**Health Information and Quality Authority
Regulation Directorate**

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

Centre name:	St Vincent's Centre
Centre ID:	OSV-0005623
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jackie Daly
Lead inspector:	Kieran Murphy
Support inspector(s):	Geraldine Ryan
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	21

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 March 2017 16:00	29 March 2017 17:00
20 April 2017 09:30	20 April 2017 13:00

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 14: Governance and Management

Summary of findings from this inspection

Background to the inspection:

This was the fifth inspection of this designated centre by the Health Information and Quality Authority (HIQA).

During the previous inspection undertaken by HIQA undertaken on the 20 February 2017 and 24 March 2017, all five outcomes inspected against were at the level of major non-compliance; social care needs (outcome 5); fire safety (outcome 7); healthcare needs (outcome 11); governance and management (outcome14) and resources (outcome 16). Following that inspection, representatives of St Vincent's centre were requested to meet with HIQA on 14 March 2017. At that meeting a notice of decision to refuse the centre's application to register the centre, on the grounds specified in Section 50(1) (a) and (b) of the Health Act 2007, was issued on 14 March 2017. A notice of decision to cancel the centre's registration, on the grounds specified in Section 51(2)(b) and (c)(i) of the Health Act 2007, was also issued on 14 March 2017.

On the 29 March 2017, the registration of the centre was cancelled under the Health Act 2007. Following this cancellation of the centre's registration as a designated centre, the Health Service Executive (HSE), in accordance with Section 64(4) of the Health Act 2007 took charge of the centre and was to carry on its business with the HSE as the centre's registered provider.

This fifth inspection took place over two days; 29 March 2017 and 20 April 2017. Day one; 29 March 2017, of inspection was undertaken to ensure that the HSE, the registered provider, was in place in the centre. Day two; 20 April 2017, was undertaken to ensure that the quality and safety of care provided to residents was of a sufficient standard following the HSE taking charge of the centre as the registered provider.

Description of the service:
The centre was a congregated setting which had the capacity to provide residential care services for 60 women residents. On the date of inspection, 39 residents were living in the centre. Many of the residents had been living in this centre for a significant period of time.

How we gathered our evidence:
Inspectors met and spoke with approximately 15 of the residents. Inspectors also met with the interim person in charge of the centre and staff. Inspectors observed staff practices and interactions with residents and reviewed residents' personal plans.

Overall judgment of our findings:
Notwithstanding matters that were being discussed at a senior and strategic level concerning the transitioning of the service to another provider, the current management arrangements did not ensure that the service delivered safe and quality care to the residents accommodated in the centre, and on a daily basis. Significant and ongoing non compliances were identified in relation to the care and safety of the residents. These findings were presented to the interim person in charge throughout, and at the end of the inspection.
Of the five outcomes inspected, all five were judged as a major non-compliance.
These matters particularly pertained to:
• risk management; in particular fire safety (outcome 7). A significant fire incident had occurred in the centre on the 9 April 2017 and a number of issues had been identified for the provider to address in order to ensure that a similar incident did not occur again. Some, but not all, of the issues had been addressed. In addition, the effectiveness of fire doors to prevent the spread of smoke in the event of fire was not demonstrated.
• absence of a comprehensive multidisciplinary assessment of needs; particularly for identified residents with co-complex conditions (outcome 5)
• no oversight of externally contracted services provided for one resident whose discharge was being supported by an external contractor. The external contractor was appointed by the HSE to provide a new service to the resident. There was no clarity on Garda Síochána (police) vetting of staff, status of staff training or on the use of social media for staff to staff communication (outcome 5)
• appropriate safeguarding measures were not in place; specialist behaviour support was not available to provide clear guidance to staff on how a resident was to be supported, and as required (outcome 8)
• inadequate care planning for residents; with an emphasis of the absence of information in care plans to guide staff, notably agency staff (outcome 11)
• governance and management arrangements in the centre (outcome 14).

Furthermore, clarity was sought in relation to the status of two persons who lived in

a house adjacent to the centre and who received care and support from staff in the centre.

