

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Greenfields
Centre ID:	OSV-0001893
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Saint Patrick's Centre (Kilkenny)
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	12
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 inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 22 March 2018 11:00 To: 22 March 2018 18:45

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 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to Inspection.

This inspection was an announced registration inspection that took place over one day. The centre had previously been inspected when it formed part of a designated centre known as St. Michael's Centre. Subsequently, the provider reconfigured St. Michael's Centre into two centres. Greenfields is one of the original residential units that comprised St. Michael's Centre centre.

The provider had applied to register this centre under Section 69 of the Health Act 2007. The purpose of this inspection was to assess the provider's compliance with the regulations and standards and to assess if the provider had continued the positive improvements in compliance and outcomes for residents as were found on the previous inspection. Eleven outcomes were reviewed during this inspection and actions from the previous inspections followed-up on to ensure the provider had completed them in line with their action plan response and timelines that had been agreed.

How we Gathered Evidence.

As part of the inspection, the inspector met with the recently appointed team leader

of the designated centre, nominated persons participating in management of the centre and staff. The person in charge at the time of inspection was on extended leave. The provider had appointed a clinical nurse manager 1 from within the service to fill a management position within the centre and to provide nursing oversight of residents in the absence of the person in charge.

The inspector also met and spoke with all residents during the inspection. Residents' specific communication repertoires meant they could not speak directly with inspectors or describe the service they were receiving.

As part of the inspection, the inspector observed practices and reviewed documentation such as risk assessments, behaviour support plans, personal plans, healthcare plans, medication management systems and provider audits and reviews. An observational review of the premises throughout also occurred.

Description of the Service.

The centre comprises a one storey purpose built premises with two separate living areas, referred to in the report as residential units. The centre is located in the congregated campus setting of St. Patrick's Centre, Kilkenny. The centre could accommodate up to 12 adult residents with intellectual disability and complex healthcare co-morbidities. Residents required specific support needs in the management of healthcare, dysphagia management (risk of choking due to compromised swallow) nutritional management, epilepsy and behaviour support needs relating to self injurious behaviour.

At the time of inspection there were 12 residents living in the centre. There were plans to transition residents from this centre to community residential designated centres and transition planning was underway at the time of inspection, a number of residential properties had been identified by the provider and they intended to make applications to register the properties as designated centres in the coming months.

Overall Judgment of our findings.

While compliance was demonstrated in a number of areas some improvements were required.

Significant improvements had occurred in relation to fire safety containment and detection measures in the centre and refurbishment and upgrade of the premises had occurred to bring it to an adequate standard. However, while improvements had occurred the premises still presented as institutional in nature and could not provide residents with an optimum home environment similar to their peers.

Improved comprehensive assessment of residents' social and healthcare needs, by a team of allied health professionals, had brought about improvement in personal planning for residents. . This process now ensured support planning was evidence based to meet the assessed needs of residents. Through this assessment of needs residents had been identified as requiring specific supports such as increased opportunities to engage in activities to prevent incidences of self injurious behavior. This had begun at the time of inspection and initial feedback indicated this process was effective in reducing self injurious behaviour instances during this time.

The provider had refurbished the premises throughout and each resident's bedroom was decorated and furnished to reflect their individual personal style. The provider had also resourced the centre with a plentiful supply of hoists throughout, including overhead tracking hoists in residents' bedrooms and bathing facilities.

Improvements were required.

Meal preparation and cooking facilities in the centre were not adequate and therefore residents' main meals were prepared in another designated centre on the campus of Saint Patrick's Centre. This was not as sustainable way to provide for a nutritional diet and required review.

Risk management systems required improvement to ensure risks and hazards in the centre were correctly assessed and practical control measures were in place. The risk register for the centre did not reflect all risks for the centre and therefore reflect the overall risks present in the centre.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

Not all aspects of this outcome were reviewed on this inspection. The inspector reviewed the management of complaints, residents' meetings and privacy arrangements for residents living in the centre.

