details of the previous designated officer have been removed from the centre.

Proposed Timescale: 28/02/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Nurse care planning and evaluation of the effectiveness of the care plans required improvement to ensure that issues such as pressure care were appropriately managed.

7. 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:
• The care planning in relation to the management of residents at high risk of pressure sores has been amended to ensure that their pressure ulcer risk assessment is reviewed every fortnight or sooner if required.
• All residents will avail as a minimum a full annual medical review. The organization has arranged an increase in GP hours which will see a GP visit the center an additional 1 day per week to complete a comprehensive review of all resident's health care needs.

Proposed Timescale: 28/02/2017

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:
The provider was required to appoint a person in charge of the centre.

8. Action Required:
Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

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

Documentation in relation to dividing the centre into 2 designated centres has been submitted to the authority and the names of 2 new PIC's will be confirmed on Monday February 20th.
Proposed Timescale: 20/02/2017