

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Michael's Centre
Centre ID:	OSV-0003497
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Patricks Centre (Kilkenny) Ltd
Provider Nominee:	David Kieran
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Gary Kiernan
Type of inspection	Announced
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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 October 2016 11:00 To: 06 October 2016 21:00

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

Summary of findings from this inspection

Background to Inspection.

The Health Information and Quality Authority (HIQA) in May of 2016 met with representatives of the newly appointed board of management for St. Patrick's Kilkenny Ltd. At that time the provider gave assurances that new structures and systems of governance and management would be promptly put in place to improve the quality and safety of the service and address previous inspection findings. This inspection was announced and the provider was informed that the findings of the inspection would be used to assess if improvements were being implemented in line with the undertakings given to HIQA.

In response to the announcement of this inspection the provider carried out an internal audit of the service in advance of the inspector's visit. The provider informed HIQA that during this internal audit they found significant issues relating to the management of residents' healthcare needs which they deemed to be acts of omission/neglect. In direct response the provider made steps to address these issues including implementing human resource management procedures for staffing in the centre. Three notifications of alleged abuse relating to acts of omission and/or neglect with regards to residents healthcare were received by the Chief Inspector prior to the announced inspection. During this inspection inspectors followed up on the matters notified to HIQA and also assessed governance and management

practices in the centre.

Of the seven outcomes assessed not all aspects were reviewed in each outcome on this inspection.

Since the previous inspections in 2015 and 2016 a number of fire safety works had been carried out in the centre in order to address significant fire safety non compliances which had been identified by HIQA and also the regional fire officer. At the time of the inspection substantial works had taken place to upgrade fire safety infrastructure and address these non compliances.

How we Gathered Evidence:

As part of the inspection, inspectors met with staff working in the centre and spoke to them about practices and their knowledge of the residents. Inspectors spoke to residents they met during the inspection taking guidance from staff as to the particular way in which residents liked to interact with others. In all instances residents did not verbally communicate with the inspectors.

Inspectors observed practice throughout the inspection and interactions they observed between staff and residents. Inspectors also reviewed documentation such as personal plans, risk assessments, incidents and accidents logs. Inspectors also spoke with the quality, standards and compliance officer and social worker allocated responsibility for the centre and the management of the allegations of abuse. Inspectors also met and spoke with the person deputising for the person in charge, assistant director of services and clinical nurse manager 1 (CNM1). All three persons had been redeployed to work in the centre in response to issues which the provider had identified during an internal audit.

Description of the Service:

The centre is part of St Patrick's Kilkenny Ltd, 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 outside Kilkenny town.

The centre is home to 19 residents. Residents living in the centre had high dependency needs and severe to profound intellectual disabilities. Some high dependency needs include the requirement for modified consistency meals to support them due to compromised swallow (dysphagia) and risk of choking or aspiration (inhaling food/drinks). Many residents required significant healthcare supports and had a number of co-morbidities meaning they each had a number of healthcare issues.

While the provider had made improvements to the living environment for residents by refurbishing the centre throughout, it still presented as an institutional type setting located in a congregated setting. Residents' meals were still provided in an institutional style whereby they were cooked in a centralised kitchen and transported to the centre in heated containers.

Overall Judgment of our Findings:

The governance and management arrangements in the centre were not adequate to

ensure the effective oversight and monitoring of the service. Inspectors found not all actions from the previous inspection had not been adequately addressed.

Inspectors were significantly concerned in relation to the management of residents healthcare needs, health and personal risk assessment and personal planning. Inspectors found residents social care planning documentation, which included nursing healthcare plans, were disorganised and disjointed which could result in inconsistent care practices for residents.

Some staff spoken to during the course of the inspection did not demonstrate knowledge in how to manage some healthcare risks for residents such as evidence based prevention of pressure ulcers or the grades of pressure ulcers and administration of oxygen for residents while unwell.

Inspectors found significant gaps in staff training to support residents' specific healthcare needs. As mentioned, residents required supports in relation to management of dysphagia (compromised swallow). However, of the 50 staff allocated to work in the centre only 12 staff had received training to meet this care need.