Subsequently, due to the seriousness of the findings and concerns regarding the care and safety of the residents, matters were escalated on the day of the inspection to the office of the Chief Inspector; following which, the instruction was issued to convene a meeting with the provider to seek assurances that residents were safe. This meeting was convened on Tuesday 25 April 2017 where assurances were sought in relation to safe care and welfare of the residents accommodated in the centre.

The reasons for these findings are explained under each outcome in the report and the regulations which 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:
Comprehensive multidisciplinary assessment of each resident’s needs had not been undertaken. Of particular note, residents with co-complex care needs had not yet been assessed by a multidisciplinary team.

Inspectors reviewed a sample of residents’ healthcare plans. There was evidence that nursing notes were recorded daily and there was evidence that residents’ weights and other clinical observations were being recorded. It was noted that clinical risk assessments were being undertaken, for example in relation to falls risk, skin integrity, malnutrition universal screening (MUST) and continence issues.

Each resident had a “summary profile” that outlined any relevant healthcare issue. Inspectors noted that many residents had complex healthcare needs but a multidisciplinary assessment of needs had been not been undertaken for all residents. In addition, there was no plan in place to collectively engage all appropriate healthcare professionals in a review of the resident as required by the regulations.

The person in charge outlined that one of the residents was inappropriately placed in the centre. It was planned that this resident would be discharged from the centre and would live in house based in the community. Currently this discharge was being supported by an independent company who had been contracted by the HSE to provide a new service to the resident. However, the person in charge confirmed that she had no oversight of or information on the staff provided by the externally contracts and in particular, in relation to Garda vetting, staff training and the usage of social media for

staff communication.

The person in charge also outlined that the designated centre provided care and support to two persons who lived in a house adjacent to the centre. The person in charge undertook to confirm with HIQA if the two persons were deemed to be living in the designated centre.

The person in charge outlined that a coordinator of practice development had commenced in April 2017. This role involved reviewing of nursing key performance indicators, undertaking audits of care and education staff on clinical policies, procedures and guidelines.

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

Findings:
A single aspect of this outcome was reviewed on this inspection; fire safety. The arrangements in relation to fire safety management systems were not effective to ensure that the residents were safe.

It is a requirement of the regulations that all serious adverse incidents, including if a fire took place, are reported to HIQA. It was reported that a fire had occurred in the "smoking room" of the centre on the 9 April 2017. This incident required a response from the emergency services who outlined a number of significant issues that required to be addressed by St Vincent's centre to ensure that a similar incident did not occur again. In response, the person in charge had undertaken to address some of the issues identified including removal of debris blocking emergency access to the centre and the replacement of fire equipment. However, not all matters had been addressed; for example; the location of and the use of the smoking room had not been addressed at the time of inspection; a review had not been completed of the telephone coverage throughout the building in the event of an emergency.
Following the fire incident, the person in charge had arranged for a health and safety review of the premises and informed inspectors that this review would be completed by the second day of inspection.

Inspectors observed that fire doors were available throughout the main building.

However, the effectiveness of these doors to prevent the spread of fire was not demonstrated. In particular, the fire doors on the corridors had large gaps; and all bedroom fire doors had keyholes in them. These gaps meant that smoke could get through in the event of fire. The person in charge also outlined that a review of all the fire safety arrangements in the premises had taken place in February 2017 and by a suitably qualified and experienced expert in fire safety. On the date of this inspection the report was not yet available.

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:
Appropriate safeguarding measures for residents were not in place. In addition, specialist behaviour support was not available to provide clear guidance to staff on how a resident was to be supported, as required.

The inspectors saw "post-it" notes being used in some residents' healthcare files, one of which had personal information on it; the resident's national intellectual disability database number. This could not guarantee the confidentiality of residents' personal information. In addition, there was another "post-it" note on a resident's file in relation to "staying safe". The important information on this note had not been included in the safeguarding care plan for this resident.

There was evidence of a lack of clarity around the reporting of allegations of abuse. For example, one resident had been identified as requiring a safeguarding plan. However, this safeguarding plan had had not been completed. There was a further "post-it" note in this resident's healthcare record outlining that "a risk assessment for allegations (was) complete". However, this risk assessment was not in the resident's healthcare file.