The complaints procedure was displayed in a prominent location in both residential units that made up the centre. This procedure was developed in an easy read accessible picture and written word format. It provided clear direction for residents, staff members and visitors on how to make a complaint, who the complainant could approach with a concern and how the centre and organisation would respond to and try to resolve the complaint. Nominated persons as part of the complaints process were clearly identified in the procedure.

Logging of complaints had begun in the centre. There was evidence to indicate this process was still in it's initial period and therefore very few complaints actually logged in the centre despite feedback from the team leader that complaints had been managed in line with the complaints procedure. Improvement was required in the logging of complaints, how they were responded to and investigated and the satisfaction of the complainant with the outcome of the complaint. This was required to evidence the implementation of the complaints policy and its procedure and to ensure residents' rights and feedback were valued and listened to. An action in relation to this is assigned to outcome 18; Records and Documentation.

Natural privacy arrangements in the centre had improved since previous inspections of the centre. Each resident had their own bedroom, privacy curtains were in place and bathrooms and toilets provided suitable arrangements to ensure residents privacy and

dignity. Overall, it was evident that the provider and management team of the centre had made significant efforts to improve the overall home like quality of the centre throughout and each resident's bedroom was individualized and personalised as much as possible.

Residents' meetings had also begun in recent times and this was evidence of a strive to improve opportunities for residents to provide their opinion and feedback about the service. Residents living in the centre communicated in their own personal style which staff understood well. At the time of inspection two meetings had occurred and it was evident that by the second meeting more improved initiatives had been put in place by the management team for the centre to encourage residents to participate and make it an enjoyable experience for them. Objects of reference were also used as were some other activity items. Residents were allowed to leave if they wished and supported to take turns in the process.

No other aspect of this outcome was reviewed on this inspection.

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:

Assessment of residents' needs were ongoing and support planning to implement their recommendations was in place to guide staff in how to support those assessed needs. Out-of-date information had been archived and in general residents personal plans provided a clearer more concise plan of supports for each resident. Actions from the previous inspection had been addressed. However some improvement was still required with regards to person centred planning.

The inspector reviewed a sample of residents' personal plans. Of the plans reviewed there was evidence that an assessment of residents' social care needs had been carried out which identified residents' specific needs.

All residents had received an annual multi-disciplinary allied health professional assessment from which their specific support needs were identified. Each month residents' needs and support planning was reviewed through a multi-disciplinary allied health professional process. This was evidence of comprehensive review of residents' needs.

Through an assessment of needs process it had been determined that a resident required more activities and social participation which in turn would reduce incidents of self injurious behaviour. Improvements in the resident's daily activity schedule had occurred with the resident now attending a day activity service for a number of hours each day. This had resulted in reduced incidences of the personal risk behaviour. While this had only begun it was evidence of the effective implementation of recommendations by the local management team for the centre with the support of the provider.

Transition planning was also in place for residents identified to move to more appropriate residential homes in the community. Residents had been involved in picking out furniture and furnishings for their new home and bedrooms. Transition plans also included colour photographs, and descriptions of the location of the centre, photographs of other residents that would live with them and the staff team that would support them in their new home. Compatibility assessments had also been carried out and conditions for success identified as part of the transition process.

Overall, residents' personal plans had improved in quality since previous inspections and detail provided in them ensured improved information for staff with regards to how to support residents and carry out allied health professional recommendations. Daily notes were documented to provide a running commentary of how residents' days had progressed and evidence implementation of support planning.

However, person centred planning still required improvement for some residents. In some cases there was a lack of plans for residents and associated goal setting with action plans to achieve goals identified.

Judgment:

Substantially 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:

As was found on previous inspections of this centre, the presentation, location and layout of the centre presented as institutional in nature and did not provide residents with the most optimum living environment similar to their peers living in community residential settings.