Some residents required oxygen therapy during times of illness, however only six out of 50 staff had received training in the use and management of oxygen therapy. With regards to the management of percutaneous endoscopic gastrostomy (PEG) nutrition only six out of 50 staff had received training in how to manage this care need.

Inspectors also found that while all staff had received training in abuse prevention only 20 out of 50 staff had received training in the new national safeguarding vulnerable adults policy, despite this policy being implemented throughout the services. Staff spoken to by inspectors did not demonstrate knowledge of the signs and types of abuse residents with severe to profound intellectual disabilities may present with.

An immediate action was issued during the inspection to instruct the provider to ensure the safe use and management of bedrails in the centre. Inspectors requested the provider to ensure all beds with bedrails attached were appropriately risk assessed and all risks mitigated in line with best practice and safety guidelines before residents retired to bed the night of the inspection.

This inspection found of the seven outcomes inspected five outcomes were majorly non compliant and two were moderately non compliant. 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 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 residents' social care needs were still not consistently supported by a cohesive, comprehensive assessment of need. There was evidence to indicate allied health professional assessments, intervention and recommendations for residents were ongoing.

Inspectors reviewed a sample of residents' personal plans. However, from the sample of personal plans reviewed there was little evidence to indicate improvement had occurred since previous inspections of the centre.

As had been found on previous inspections residents' personal plan information was still 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. Not all recommendations and information contained in residents' personal plans had been reviewed annually or more frequently.

Residents were receiving allied health professional assessment based on a referral made by nursing staff in the centre. There was evidence that referrals had been made and residents were receiving assessments based on these. However, inspectors found there was a lack of cohesion between the reviews and recommendations and the development of person plans for residents. In the absence of clear documented guidance for staff there was an increased risk of inconsistent care practices.

Following resident reviews allied health professionals made a note of the visit or recommendation in residents' medical file. However, this information was not consistently used to formulate a support plan of care for residents thereafter. For example, speech and language recommendations (SALT) were maintained in a folder in the kitchenette of the centre. However, residents' personal plans did not contain a copy of the SALT recommendations and an associated support plan for staff to implement with regards to residents' dysphagia.

Inspectors formed the view that residents support planning was disjointed. Personal plans lacked an overall comprehensive identification of the needs of residents and contemporary plan of care to meet the needs of residents which in turn would guide staff practice. There was a risk that resident's specific care needs might not be met due to a lack of organisation and collation of relevant information for each resident into a workable, meaningful and robust personal plan of care.

Judgment:

Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

The systems to promote the health and safety of residents had improved somewhat following fire safety works having been completed. However, inspectors were still not assured that residents' health and safety was sufficiently promoted and protected, particularly in relation to healthcare risks for residents.

Since the previous inspection most 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. Emergency lighting and a functional fire alarm was also in place.

Inspectors reviewed fire safety training records for staff working in the centre. There were some training gaps evident. While all staff had completed level 1 fire safety training not all staff had completed level 2 fire safety training which would give them training with regard to implementing fire safety procedures specific to the centre. This concerned inspectors in light of previous fire safety concerns which had been raised.

Previously accidents and incidents for the designated centre were logged in an electronic

system. However, there had been issues with this system and a decision was made to revert to a paper based system. Systems for the documentation and auditing of incidents and accidents had improved. A triplicate book was in use in the centre where incidents and accidents were documented. A copy was sent to the health and safety officer and another to the director or assistant director of services for auditing leaving a third copy in the centre for record keeping. This ensured better documentation and recording of incidents practice as the previous system had not been effective to ensure all information was adequately recorded or retrievable. There were improvements required however.

There was inadequate review and analysis of identified risks to residents living in the centre. While there was evidence, of personal risk assessments in place, they were not reviewed with enough frequency to ensure risk control measures were working adequately to mitigate risks identified. In some instances where healthcare risks had been identified there was no reassessment to ascertain if the control measures in place were working to mitigate the risk.