One resident had a risk assessment relating to "challenging behaviour", completed in March 2017 and the hazard was rated as a "high risk". As an additional control, it was

outlined that the resident required additional support services. However, there was no evidence of a referral having been made for these additional support services.

In the resident healthcare records, where a resident required positive behavioural support strategies, these had been developed, without input, from specialists in behaviour support. As an example, one plan described as "an intervention plan" for a specific issue had been dated. However, it was not clear who had prepared or authorised the intervention.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
There was evidence that some residents' assessed healthcare needs were not being met. In particular, the service could not meet the assessed needs of all residents, particularly residents with dementia. Residents' care plans did not contain information to guide and inform staff, particularly agency staff. A resident with decreasing ability to communicate had not been assessed by a speech and language therapist; this matter was highlighted in previous inspections.

In the sample of residents' healthcare files reviewed, each resident had access to a general practitioner (GP). There was evidence in the healthcare records that the GP was regularly reviewing residents' health needs and as required. There was evidence that residents were supported to attend appointments in acute general hospitals and had been referred to consultant specialists if required. There was also evidence of good access to specialist care in psychiatry. However, a resident with decreasing ability to communicate had not been assessed by a speech and language therapist.

The person in charge confirmed that currently there was a heavy reliance on agency staff. However, inspectors noted that the information in the care plans was inadequate to guide staff and in particular agency staff. It was difficult to ascertain appropriate information from a sample of the care plans reviewed by inspectors. For example, one resident had a care plan for epilepsy and for agitation. However, there was inconsistency of information in both care plans so that a seizure may not have been accurately recognised.

It was noted that one resident with epilepsy experienced three different types of seizures and on a frequent basis. The direction on the care plan guided staff regarding the administration of medication in the event of a seizure. However, it was not clear if the medication was to be administered in the event of all types of seizures. Staff were knowledgeable with regard to when the medication was administered. However, the information in the care plan was not clear to guide staff, particularly agency staff, on what to do in the event that the resident experienced a particular type of seizure. Furthermore, there was evidence that not all seizure activity was recorded; for example the nursing notes indicated that the resident exhibited seizure on the 4 April 2017 and 7 April 2017. However, this significant information was not recorded on the seizure activity record for this resident. The staff on duty concurred with this.

One resident's healthcare record had a care plan relating to dementia. However, there was no evidence of input from specialists in dementia to guide appropriate care, therapies and activities to promote quality of life and well being for this resident. On review, the care plan contained very little guidance on activities that would best capture the interests or meet the needs of the resident. This matter had been highlighted in previous inspections.
In addition, staff had not yet received training on how to best support a resident with dementia. The person in charge stated that training in this matter was scheduled for three staff in May 2017.

The nursing notes reviewed evidenced that a resident exhibited behaviours that challenged. However, the resident's behaviour record was not updated to reflect the incidents and the resident's care plan in relation to this matter was not up to date to guide staff, particularly agency staff.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The management systems were ineffective to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored. During the inspection, clear deficiencies were identified in areas including:
fire safety management; absence of a comprehensive multidisciplinary assessment of needs for residents and inadequate care planning for residents. Furthermore, notwithstanding other matters that were being discussed at a senior and strategic level concerning the transitioning of the service to another provider, the current management arrangements did not ensure that the service delivered safe and quality care to the residents accommodated in the centre and on a daily basis.

From 29 March 2017, the registration of the centre was cancelled under the Health Act 2007. Following this cancellation of the centre's registration as a designated centre, the Health Service Executive (HSE), in accordance with Section 64(4) of the Health Act 2007 took charge of the centre and was to carry on its business as if the designated centre were registered with the HSE as its registered provider.

There was an interim person in charge who had commenced on 5 December 2016 on secondment from the HSE. The person in charge outlined that she was supported by a management group that included senior members of the disability services of the HSE. This group also included members from maintenance, finance and communications in the HSE. Inspectors were told by the person in charge that this management group met weekly.

The person in charge outlined that in addition to her role as person in charge she also had day-to-day responsibility for operational management. An interim acting coordinator of services had been appointed to oversee this role and was due to take up post on 12 May 2017. However, the management arrangements as configured at the time of inspection did not provide sufficient oversight of residents' clinical care, including for example, care planning for residents' healthcare needs and audit of clinical practices or medication management.

