

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Mount Oliver's Centre
Centre ID:	OSV-0003499
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):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 06 December 2016 11:00 To: 06 December 2016 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
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, rights, use of restraint and the management of alleged abuse and safeguarding.

In May 2016 a new board of management had been appointed to St. Patrick's Kilkenny. The board had been in place six months at the time of the inspection. The provider had been given a six month time frame 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.

How we Gathered Evidence.

The inspector visited two of the three residential units that made up the designated

centre. As part of the inspection, the inspector met with residents and staff in each residential unit, the newly appointed team leader for the designated centre, a recently appointed project coordinator, the newly appointed staff training coordinator, the quality and compliance manager and a member of the practice development team for the service.

The inspector spoke to 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 the inspector respected their wishes at all times. The inspector observed residents' interactions with staff, their peers and their environment.

The inspector also reviewed documentation such as personal plans, risk assessments, and assessment of needs, audits and minutes of board of management meetings, change management meetings, sub-committee meetings 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 three residential units.

All previous inspections of this centre have found significant non compliances with regards to the premises. These non compliances have related to the inappropriate lay out of the premises, locked doors and restrictions.

One of the residential units, comprising of three individualised dwellings, referred to as apartments, was undergoing a significant upgrade and refurbishment of facilities. At the time of this inspection it was being reconfigured into premises which could contain four individualised apartments for four residents identified as requiring specific individualised living arrangements. This reconfiguration, when completed, would result in significant improvements in the quality of life of all residents living in the centre. It would result in restrictions in other areas of the centre, such as locked doors, being removed when a resident moved into their new individualised apartment.

The provider intended to implement a full refurbishment and reconfiguration of all three residential units that comprised the centre with a completion date identified as end of December 2016. The inspector reviewed the reconfiguration underway at the time of inspection and found there had been comprehensive planning and attention to the needs of residents incorporated in all planning stages.

Overall Judgment of our Findings.

The inspector found significant 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.

The inspector also noted 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.

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 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

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

Findings:

All previous inspections of this centre by the Health Information and Quality Authority (HIQA), have found that some residents living in parts of the centre experienced a poor quality of life where their civil liberties were impacted on due to the configuration of their living spaces. The inspector assessed the provider's response to the previous actions given to address non compliances and found the provider had made considerable improvements. There were comprehensive, time bound plans in place to address the issues which would have a positive impact for all residents.

Previous inspection reports have documented the lack of free movement some residents experienced in some parts of the centre. The inspector observed this was still the case on this inspection. However, on this inspection the inspector observed a concerted effort by the provider was underway which would comprehensively address this issue resulting in a permanent cessation of such restrictions.

Since the previous inspection the provider and the senior management team for St. Patrick's Centre, Kilkenny had carried out an assessment of need for all residents living in the three residential units that comprised the designated centre. It was identified that significant restrictions in one residential unit were in place for the management of behaviours that challenge presented by a resident living there. It was also determined from this assessment that the resident required a specific living arrangement that would specifically meet their needs.

At the time of inspection, the provider was implementing a schedule of works in one residential unit of the designated centre. This would result in the residential unit

comprising four individualised apartments for residents that required an individualised service. Previously this residential unit comprised of three individualised apartments.

The inspector visited the residential unit and found there were considerable works underway that were in their final stages. When the resident moved into the fourth apartment it would allow for all restrictions in the residential unit to be removed, improving greatly the civil liberties and freedom of residents living in the unit.

This action taken by the provider was a significant step in demonstrating their ability to take appropriate action to address the non compliance relating to restrictions. It would bring about considerable improvement for all residents' quality of life.

Since the previous inspection all bedroom door windows had been covered with an opaque contact material which meant it was no longer possible to look directly into residents' bedrooms. Similarly, bathroom windows had been covered with this material rendering them opaque. This had addressed the non compliance in the short term.

The inspector was encouraged to note that the provider had a schedule of works intended for all residential units comprising the centre which would result in bedroom and bathroom doors being changed to fire compliant doors. This in turn would ensure residents' privacy arrangements to a better standard.