For example, where residents were identified as being at high risk to developing pressure ulcers, there was no evidence that the risk identified had been reassessed or a specific plan of care was in place to mitigate the risk of a resident developing a pressure ulcer. There is further discussion with regards to this issue in Outcome 11; Healthcare Needs.

Where residents had been identified as requiring the use of a hoist there were no risk assessments carried out with regards to their use. Therefore, equipment such as the type of sling specific for residents were not identified or the supports required by the resident during manual handling procedures had not been identified.

Risk assessments for the use of bedrails had been completed. However, in an incident report dated July 2016 a resident's feet had become trapped between their mattress and bedrail. The response to address the risk at the time was not in line with national guidelines with regards to the safe use of bedrails.

The incident report had identified that there was a gap between the mattress and the bedrail. Staff had addressed this by putting pillows in the gap to prevent the resident's leg from becoming trapped again. It had also been identified in the incident report that a larger mattress was required to fit the bed appropriately and address the issue. However, when inspectors reviewed if the risk had been addressed they found it had not.

A larger mattress had not been procured and the practice of using pillows was still in place. This concerned inspectors as it posed a significant risk of injury or suffocation to the resident using the bed. Inspectors issued an immediate action for the provider to review the use of all bedrails in use in the centre and ensure any risk was mitigated before residents retired to bed that night. Following the inspection the provider nominee contacted the Chief Inspector to assure that all bed rails had been appropriately risk assessed and staff supervision of residents had been increased during the night until appropriate actions were complete.

Inspectors informed the provider nominee and management team present during feedback at the close of the inspection that they were not assured that risk management system in place were adequately identifying and mitigating risks for residents despite risk assessments carried out.

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):

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

Findings:

Not all aspects of this Outcome were reviewed on this inspection. Inspectors focused on ensuring the provider had safe and appropriate systems in place to ensure staff were suitably trained and skilled to respond to suspicions or allegations of abuse. There had been improvements in the organisational policy and procedures with regards to detection, management and response to allegations of abuse in the centre since previous inspections. However, inspectors found improvements were still required.

As referred to in the summary of this report, the Chief Inspector had received three notifications of alleged abuse of residents living in the centre. These related to alleged acts of omission and/or neglect with regards to residents healthcare needs. In response to the allegations the provider had implemented human resource management steps and had initiated investigations in line with the centre's safeguarding policy.

As part of their response the provider had ensured each resident subject of the allegations of abuse had received a review by their general practitioner and other allied health professionals involved in their care. The provider also informed inspectors that it was their intention to have all residents living in the centre reviewed by their general practitioner to ensure there were no healthcare risks to them. The quality and compliance co-ordinator would also carry out a full review of residents files and healthcare supports to ensure they were meeting their specific needs.

The allegations of neglect and acts of omission notified by the provider to the Chief

Inspector prior to the inspection, had also been reviewed by the social worker and a senior social worker allocated to the organisation. Preliminary screening of the allegations had been completed and submitted to the HSE in line with the National safeguarding policy and procedures.

Inspectors reviewed the training records for the centre and found while all staff had received training in abuse prevention, they had not all been trained in the new national vulnerable adult safeguarding policy and procedures which now governed the policies and procedures for St. Patrick's Kilkenny Centre Ltd. Of the 50 staff working in the centre 30 staff had not been trained in the new policy and procedure guidelines.

Furthermore, staff spoken with during the inspection could not give any examples as to what types of abuse they should be vigilant for in supporting residents that lived in the centre, in particular residents with severe to profound intellectual disability. This concerned inspectors as residents living in the centre were unable to verbally communicate with staff and would require staff to be vigilant in signs of abuse.

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):

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

Findings:

Inspectors reviewed healthcare supports and systems in place for residents on the day of inspection. Inspectors identified significant improvements were required with regard to the management of a number of ongoing healthcare needs.

There was a lack of comprehensive evidence based nursing assessment for residents that presented with healthcare issues. Care planning documentation did not support consistent care practices. Most residents living in the centre had complex medical needs and co-morbidities however, a comprehensive nursing assessment had not been carried out in order to facilitate clear and consistent care plans to support these needs.

