

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Raphael's Residential Centre
<b>Centre ID:</b>	OSV-0003999
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Deborah Harrington
<b>Lead inspector:</b>	Geraldine Ryan
<b>Support inspector(s):</b>	Conor Dennehy
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	18
<b>Number of vacancies on the date of inspection:</b>	32

## **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: 03 November 2017 08:30 To: 03 November 2017 14:30

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

Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

On 6 November 2015, HIQA applied to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities which were managed by the Health Services Executive (HSE). The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This was the eight inspection undertaken of this centre, the purposes of which were:

- to review the measures that the HSE, as service provider, had put in place to ensure that the healthcare needs of residents were being managed effectively.
- to ascertain the progress of the provider's programme for the transition of residents to the community

Description of the service:

The centre was based in a campus-style environment with other designated centres on site in Youghal. This centre provided accommodation to 18 residents in three different units. Residents had complex healthcare needs, used varying communicative processes and required a high level of support.

How we gathered our evidence:

The inspectors met with 15 residents, staff and the management team. Residents, who chose to, engaged with inspectors. Staff were knowledgeable in how residents

communicated; for example, use of non-verbal cues and facial gestures. Inspectors observed practices and reviewed documentation such as residents' care plans, medical and nursing records. Inspectors spoke with staff, the person deputising for the person in charge and the project manager who was the representative on behalf of the HSE.

Overall judgment of our findings:

The HSE was implementing its action plan to move the remaining 18 residents from this centre; a congregated setting to a community-based model of service.

Residents appeared well-cared for, displayed a happy demeanour and interacted where possible with inspectors. Inspectors sought residents' permission to be in their home and to view their documentation. Respectful engagement was noted between staff and residents. There was evidence that actions from the most recent inspection were completed or in the process of being completed.

From a review of sample of residents' care plans and speaking with residents and staff, it was evident that the residents' access to social outings had increased; visits to the hairdresser, horse riding, the local wildlife park and out for lunch. However, residents' access to transport was a problem. Residents were observed in and out of the centre during the inspection. The inspector met with residents from another centre who dined in this centre. The dining experience was pleasant, relaxed and a social occasion. Staff were knowledgeable of the residents and their needs.

However, further improvement was required in relation to the oversight and monitoring of residents' dietary and fluid intake, staff use of a restrictive practice and supervision of staff and staffing levels in one of the units.

The reasons for 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.

**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 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:**

The provision of healthcare within the designated centre had improved since the previous inspection but further improvement was required to ensure that healthcare as outlined in residents' plans was provided for. These matters were brought to the attention of the staff and management who concurred with the findings.

Inspectors reviewed a sample of residents' personal plans in all units and noted that residents had appropriate healthcare assessments completed. Corresponding plans were then put in place to address residents' identified healthcare needs; the assessments and care plans were well presented with sufficient detail. While residents were well cared and there was no concern with regard to residents' nutritional status, some documentation errors and omissions were observed in residents' plans in one of the units. For example, one resident's malnutrition assessment was incorrectly calculated on multiple occasions while there were some instances noted where residents' monthly weights were not recorded.

In all units, staff spoken with demonstrated a good knowledge of residents' healthcare needs and the steps to be taken to meet residents' needs as outlined in the care plans. Evidence reviewed on inspection indicated that these plans were followed for the most part. However, inspectors noted occasions where plans were not followed. For example:

- inspectors reviewed the care plan in place for a resident with a percutaneous endoscopic gastrostomy (PEG) feeding tube which outlined a specific procedure that was to be carried out 1-2 times a week to maintain the PEG site. Records reviewed indicated two instances where this procedure was not recorded as being carried out for periods of 9 and 10 days respectively. Some gaps were also noted with regard to the fluid balance charts for this resident
- another resident's care plan included an assessment carried out by a speech and language therapist (SLT) relating to modified diets with resulting recommendations. These recommendations were included in a corresponding care plan. However, during

the course of the inspection an agency staff was observed providing assistance to this resident with their meal in a manner which was not consistent with the directions outlined by the SLT and furthermore, did not demonstrate their knowledge of the SLT guidance for this resident

- one resident with co-existing medical and nursing care needs had a comprehensive suite of care plans in place to guide and inform staff. However, while there was evidence that the resident had been reviewed regularly and as required by allied professionals, a care plan capturing the nutritional requirements for the resident as outlined by a dietitian was not in place; this was addressed by the end of the inspection.

Arrangements had been put in place since the last inspection for residents who required meals served in a modified consistency. For example, specific folders containing all of the residents' information in this regard were maintained in the individual units of the centre and this information was also shared with the kitchen where meals were prepared. Food received from the kitchen was also noted to be labelled. The inspector observed the dining experience and residents voiced their satisfaction with the choices on offer. Food was plated and presented in an appetising manner.

**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:**

A single aspect of this outcome was reviewed on this inspection relating to the receipt of medication prescriptions over the telephone. The action required from the previous inspection was satisfactorily addressed.

A protocol for the receipt of medical prescriptions over the telephone was in place, included in the centre's policy on medicines management and staff were knowledgeable of same.

**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:**

This inspection was to review the clinical governance of the care being provided to residents. Inspectors noted that while improvements were noted in the care and welfare of residents, further improvement was required in how the provider assured itself that there was effective monitoring of the service provided to residents by staff.

A new person in charge for this centre had been appointed in May 2017 and due to a prior commitment, was not in the centre on the day of inspection. Staff stated that the person in charge was supportive and actively engaged with residents and staff. The deputising person in charge demonstrated an in-depth knowledge of all residents, regulatory requirements and engaged with residents, staff and the inspectors in a very positive manner.