The provider had refurbished the premises and had installed wooden flooring throughout, painted and redecorated residents' bedrooms and communal spaces and installed windows that provided better heat and ventilation to the premises.

While these improvements were noticeable throughout, the premises was still institutional in presentation. Residents had limited access to outdoor spaces and could only leave the premises with a member of staff. Communal living room spaces lacked a homely appearance and kitchen areas were somewhat limited in space. Furthermore, residents meals could not be prepared in the centre as kitchen facilities were not adequate to cook and prepare residents meals. While the centralized kitchen had been de-commissioned residents meals were still prepared and cooked in another designated centre. This was not in line with the requirements of the regulations.

There was evidence however, that maintenance issues were addressed in a timely way and equipment used in the centre had received up-to-date servicing, for example all types of hoists in the centre had received an up-to-date service. This was also the case for resident's high-low beds and mobility equipment.

Overall, the premises presented with a good standard of cleanliness.

A number of residents living in the centre had been identified to transition to community residential homes in the coming months with further transitions to occur for all residents before the end of 2018.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

The health and safety of residents, visitors and staff to this centre was promoted and

met to a good standard overall. Improvements were required in relation to the frequency of fire drills. Analysis of risks and identification of risks required significant improvement.

Fire safety improvement works were carried out since the previous inspection. Appropriate fire compliance and containment systems were in place in the centre. Each residential unit within the centre was fitted with a functioning fire alarm which had been serviced on a quarterly basis. Fire safety checks were carried out regularly and were up-to-date. Fire safety equipment such as fire extinguishers and fire blankets were located in the centre and serviced annually.

Fire drills with residents had been carried out and each resident had an up-to-date personal evacuation plan in place which set out supports required in the event of an evacuation of the centre being required. All residents required additional supports for evacuation purposes, these were documented in their personal evacuation planning.

Some improvement was required in relation to the frequency of fire drills. While it was evident that fire drills had occurred at a minimum of twice a year, it was not demonstrated that residents having transferred from other designated centres as part of the overall de-congregation process, had participated in a drill in the centre. Given that all residents living in the centre required support and assistance in the event of a drill, more frequent drills were required to ensure all residents had participated in a fire drill. This was also required to ensure fire evacuation systems, including resources to support the drills, were assessed for their adequacy on a more frequent basis.

A risk register was in place which detailed the risks and control measures specific to the centre and residents' personal risks also. However, significant improvement was required in relation to this.

Residents living in the centre required dysphagia (risk of choking due to compromised swallow) management supports. However, this specific risk did not have an accurate risk rating to represent the level of actual risk to residents in the centre. The risk rating applied indicated the risk of choking was low and staff in the centre could not demonstrate that this was an accurate reflection of the level risk involved.

The risk analysis of self injurious behaviour also required review. A risk of self harm presented for a resident with the result of significant weight loss and nutritional challenges. In another instance a resident that presented with significant self harm challenges which could result in head injuries and required specific modification of their bedroom. However, self harm was not identified as a separate risk within the risk register and was deemed a challenging behaviour risk, rated as unlikely to occur and the impact as low if it did.

Many residents living in the centre required the use of bedrails as part of their overall support and safety requirements. However, there was an absence of bed rail specific risk assessments in place which would ensure the risks of entrapment, suffocation, for example, had been assessed with practical control measures and checks documented and in place to mitigate any risks should they be identified.

Overall, assessment of hazards and personal risks, their analysis and associated documented control measures required significant improvement to ensure risks and hazards in the centre were monitored in a consistent and accurate way.

This was required to ensure the provider was aware of the overall presenting risks in the centre which would inform resource allocation for the centre to meet the assessed risk requirements for the centre. It was also required to ensure staff were informed of practical control measures in place to reduce the likelihood of a risk occurring and how to manage it if it did occur in order to minimise risks to residents, staff and visitors.