Two residents shared a bedroom in one residential unit of the designated centre. The sharing arrangement did not promote adequate privacy and dignity for residents similar to their peers that lived in the centre who all had individual bedrooms. There were now specific plans in place for how the provider would address the issue. A resident that used the bedroom was scheduled to move to another residential setting resulting in the bedroom becoming a single occupancy space.

On the previous inspection, inspectors had observed some residents spending long periods of time not engaged in any meaningful activities throughout their day. The inspector observed improvements on this inspection.

Despite the restrictions still being in place the inspector observed residents were more engaged in activities which resulted in them leaving the designated centre more often. There were times during the days when the locked doors were unlocked which was now allowing residents more space to mobilise. This was an improvement since the previous inspection.

A resident who had refused to leave their bed with the exception to use the bathroom facilities was now leaving the designated centre to go for walks with staff. They were now also joining their peers to eat their meals and were mobilising around more during the day. This was a significant improvement in this resident's quality of life.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

This inspection found there were improvements with regards to the assessment and identification of residents' social care needs.

There was evidence to indicate allied health professional assessments of residents were taking place. Planned supports would also be in place when residents transferred between services.

As mentioned in Outcome 1 of the report, residents were now engaging in more activities both in and out of the designated centre.

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.

However, 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. There had been some improvement in that personal plans now contained up-to-date information and information no longer in date had been archived.

Residents were receiving allied health professional assessment. 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.

All residents were now receiving a full allied health professional assessment from which their specific social care needs could be identified. This was bolstered by the assessment of needs residents' key workers were implementing.

Some residents preferred their medications to be administered in specific ways for example, some residents liked to take their medication with a yogurt or a specific drink. This information was now being documented in residents' personal plans so as to direct staff carrying out medication administration in the centre. This was an action that had been addressed since the previous inspection.

Overall, the inspector found there were improvements with regards to the assessment, review and drafting of recommendations with regards to residents' social care needs. This improvement appeared to be driven by the introduction of a key working system and staff trained in how to implement key worker systems, for example, assessment of needs for residents and personal planning.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

On the previous inspection, inspectors found two of the three residential units in the centre significantly did not meet the needs of residents that lived there. The inspector observed, particularly in one residential unit, the premises were visibly dirty. Bathing and toileting facilities were particularly dirty and unsanitary in some residential units of the centre. There was a lack of decoration and homelike quality in other residential units.

The two residential units referenced in the opening paragraph of this Outcome were reviewed by the inspector. The inspector found significant improvements had occurred in one of the residential units which, as referred to in Outcome 1 of this report were in the process of a schedule of works which would reconfigure the residential unit.

The inspector observed the works that were underway and found them to be considerable in that the already existing apartments for residents were also being refurbished and reconfigured to provide each resident with a self contained spacious living environment that would provide each of them ample space and home comforts similar to their peers.

Each resident would have their own bedroom, kitchenette, living room space and hall. Colour schemes for the residential unit had been chosen with care and due consideration to the needs and preferences of residents. Community connector staff had chosen colour schemes for residents' apartments in consultation with residents living there or intending to move there. The inspector noted the colour scheme and facilities that had been fitted already were tasteful and modern.

Inspectors reviewed the cleaning audits for the centre and found they were now more robust with staff assigned specific duties to implement when they came on shift in the centre. Overall the inspector did note improved cleanliness in the centre.

While some residents could damage property as part of their behaviours that challenge; it was now been taken into consideration as part of the refurbishment and purchase of equipment and facilities in the centre. Discussions were taking place between the health and safety officer for St Patrick's Kilkenny, architects, builders, the multi-disciplinary team for residents and residents themselves to ensure their homes were being optimised to meet their needs.

When the refurbishment of one of the units was complete a schedule of works was planned to take place in another residential unit of the centre. During this time residents would be supported to use other parts of the centre and/or to go on a short break while some of the works were being completed. The provider intended to reconfigure one of the residential units into three separate living spaces where residents had their own front door and a full refurbishment of the living space.

Overall, the inspector saw evidence that steps were taken by the provider to improve the overall quality of residents' homes. Actions from the previous inspection were being addressed in a comprehensive way.