Inspectors met with the provider representative who was also the project manager for the transition of residents from this centre, a congregated setting, to a community based model of service. The provider representative outlined a comprehensive account of the current status of the provider's transition plan and how plans were at an advanced stage with properties in various stages of the procurement process; the HSE was in ongoing negotiations for the purchase of a number of other houses. The community transition coordinators were actively involved in facilitating service coordination for residents who choose to relocate from the institutional setting to community living. The provider representative demonstrated an in-depth knowledge of the residents and their requirements to ensure a safe transition to their new homes.

The project manager stated that engagement with residents' families and or representative was ongoing.

Management acknowledged that there were some inconsistencies of care across the three units that made up this centre. As was found on the previous inspection, improvement was still required in relation to oversight of staff documenting that residents received adequate food and nutrition. In addition, improvement was still required in the residents' care planning process to ensure that each resident's assessed healthcare needs were being met.

The provider had not put in place appropriate transport services for residents. While residents' access to social activities had increased, residents' access to transport was an issue, particularly during the week; this matter had been raised and noted in a number of meetings convened by the operational managers group.

**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):**

No actions were required from the previous inspection.

**Findings:**

This Outcome was not inspected in full. The provider representative was asked to review the staffing levels in one of the units. This unit accommodated residents with a dual diagnosis and who required significant supports with regard to their medical and nursing care. Inspectors observed that all residents required 2:1 support.

In addition, in this unit, a staff nurse position was vacant due to leave and the hours had not been replaced. While residents appeared well cared for and in good form, it was evidenced that staff in this unit were under pressure to attend to their duties; for example, the inspectors noted that one staff nurse was providing support on the ground to healthcare staff attending to residents' personal care requirements, attending to clinical and palliative care requirements of residents, contacting allied health providers and attending medicines management. The level of activity in the unit, the specific needs of the residents accommodated there and the reduced staff hours resulting in reduced oversight relating to clinical matters such as one resident's PEG feeding tube, was discussed in further detail under Outcome 11. The deputising person in charge acknowledged that there were some inconsistencies of oversight of care across the three units that made up this centre.

During the course of inspection two instances were observed by inspectors involving agency staff members which raised concerns. The first involved the inappropriate locking of a door to a room which a resident was occupying and the second incident involved SLT recommendations not being followed by agency staff as discussed under Outcome 11. These instances did not provide adequate assurances that appropriate supervision arrangements were in place for agency staff members. The deputising



person in charge attended to these matters immediately.

**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:***

Geraldine Ryan  
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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0003999
<b>Date of Inspection:</b>	03 November 2017
<b>Date of response:</b>	24 November 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 11. Healthcare Needs

**Theme:** Health and Development

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

SLT recommendations were observed not being followed by one member of staff.

Directions in relation to the maintenance of a PEG feeding tube site were not recorded as being carried out while fluid balance charts were not always completed.

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

Monthly weights for residents were not always recorded.

**1. 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:**

SLT Declaration sheet in place to be signed off by all unfamiliar /agency staff stating that they have read, understand and will adhere to each SLT plan. This commenced on 21st November..

- Recording sheet has been put in place to be documented daily in relation to the monitoring of the stoma /peg site. This is included in the daily planner which is completed in the morning report.
- Fluid balance charts are now recorded daily and signed off by the nurse on duty. This is also discussed and documented at report time and has been included in the daily planner.
- Attempts will be made to weigh all non compliant residents monthly. In the event that a resident is non compliant over a two month cycle, the GP will then be informed.

**Proposed Timescale:** 21/12/2017

**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 management system in place did not provide adequate oversight or review in the following matters:

- improvement was required in relation to oversight of staff documenting that residents received adequate food and nutrition.
- improvement was required in the oversight of the residents' care planning process to ensure that each resident's assessed healthcare needs were being met.

The provider had not put in place appropriate transport services for residents. Residents' access to transport, particularly during the week had not been addressed by the provider. This matter had been raised in a number of meetings convened by the operational managers group.

**2. 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:**

- Staff training in relation to recording the MUST assessment is being put in place.
- Hospice team has been contacted in relation to documenting food intake for a resident

who is in Palliative care. There is documentation in place from the Hospice team taking into account evidence based practice that food intake is no longer to be recorded. The dietician has been informed of this decision. However we continue to document the fluid intake using a fluid intake chart as advised by the Palliative care team. This is discussed at handover each morning.

- In relation to appropriate transport, funding has been approved and there is now a plan in place to purchase additional vehicles via tender.

**Proposed Timescale:** 30/12/2017

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Appropriate levels of nursing staff in one unit of the centre required review to ensure that staffing met the assessed needs of all residents.

#### **3. Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

- There is on-going recruitment in place to fill the vacant nursing post. However the number of residents in this area is decreasing to 7 with one resident leaving on 27th November 2017 as well as two residents from an adjacent unit.
- The service is reconfiguring staffing hours to better support the residents needs.

**Proposed Timescale:** 30/12/2017

**Theme:** Responsive Workforce

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

Supervision arrangements of agency staff members working in the centre required review.

#### **4. 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:**

- There is now a supervision book in place where nurses and managers sign to confirm visits throughout the day especially at mealtimes to areas where agency staff are employed. Mealtime audits will be instigated with a particular focus on agency staff.

- There is a Declaration form in place where agency staff will read and sign all plans/risk assessments for the residents.
- Furthermore a Communication passport/accessible format of the PSP will include all relevant documentation. This will be with the resident at all times where possible.
- Placemats are being set up where residents SLT plans will be put in as needed.

**Proposed Timescale:** 30/12/2017