Where residents were identified as being at risk of associated healthcare conditions nursing support plans were not in place to mitigate the risk. As mentioned in outcome 7; Health and Safety and Risk Management, a risk for development of pressure ulcers was assessed as high for a resident. However, during the course of the inspection, inspectors observed the resident identified at high risk sitting in the same position for the 10 hours

without being repositioned. This concerned inspectors as this was not in line with pressure ulcer prevention best practice. On further review an inspector identified that an incident had been documented whereby the resident had been identified as having red mark on their skin.

Staff spoken with however, were not aware that this constituted a possible grade 1 pressure ulcer and informed the inspector the resident often had red marks from sitting. When the inspector asked if the resident had any alternative seating arrangement they told the inspector the resident had however, the seating was broken and had been so for over nine months. Inspectors brought this to the attention of the provider nominee during the feedback from the inspection.

Inspectors were informed that a resident was ill at the time of inspection. The resident had been seen by the GP on the day of inspection. Inspectors asked a member of staff who was responsible for caring for the resident to describe the care interventions for the administration of a particular therapy. The staff member did not demonstrate accurate knowledge of the prescribed intervention and how it should be used and monitored. A care plan was not in place to guide staff in the consistent administration of this therapy.

Inspectors were also concerned that although the resident had been seen by the GP staff could not interpret the written instructions left by the GP. Therefore inspectors were concerned that prescribed interventions, such as oxygen therapy, would not be consistently implemented. This matter was brought to the attention of the person who was deputising for the person in charge who took steps to address it at the time of inspection.

The provider did not demonstrate that staff working in the centre had the scope of practice to carry out some prescribed interventions made by allied health professionals visiting the centre and making recommendations for residents. The provider was required to review this to ensure staff had the necessary skills and training to carry out recommendations made by residents' allied health professionals.

Annual medical reviews for residents, which were a policy-requirement within the organisation, were not up-to-date.

Residents living in the centre required modified consistency meals and drinks due to dysphagia. Inspectors found risks associated with regards to this on inspection. This is further discussed in Outcome 17: Workforce.

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):

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

Findings:

Not all aspects of this outcome were reviewed on this inspection.

Oxygen therapy was not prescribed in resident medication administration documentation despite residents receiving oxygen therapy. Staff spoken with were not aware of what specific criteria was required before residents were administered oxygen and inspectors formed the view that residents received oxygen at the discretion of staff as opposed to prescribed treatment by a medical professional.

Oxygen therapy was prescribed for a resident by their general practitioner before the close of inspection.

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):

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

Findings:

Previous inspections of the centre found systems of governance and management within St. Patrick's Kilkenny Centre were not ensuring residents received a safe, quality service.

On this inspection, it was found that the governance and management of the centre was still ineffective in ensuring residents' care and welfare was safely managed and in line with the Regulations. Governance and management arrangements in the centre were not adequate. On-going oversight and management of risks and healthcare issues was not effective.

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 not been implemented until immediately before this announced inspection

In preparation for this inspection the provider had instructed for an internal audit to be carried out. It was during this internal audit that the quality and compliance officer and other relevant persons, as part of the auditing team, had identified serious issues with regards to the management of residents' healthcare in the centre. However, internal checks and oversight should have been an on-going and continual process which had not been carried out by the provider.

As part of the inspection inspectors met with the newly appointed quality, standards and compliance co-ordinator for the service who had been identified as one of the persons delegated responsibility for identifying the significant non compliance issues in the centre as part of the internal audit by the provider.

She discussed the audit she had carried out in preparation for the inspection and her findings which she had reported to the provider nominee. She outlined plans to carry out a full audit and review of residents' personal plans to ensure they contained the most up-to-date information for residents with regards to their healthcare and social care needs.

The provider had instated a person deputising for the person in charge to manage the centre in the absence of the permanent person in charge for the centre who was on leave. However, inspectors raised concerns with this arrangement as the person deputising for the person in charge was already a person in charge of another designated centre within the service and she had not been relieved of her duties to that centre. Immediately after the inspection, the provider indicated that this matter had been addressed.