Judgment:

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):

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

Findings:

The systems to promote the health and safety of residents had improved since the previous inspection of the centre. Some fire containment measures required improvement. However, there was a scheduled plan of works to take place to address

these before the end of 2016. 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.

As was found on the previous inspection the systems for the review of accidents and incidents and identification of personal risks to residents had improved. There were plans in place to introduce an electronic documentation system of incidents for the overall St. Patrick's Centre, Kilkenny designated centres which could be accessed by all staff for the recording of incidents.

The inspector noted incidents were being recorded as they occurred. However, in some instances information with regards to what actions were taken to address the risk were not always informative or adequate. For example, where a resident had fallen the incident was recorded, however, with regards to the review of the incident, 'a falls plan is in place', was the only other information entered. This demonstrated the organisational risk management policy was not being adequately implemented. Incidents recorded did not provide evidence of investigation of adverse incidents or detailed control measures in place to address the risk.

Personal risk assessments were in place for residents. While they had been carried out for risks identified, they 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. Staff spoken with confirmed that they found the document confusing and unclear. Personal risk assessments did not adequately set out in a clear way the control measures that were in place to prevent risks to residents.

Most priority fire safety works for the centre had been completed. For example, the inspector 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. In the residential unit which was being reconfigured at the time of inspection, the provider and health and safety officer had liaised with the local fire safety engineer for Kilkenny County Council and consulted with them their plans and the fire safety works that would be carried out.

The inspector also reviewed the plans which set out compartmentalisation would be included in the schedule of works. Fire alarms would be installed in each apartment and where necessary would be enclosed in a fire safety compliant tamper proof container. This was necessary given the specific needs of residents living in the apartments. Compartmentalisation would also be installed in the attic spaces of the apartments and emergency lighting and escape routes would be available in each apartment also. This was evidence of good planning on part of the provider and a due consideration of their regulatory responsibility to provide appropriate fire safety for residents.

There were still some fire safety works outstanding in the other residential units which would require some residents to move from their residential unit while they were undertaken. As referred to in the opening paragraph, a schedule of work was to take place on a systematic basis which would ensure all residential units comprising the centre were fitted with fire compliant doors and the removal of Perspex windows in

residential units, for example.

Since the previous inspection all staff had now attended level 1 fire safety training, most staff had also participated in level 2 fire safety training which included participation in an actual evacuation of the centre overseen by an external fire safety consultant.

The inspector also reviewed fire evacuation drills for the residential unit where key padded locked doors were in place. Documentation maintained in the centre indicated they had been implemented. The most recent drill had occurred in August 2016 and while the regulatory requirement for at least two drills per year had occurred the provider and person in charge were required to carry out a further drill in light of the transfer of residents within the residential units of the centre and the reconfiguration of the premises.

On the previous inspection the inspector had been concerned with regards to the inadequate prevention and management of falls in the centre. At the time there was no falls management policy to direct staff in the appropriate systematic management and prevention of such incidents. Some residents had received serious injuries from falls in the centre.

Since then there had been a reduction in the number of falls that had occurred in the centre. The quality and compliance manager also provided evidence to the inspector that a 'falls pathway' management strategy had been developed and would be implemented in the service starting in key areas where falls had been identified as a risk. This was evidence that the provider was implementing a system change in the management of this risk type within the organisation and in the centre.

Infection control systems in the centre had previously been inadequate and significant to such a nature that an immediate action had been issued by inspectors to improve the cleanliness of the designated centre.

On this inspection, mentioned in Outcome 6 also, the inspector noted there had been an improvement in the overall cleanliness of the residential units that comprised the centre. Following the previous inspection, the director of services had contracted a company to carry out a deep clean of the centre. Delegated infection control management and cleanliness management duties were in place. The health and safety officer had also implemented some control measures to ensure more robust infection control measures in the centre.

Hand washing, drying and bathing facilities for residents and staff had improved and appeared to be of a better standard than had been found previously. Further improvements would occur when reconfiguration of the premises had been completed.

Judgment:

Substantially Compliant

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

There had been improvements in the detection, management and response to allegations of abuse. There was also evidence of improvement in staff training in the management of behaviours that challenge and de-escalation techniques.