The person in charge outlined that the HSE proposed to transfer the management and operation of the centre to another provider of services. However, on this inspection the negotiations with the other service provider were still ongoing and there was no agreement in place.

HIQA had been notified of alleged financial irregularities, potentially involving residents' finances. A final report was due to be issued and inspectors requested a copy of this report to be sent to HIQA once available.

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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005623
Date of Inspection:	29 March 2017 and 20 April 2017
Date of response:	31 May 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A multidisciplinary assessment of needs had been not been undertaken for all residents and there was no plan in place to collectively engage all appropriate healthcare professionals in a review of the resident as required by the regulations.

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

Please state the actions you have taken or are planning to take:
Multi-disciplinary Team meeting to commence in 17th May 2017. At this meeting a schedule will be agreed to meet on a 6 weekly basis. Complex cases will be prioritised for each meeting. The priorities will be determined by referral to all MDT specialist areas i.e. referral across the full team and then worked back from there.
17th May 2017. Deirdre Carr

Audit of 39 care plans currently being undertaken and action plans developed to ensure all MDT referrals are being made. Follow up care plans, where indicated, are being written by the staff nurses with guidance from the Practice Development Coordinator (PDC). Four care plans are being audited each week and a schedule has been prepared prioritising residents presenting with assessed needs. The audit commenced on 8th May and is expected to be completed by 14th July 2017.
14th July 2017. Grace Hourihan, PDC

The PDC and CNM1s will meet weekly to discuss the outcomes of the audits and ensure that timely MDT referrals are made and followed up.
Ongoing from 16th May 2017. Grace Hourihan and CNM1s

Proposed Timescale: 14/07/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident's discharge was being supported by an independent company who had been contracted by the HSE to provide a new service to the resident. However, there was no oversight of this externally contracted services. In particular there no documentation provided to the person in charge in relation to police vetting of staff of this other service, status of staff training and the use of social media for staff of the other service to communicate.

2. Action Required:
Under Regulation 25 (4) (b) you are required to: Discharge residents from the designated centre in a planned and safe manner.

Please state the actions you have taken or are planning to take:
This independent company have provided Garda vetting and qualifications for all staff providing a service to this resident. Complete. Deirdre Carr

Staff Communication policy for this independent company has been requested. Awaiting same.
30/05/2017. Deirdre Carr

The company has been informed we expect appropriate communication mechanisms to

be used as set out in the HSE Communications Policy.
Complete. Deirdre Carr

This independent company are providing a daily update of activities undertaken with the resident.
On-going. Deirdre Carr

This independent company have been instructed that their staff are to inform the centre in writing on the day of any incidents that occur whilst working with the resident.
Complete. Deirdre Carr

An independent living plan is currently being reviewed for this resident. A submission will need to be made in regards to funding for this proposal to the Head of Social Care Services.
Submission to be made by 31st May 2017. Jackie Daly and Deirdre Carr.

With regards to the house in Peacock Row, the legal position around tenancy of the address is being clarified. SVC will continue to provide outreach support to this house until the matter is clarified.
16th June 2017. Jackie Daly and Deirdre Carr.

Proposed Timescale: 16/06/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The effectiveness of fire doors to prevent the spread of fire was not demonstrated. In particular, the fire doors on the corridors between blocks had large gaps; and all bedroom fire doors had keyholes in them. These gaps meant that smoke could get through in the event of fire.

3. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
FCC Fire Safety Consultants have undertaken a risk assessment of the building. One red risk notified in relation to a fire alarm and immediate steps are underway to eliminate the red risk in this report. 19th May 2017. Estates in conjunction with Jackie Daly

Colin Yelland Architects assessment of structural building in compliance with Fire Safety underway. 31st May 2017. Estates in conjunction with Jackie Daly

HSE Estates Department arranging for fire and safety expert to reconcile risk and structural analysis and provide an integrated report setting out risks, works required,

costs etc. 22nd May 2017. HSE Estates Department

Proposed Timescale: 31/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements in relation to fire safety management systems were not effective.