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):

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

Findings:

There had been an improvement in staff numbers working in the centre. However, there were significant gaps in staff training to ensure appropriate and necessary skills to implement safe and quality care and support to residents in line with recommendations made by allied health professionals and in line with their assessed needs.

The staff members present during this inspection were observed to engage in a positive and caring way with residents. Inspectors also noted there were an adequate number of staff allocated to the centre to support residents.

However, training records reviewed for staff indicated significant gaps in training for staff in the areas such as management of modified consistency meals, safeguarding vulnerable adults training, level 2 fire safety training, oxygen therapy management, management of percutaneous endoscopic gastrostomy (PEG) nutrition and administration of emergency medication for the management of seizures.

Residents required support with management of their nutrition due to compromised swallow or dysphagia. However, out of the 50 staff working in the centre only 12 staff had received training in the management of dysphagia, yet all staff working in the centre supported residents to eat. A number of residents living in the centre required their nutrition by percutaneous endoscopic gastrostomy (PEG). However, only six out of 50 staff had received training in how to manage this care need.

Similarly there were residents living in the centre that required oxygen therapy, as referred to in Outcome 11, and also required the administration of emergency medication to manage seizures associated with epilepsy. Six out of 50 staff had received training in oxygen therapy and six out of 50 staff had received training in administration of emergency medication for seizures.

These findings significantly concerned inspectors as it indicated not all staff working in the centre had the appropriate skills and training to manage the clinical care needs of residents living in the centre.

Staff spoken with during the course of the inspection did not demonstrate adequate knowledge with regards to prevention of pressure ulcers for residents who were at risk.

Judgment:

Non Compliant - Major

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:

Ann-Marie O'Neill
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-0003497
Date of Inspection:	06 October 2016
Date of response:	02 December 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:

Personal plans lacked an overall comprehensive identification of the needs of residents and contemporary plan of care to meet the needs of residents which in turn would guide staff practice.

1. Action Required:

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

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Members of the MDT in conjunction with management have developed a new clinical pathway that will include the identification of the needs of residents which will inform a comprehensive plan of care which in turn will guide staff practice. This new pathway which will include weekly clinical review meetings in each house which will inform who needs to be reviewed by the MDT and why. It will also include monthly sector (designated centre) reviews by the MDT during which all residents within the designated centre will be discussed. In addition, all residents will receive an annual review by all members of the MDT.

This new pathway is currently being trialled in another sector and information gathered as part of this process will be discussed at a meeting of the MDT on 12/12/16. If shown to be effective in supporting the identification of needs and the implementation of recommendations to address those needs, this new pathway will be rolled out across the organisation from January 2017.

To support this process and the effective exchange of information between staff, management and the MDT it has been agreed to introduce the SBAR (Situation, Background, Assessment, Recommendation), Communication Tool which is an effective and efficient way to communicate important information. SBAR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

The introduction of the new clinical pathway coupled with improved communications will ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

Following resident reviews allied health professionals made a note of the visit or recommendation in residents' medical file. However, there was little evidence that this information was used to formulate a support plan of care for residents thereafter.

2. Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

Medical/Non-Medical forms are now in place to be completed during all appointments. This will ensure each personal plan can be amended in accordance with recommended changes.

Proposed Timescale: 24/11/2016

Theme: Effective Services

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

Residents' health and social care needs were not consistently supported by a cohesive, comprehensive assessment of need.

3. 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 service users have a comprehensive assessment of need through the A1 health check and social care needs are being identified through the community transition toolkit assessments. All corresponding care plans and support plans will be reviewed to contain accurate information which will lead to a workable, meaningful and robust personal plan of care.

Proposed Timescale: 31/12/2016

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:

Inspectors were not assured that risk management systems in place were adequately identifying and mitigating risks for residents.

There was inadequate review and analysis of identified risks.

Where residents had been identified as requiring the use of a hoist there were no risk assessments carried out with regards to their safe use.

4. 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:

All risk management assessments are currently being reviewed. A risk assessment clinic has commenced within the service to support staff with these assessments.

The centre will introduce a review system to ensure that all identified risks are analysed and changes/improvements recommended are implemented.