A number of designated persons for the organisation had been trained. There was evidence of staff reporting potential safeguarding issues such as unexplained bruising, for example with preliminary screening of allegations and more consistent follow up to allegations of abuse than there had been previously. This was evidence of designated persons implementing the national vulnerable adult safeguarding policy in the centre.

The Chief Inspector had received a significant number of notifications of alleged abuse in the months since the previous inspection. These notifications in the main related to incidents of peer-to-peer aggression or assault and unexplained bruises or injuries to residents. In the majority of incidents notified it was reported that unexplained bruising or injuries were as a result of probable self-injurious behaviour, whereby residents inflicted some of the harm to themselves. Peer-to-peer incidents were also attributed to inadequate management of behaviours that challenge.

While the inspector was assured by the increased identification of incidents of this nature as abuse there were inadequate systems in place to address these incidents through the provision of behaviour support management and intervention for residents within a positive behaviour support framework.

Staff training indicated all staff had received training in the management of behaviours that challenge and de-escalation techniques. The director of services explained to the inspector there were plans in place to train up to three specific staff within the organisation in a specific behaviour support framework and become trainers to other staff subsequently throughout the service. This was a positive step in ensuring more robust, evidence based systems throughout the designated centres for the development of behaviour support planning. This was due to take place in 2017.

Behaviour support plans were in place for some residents that required them but they were not comprehensive in nature. They did not outline any assessment to ascertain the triggers that caused residents to engage in behaviours that challenge. Similarly, where

recommendations were in place they were not comprehensive and did not reflect a holistic plan of care to support residents which in turn would lessen the frequency and intensity of behaviours that challenge they exhibited, such as self harm or peer-to-peer assaults. Behaviour support planning lacked evidence of allied health professional recommendations or review.

With the reconfiguration of the premises and the internal transfer of some residents to more suitable living arrangements restraints in place, such as locked doors, wardrobes and placing of residents' belongings behind Perspex would reduce and ultimately be eliminated.

Judgment:

Substantially Compliant

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:

Since the previous inspection some improvements had begun with regards to ensuring residents' healthcare needs were assessed within an allied health professional framework and there evidence to indicate the provider was actively trying to provide less institutional practices with regards to residents' nutrition and meal preparation. On this inspection the inspector reviewed the provider's response to the previous actions in relation to this to assess their ability to bring about improved systems in the management of residents healthcare and nutritional needs.

Previously the inspector had found there was a lack of comprehensive evidence based nursing/allied health care professional assessment for residents that presented with healthcare issues which in this instance was most residents living in the centre.

To address this the provider and senior management team for St. Patrick's Centre Kilkenny, had devised a clinical review pathway which would be implemented for all residents in the centre. This comprised of a number of steps to be carried out which would ensure resident's healthcare and nutritional needs would be assessed on an ongoing basis.

A multi-disciplinary review pathway for residents had been devised since the previous inspection. The inspector reviewed the system. A description of the new assessment pathway is set out below.

Allied health professionals for the service meet weekly. Residents' healthcare and nutritional needs are discussed during these meetings and action plans are drawn up following discussion by the allied health professional group attending the meetings.

Each designated centre in the service is allocated a discussion slot at least every five weeks and the meetings are also attended by the person in charge for the relevant designated centre. The person in charge subsequently brings back an action plan for each resident discussed and meets with the residents' key worker at a clinical 'in house' meeting.

The clinical 'in house' meeting for each resident is scheduled to occur twice monthly. The person in charge and the resident's key worker staff attend the meeting. During this meeting the person in charge and key worker follow-up on actions from the allied health professional meetings for the resident. They also discuss any current issues for the resident which may result in a specific referral to allied health professionals for review and assessment if necessary. Healthcare appointments the resident must attend are planned during these meetings and healthcare plans for residents are reviewed and updated where necessary.

Furthermore, each resident in the designated centre will now have an annual clinical review multi-disciplinary team meeting. The details of the meeting are documented and a summary file is added to the resident's clinical file section of their personal plan. Should an urgent review of a resident be necessary a senior manager calls a case conference meeting which is attended by relevant clinicians, the person in charge and the resident's key worker.