4. 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:
Monitoring station in place and linked to CHUBB. Complete. Deirdre Carr

Increased staff numbers at night duty. 2 additional care assistants. Complete. Deirdre Carr

Fire System serviced and maintained. Complete. Deirdre Carr/Jackie Daly

Atlantic Fire Company have reviewed the fire extinguishers and are going to replace any fire extinguishers and blankets that are not compliant with standards. Complete. Deirdre Carr/ Jackie Daly

Internal Smoking room has been closed for use. Complete. Deirdre Carr

Assessment of residents' smoking area has been undertaken with SOP established for residents who use the external smoking area. External smoking area has fire blanket, bucket with sand for extinguishing cigarettes and fire aprons are available. Each resident who smokes has been assessed regarding the supervision they require while smoking. Complete. Deirdre Carr

On a Daily basis – new agency staff are provided with a tour of the centre, shown the fire exits and equipment. They are provided a fire safety procedures, colour coded list of resident's needs, red (need help), yellow (need a small bit of help) and green (no help required). They are also shown each resident's PEEP which is located at the back of the resident's door. This checklist is signed by the agency staff member and the resident staff member giving the induction. Complete. Deirdre Carr

The Director of Nursing is visiting the centre at weekends to check that this is in operation. Complete. Deirdre Carr

Management Structure being put in place to share the on-call rota for the centre at weekends. 31st May 2017. Jackie Daly

The staff roster in Santa Barbara has been changed from staff providing "sleep over" to

waking cover at night time. 8th May 2017. Jackie Daly and Deirdre Carr.

The HSE undertakes to submit any and all fire safety responses to HIQA as they become available. On-going. Jackie Daly

Proposed Timescale: 31/05/2017

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:
Specialist behaviour support was not available to provide clear guidance to staff on how a resident was to be supported, as required.

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

Please state the actions you have taken or are planning to take:
Referral made to An Cuan for Specialist Behaviour Support for five residents. On-going. Deirdre Carr

Specialist Behaviour Support Training to be obtained for Staff in SVC through An Cuan. Sessions to have commenced by 31st July 2017. Deirdre Carr

Nursing Documentation and notes in resident file – communication has taken place with all nursing staff to advice of the documentation process and no post-it notes to be put into the file. Confidentiality and data protection explained to the staff. 3rd May 2015 – action complete. Deirdre Carr

GP is requested to refer any resident that requires assessment and referral to psychiatric and / behaviour support services. Complete. Staff Nurses

ID Dementia Assessment Tool to be introduced to SVC. (The Adaptive Behaviour Questionnaire and Dementia Screening Questionnaire for Individuals with Intellectual Disability). 31st July 2017. Grace Hourihan

Training will be provided to staff on the use of the ID Dementia Assessment Tool. 16th May 2017. Grace Hourihan

Two staff nurses are attending the 'Enabling and Enhancing Dementia Care' course provided by the Centre of Nurse Education at the Mercy University Hospital. June 14th 2017. Deirdre Carr

A request has been made to the national office that the National Assessment Tool for profiling residents would be undertaken in the centre. The National office has agreed to undertake same. Dates are to be confirmed. Awaiting Date from the National Office. Jackie Daly

Proposed Timescale: 31/07/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence of a lack of clarity around the reporting of allegations of abuse. For example, one resident had been identified as requiring a safeguarding plan. However, this safeguarding plan had had not been completed. There was a further "post-it" note in this resident's healthcare record outlining that "a risk assessment for allegations (was) complete". However, this risk assessment was not in the resident's healthcare file.

6. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
Staff reminded of the Safeguarding Policy. 26th April and 3rd May 2017. Deirdre Carr

Both interim and final Safeguarding plans where they exist will be stored in the residents' file. Staff will be informed of same as appropriate and have been advised that this is the procedure in St Vincent's centre. 26th April and 3rd May – action complete. Deirdre Carr

Risk assessments have been carried out on residents who may make false allegations and / or cause injury to staff and safeguarding plans have been put in place. Complete. Deirdre Carr

Residents whose behaviour can put themselves or others at risk have been referred to specialist behaviour services for Behaviour Support Plans. Complete. Deirdre Carr

A Clinical Nurse Manager 3 from another service provider who has expertise in dementia and intellectual disability will provide training for staff in July. 03 July 2017. Grace Hourigan

The Centre complies with the National Safeguarding Policy of the HSE for reporting and investigating any allegation or suspicion of abuse. Training for staff was carried out in March 2017 and further training dates are being arranged. Ongoing. Deirdre Carr

Staff have received written instructions on how to deal with an allegation of abuse and are signing that they have read and will adhere to the procedure. All new or agency

staff will receive the same document. Ongoing. Deirdre Carr

Proposed Timescale: 03/07/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident with decreasing ability to communicate had not been assessed by a speech and language therapist.