Risk assessments are underway in relation to the use of the hoist with regard to its safe use.

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

While all staff had completed level 1 fire safety training not all staff had completed level 2 fire safety training which was required to give staff training with regard to implementing fire safety procedures specific to the centre.

5. 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:

56 staff are trained in Fire Level 1 and 39 staff are trained in fire level 2. 21 are trained in ski pad training and 41 staff are trained in ski sheet.

There is Fire Training Level 1 (refresher) on 9/12/16 and more dates are set for Fire Training Levels 1 & 2 throughout 2017. It is planned that all centre staff will have both level 1 and level 2 training completed by end of March 2017.

Proposed Timescale: 31/03/2017

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:

Of the 50 staff working in the centre 30 staff had not been trained in the new policy and procedure guidelines.

Staff spoken with during the inspection could not give any examples as to what types of

abuse they should be vigilant for in supporting residents that lived in the centre, in particular residents with severe to profound intellectual disability.

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:

- Staff are trained in Safeguarding, prevention, detection and response to abuse.
- Social work department are also carrying out local workshops in designated area.
- Safeguarding Training is scheduled for 02/12/16 and once per month for the year in 2017.
- A Safeguarding Workshop with the HSE Safeguarding Officer took place on 11/11/16 and another will take place on 05/12/16.

Proposed Timescale: 31/01/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

It was not demonstrated that a prescribed therapy for a resident was being administered as prescribed.

Appropriate interventions were not in place for a resident a risk of developing pressure ulcers.

Where residents had health care risks, support plans were not consistently in place to address them and guide medical care.

Annual medical reviews for residents in the centre were not up-to-date.

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 prescribed therapy for the resident is now being administered as prescribed. A support care plan is now in place. Completed

All residents have an up to date annual medical review on file.

A review of health care needs is currently underway and support plans are being put in place to support this review.

Proposed Timescale: 15/01/2017

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:

Oxygen therapy was not prescribed in resident medication administration documentation despite residents receiving oxygen therapy.

8. 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:

Medication policy reviewed and updated which reflects safe practices in the storage and administration of medication. Completed.

Oxygen therapy is now prescribed in resident's prescription sheet and care plan developed regarding same. Completed.

The Service is currently implementing a newer/safer system of administration of medication.

Proposed Timescale: 31/03/2017

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 person deputising in the role of person in charge was not full time.

9. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The Person In Charge is now full time in the centre

Proposed Timescale: 02/12/2016

Theme: Leadership, Governance and Management

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

Governance and management arrangements in the centre were not adequate. On-going oversight and management of risks and healthcare issues was not effective.

10. 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:

A new management team is now in place for the designated centre.

A Quality Improvement Programme for the centre has been developed, is currently being implemented and monitored on a weekly basis.

A regular audit system has also commenced within the centre which will ensure a safe service and a service appropriate to the residents needs.

Proposed Timescale: 30/11/2016

Theme: Leadership, Governance and Management

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

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 not been effectively implemented prior to the inspection.

11. 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:

An 6 monthly inspection was carried out in October 2016. Recommendations from audit have been included in the Quality Improvement Programme.

An annual Inspection of the Quality and Safety of Care in the centre will be carried out prior to end of April 2017.

Proposed Timescale: 30/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

There were significant gaps in the training provided to staff as identified in the body of the report. Not all staff working in the centre were trained to manage the clinical care needs of some residents.

12. 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:

32 staff now trained in Modified consistency meal

25 staff trained in safeguarding, plus attendance of some staff at Safeguarding Workshops

20 staff now trained in percutaneous endoscopic gastrostomy (We now have 4 PEG champions in the organisation who are qualified to train staff. The first of the new PEG training courses will begin in January/February 2017)

16 staff now trained in emergency medication.

16 staff now trained in the management of seizures

The following training is organised within St. Patricks:

The training and skills required for each staff grade have been identified and there is a comprehensive training schedule now in place to ensure that all staff have the appropriate skills and training to work effectively and safely in their respective areas.

Proposed Timescale: 31/03/2017