This process had begun in October 2016. While not all residents had received a review through this new clinical assessment pathway, the inspector found this revised systematic way of assessing residents' healthcare needs provided adequate assurances that the provider had introduced a more robust and comprehensive way of assessing residents' needs and ensuring appropriate support planning and interventions were in place for them.

The newly established practice development group had begun to instigate a number of processes and pathways for the management of specific healthcare risks for residents, for example management of falls, head injuries and epilepsy management.

A practice development update for the service dated 17 November 2016 indicated residents living in the service would be accessing a local dentist for their dental treatment. All residents' key workers were allocated the responsibility to register residents with a local dentist for a service most appropriate to them. The key workers would also create an individual dental plan for the resident they were responsible for. The inspector noted this had begun with the presence of dental care support plans in some residents' files.

A head injury management procedure had been drafted since the previous inspection. This was a detailed, descriptive document which guided staff in evidence based management and support of a resident that had received a head injury following a fall

or seizure associated with epilepsy.

Since the previous inspection the practice development unit had also developed an epilepsy risk assessment which incorporated a checklist. The checklist is completed prior to bringing a resident out on community based activities. This was an improvement in epilepsy management in the service. Previously the inspector had found residents with epilepsy and associated seizures did not leave the centre only if they were accompanied by a nurse which meant many of them did not leave the centre for months on end.

Also, a falls management and prevention pathway had been developed which would guide staff in the appropriate management of falls. This was an important development in particular for this designated centre. On the previous inspection the inspector had significant concerns in relation to the lack of a coherent, organised management of falls in the centre. Since the previous inspection there had been a number of falls however, their frequency and severity had reduced. Prevention and management of falls would improve more when the falls management pathway was fully implemented in the centre.

Institutional practice regarding preparation and serving of residents' meals was observed during the inspection. Residents' meals were prepared in a centralised kitchen away from the centre and brought to the unit in heated containers. Residents did not participate in the preparation of meals in the centre and could not experience the anticipation of a meal which would encourage them to have an appetite for the meal.

The inspector reviewed the management of residents' nutritional needs on this inspection. As was found on the previous inspection, the inspector still found institutional practices with regards to food preparation. However, the provider had made a number of changes within the organisation in an effort to address this long standing institutional practice.

Residents evening meals were cooked in the designated centre at least twice a week. Residents could now have a choice for their breakfast, for example the option of a freshly cooked breakfast was now an option. The inspector was very encouraged by this. A resident that had refused to leave their bedroom to eat their meals with other residents now enjoyed a cooked breakfast in the morning and was sitting having their other meals with their peers more often.

In the residential unit comprising the four individualised apartments, cooking facilities were being fitted. The inspector reviewed the facilities during the inspection and noted they had also been reviewed by an environmental health officer, health and safety manager and fire safety engineer to ensure they met appropriate standards for safety and food preparation.

As the refurbishment of the other residential units comprising the designated centre was ongoing plans to upgrade and refurbish the kitchen areas of each residential unit had been factored in. This would provide the facilities and greater opportunities for residents' meals to be prepared and cooked in the designated centre. Something residents indicated they really enjoyed.

The provider had instigated a number of systematic changes which the inspector was

now seeing in action in the designated centre and having a positive impact on residents.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

The previous inspection of this centre had found this Outcome compliant. 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.

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 local pharmacist had been contacted and would now 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 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 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

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

Findings:

The statement of purpose for the designated centre did not accurately reflect the service.

It did not set out accurately the following:

Whole time equivalent numbers for staffing and management of the centre.

The change in governance arrangements in the centre.

The reconfiguration of the premises and a description of room sizes for the reconfigured areas.

This is not an exhaustive list.

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

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 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 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 1 (Rights, Dignity and Consultation), Outcome 5 (Social Care Needs), Outcome 8 (Safeguarding and Safety), Outcome 11 Healthcare needs and Outcome 12 Medication Management, for example.

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 since the previous inspection. The most recent carried out by the provider nominee and director of services dated October 2016. This audit had identified a number of key areas that required improvements, for example, inadequate premises, social care planning and documentation and inadequate shift planning for staff when they reported for duty in the designated centre.