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

Please state the actions you have taken or are planning to take:
Assessment Tool for communication within ID services currently has been obtained from another service provider. It has been introduced to SVC and staff have been trained on the use of the tool. To date 26 assessments have been carried out on residents.
The assessment tool will inform the number of residents that have to be referred to a specialist SALT. 31st May 2017. Grace Hourihan

Proposed Timescale: 31/05/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' care plans did not contain information to guide and inform staff, particularly agency staff.

8. 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:
Hand over document has been developed to provide staff with all necessary information of the residents care needs and activities. It is currently being revised to document the clinical elements of care and safety issues. This document will be available to all staff in each nurses' station .19th May 2017. Grace Hourihan, CNM1s and staff nurses

A summary Health and Wellbeing record for each resident is currently being prepared and will be available for all nursing staff on the drug trolleys. 31st May 2017. Grace

Hourihan, CNM1s and staff nurses

ISBAR Communication Process to be introduced for verbal nursing handover meeting to ensure clear concise handover. 16th May 2017. Grace Hourihan

Daily report provided to the Director of Nursing by the CNM1/Staff Nurse, outlining the 24 hour activities and issues. Commenced and on-going. Deirdre Carr

Daily meeting between the Director of Nursing and Practice Development Co-ordinator: purpose of meeting to review incident forms and issues arising from the 24 hour report provided by staff in main centre and Santa Barbara and to develop action plans for follow up by staff. Commenced and on-going. Deirdre Carr and Grace Hourihan

In addition to the shift handovers a daily meeting of staff will take place at 12md to review care and activities for residents, Commenced and ongoing Grace Hourihan and all care staff

New Care Plans and Person Centred Plans (PCPs) for residents are to be introduced from 15th May. An experienced RMHN is working with the PDC to introduce the plans and provide education for staff who will be completing the plans in conjunction with residents. 31st July 2017. Deirdre Carr

Roster for the Centre prepared a month in advance and requirements identified to the agency earlier, this facilitates consistency in staff working in the centre. Commenced and is on-going. Deirdre Carr

Social Care Workers and Healthcare Assistants to receive training on epilepsy and the administration of Buccal Midazolam. 15th May 2017. Deirdre Carr

Day and night routines for staff have been written to inform staff and agency staff. Completed. Grace Hourihan and staff

Proposed Timescale: 31/07/2017

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:
Management systems were ineffective to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored. During the inspection clear deficiencies were identified in areas including: fire safety management; absence of a comprehensive multidisciplinary assessment of needs and inadequate care planning for residents.

9. 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:
The action outlined above will be implemented to ensure a safe and appropriate service for the residents in SVC. Additionally the following actions are being implemented.

Management on-call system currently being prepared to ensure sufficient support is available to the centre out of hours. 31st May 2017. Jackie Daly and Deirdre Carr.

Management are actively participating in transitioning the services to another provider. On-going. HSE management team.

Transitioning Working Group set up with supports of finance, HR, communication, maintenance and management.
Operational Aspects of the centre are worked through this group.
Weekly Meetings. Jackie Daly

An experienced RNMH has been assigned for an initial period of 1 day per week for 6 weeks to assist the management team implement appropriate care plans for the residents.
15th May 2017 for 6 weeks. Jackie Daly and Deirdre Carr.

Current Management Structure:
• Director of Nursing
• Practice Development coordinator
• Two CNM1s as PPIM
• Office Manager as PPIM
• Experienced RNMH for support for 1 day per week for six weeks.
• A Director of Services commenced in the centre on the 12th May 2017

Proposed Timescale: 31/05/2017