Systems to assess the quality and safety of care at the centre level had improved greatly 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:

Compliant

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:

The inspector 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.

The inspector 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. She had also compiled a training needs analysis for staff working with each designated centre and also for each residential unit that comprised the designated centres in the service.

From this training needs analysis the staff training co-ordinator had established a comprehensive staff training schedule with a schedule devised for the rest of 2016 and 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.

A number of nursing staff would be trained in phlebotomy, which is the practice of taking blood samples, for example. Other staff would be trained in the management of behaviours that challenge and management of percutaneous endoscopic gastrostomy nutrition, (PEG). These staff would make up part of the overall improved training systems within the service.

This was a significant systematic improvement initiative by the provider to address previous found non compliances with regards to inadequate staff training, resulting in

improved outcomes for residents by having competent, trained staff to meet their needs.

Supervision schedules had also been devised since the previous inspection. The inspector reviewed a sample of supervision schedules that had been developed which identified specific staff and dates for when their supervision meetings would occur. To bolster this process all managers would undergo supervision training provided by the service starting 16 January 2017 and ongoing until March 2017.

An initiative which had been implemented since the previous inspection was key worker training. This had brought about a significant improvement in the overall quality of personal planning and quality of life improvements for residents. All staff working in the service were now required to undergo key worker training.

The training comprised how to carry an assessment of need for residents, the development of personal planning for residents, the type of detail required in personal planning. The training also included topics such as social role valorization, residents' rights, management of residents' finances and other topics.

However, the most significant improvement this training had brought about was staff accountability for the implementation of residents' social care interventions and responsibility for driving improvements for residents. Staff feedback about the training was very positive and staff that had undergone the training said they had a greater understanding of importance of their role in supporting residents they worked with which in turn provided them with motivation and greater enthusiasm in their jobs.

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:

Ann-Marie O'Neill
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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-0003499
Date of Inspection:	06 December 2016
Date of response:	27 January 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 07: Health and Safety and Risk Management

Theme: Effective Services

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

The organisational risk management policy was not being adequately implemented. Incidents recorded did not provide evidence of investigation of adverse incidents or detailed control measures in place to address the risk.

Personal risk assessments did not adequately set out in a clear way the control

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

measures that were in place to prevent risks to residents.

1. Action Required:

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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).
- Centre specific risk assessments are currently being conducted and will be included in the risk register when completed. The current risk assessment form and process has been revised. This has made it more user friendly. Copy attached. The development of risk assessments thus ensuring: that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered and measures are in place.
- New Electronic Incident Reporting System will be piloted in the centre the week commencing 23/1/17 and expected to be fully operational soon after.

Proposed Timescale: 28/02/2017

Theme: Effective Services

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

There were still some fire safety works outstanding.

2. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- Fire works are ongoing. Due for completion March 2017.
- A health and safety statement is in place. Displayed in communal space.
- The premises are free from any dangers that could cause injury. Management and staff are continuing to refer and monitor daily H&S Checklists, Fire check reports, monitor accident and incident reports. Incident and accidents be audited quarterly.

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:

Behaviour support plans were in place for some residents that required them but they were not comprehensive in nature.

Behaviour support planning lacked evidence of allied health professional recommendations or review.

3. 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.
- 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.
- 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

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Not all residents had received a clinical assessment of healthcare needs yet.

4. 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 organization is now moving away from the A1 Health list. All A1 health lists are in place across the Sector and up to date. The new "Ok Health Check" will be completed by the assigned Keyworker with support from a registered nurse for all residents.
- All residents will avail as a minimum a full annual medical review.

Proposed Timescale: 24/04/2017

Theme: Health and Development

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

There were still ongoing institutional practices with regards to residents' nutrition

5. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

- Commenced purchasing staple cupboard ingredients on a daily basis.
- Residents prepare breakfasts with choices on a daily basis.
- Three evening meals per week are now prepared by staff and residents.

Proposed Timescale: Completed 6/1/17

Proposed Timescale: 06/01/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose for the designated centre did not accurately reflect the service.

6. Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

- Statement of purpose currently being reviewed and updated to clearly and accurately demonstrate scope of service and staffing levels.

Proposed Timescale: 01/04/2017