There was a policy on infection control. Cleaning schedules were in place and completed by staff on an on-going basis. Hand washing facilities in the centre were adequate. Hand wash and drying facilities were available to promote good hand hygiene. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces.

Safe and appropriate practices in relation to manual handling were in place. Hoists were available in plentiful supply. Most residents' bedrooms were fitted with an overhead tracking hoist as were residents' bathing facilities. This was a significant improvement since the previous inspection. The inspector was informed that overhead tracking hoists would transfer with the individual resident when they transferred to their identified community residential homes in the future. All staff had received up-to-date manual handling training.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The provider had improved safeguarding practices within the centre in relation to restrictive practice policies and procedures. However, there was improvement required in relation to the overall audit and identification of all restrictive practices in the centre.

Some improvements had occurred in relation to the management and ongoing assessment of restraint within Saint Patrick's Centre organisation. The provider had developed an assessment which staff completed to assess if a specific practice in place was a restrictive which in turn required specific control measures and management practices to ensure it's correct implementation. A number of restrictive practices in place were required as part of residents safety supports while in bed, for example the use of bed rails. Other examples included the use of mechanical equipment for the purposes of mobility and positioning equipment as recommended by residents' allied health professionals.

Overall, there were minimal restrictive practices in place. However, a restraint register was not in place which provided an overall capture of restrictive practices used in the centre, the date they were recommended or prescribed, their most recent review date, rationale for their use and control measures in place to ensure they were only used for the least amount of time possible and in line with prescribed recommendations. This required improvement.

The provider had developed systems within Saint Patrick's Centre to implement the National safeguarding vulnerable adults policy. Previously the policy was a printed copy of the HSE safeguarding vulnerable adults policy only. Since the previous inspection of the centre the provider had revised the policy to incorporate guidance for staff on who the current designated officer(s) for Saint Patrick's Centre were, how to contact them and what localised reporting structures they were to follow. This was a tangible improvement and provided clearer guidance for staff in relation to safeguarding vulnerable adult procedures within Saint Patrick's Centre.

A sample of safeguarding plans was reviewed by inspectors. While it was evident that safeguarding allegations had been investigated and responded to as they occurred safeguarding plans did not give a descriptor of what the safeguarding risk for the resident was. Therefore, safeguarding plan guidance was not as effective as it could be in order to guide staff on how to mitigate and manage residents.

Personal and intimate care plans were in place and provided guidance to staff ensuring, consistency, privacy and dignity in the practice of providing personal care provided to each resident.

Positive behavioural support plans were in place if required by residents. Of those behaviour supports plans reviewed they were found to be in the main individualised and person centred in their approach. The plans gave guidance for staff on the support required by individuals with a descriptor of the behaviour of concern, proactive and reactive strategies. The use of chemical restraint in response to behaviours that challenge was infrequent and there was evidence that alternatives were trialed before it was administered.

To support residents displaying self injurious behavior improvements in their daily activity schedule had been introduced as recommended by the resident's behavior support specialist. As discussed in outcome 5; Social Care Needs, this initiative had occurred recently and was proving successful for the resident as it appeared to successfully reduce the number of self injurious incidents displayed by them.

The provider had also reconfigured a bedroom for a resident to ensure they had adequate support systems in place to manage episodes of self injurious behavior. The resident's bedroom was a larger bedroom than the one they had used in their previous home setting. It presented as a larger, brighter, better resourced and well ventilated space for the resident. This improved bedroom space and the location of their bedroom away from noise, appeared to meet the assessed needs of the resident as the number of self injurious incidents for the resident had reduced in frequency and severity.

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):

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

Findings:

Improvements in the overall comprehensive medical and allied health professional assessment of residents' healthcare had occurred and were still ongoing. However, improvements were required in relation to meal provision for residents who required specific modified consistency meals.

All residents had their own General Practitioner (GP) and had received an annual health check with them. Where required residents had also received blood tests and reviews of their medication. A yearly health assessment was also completed by staff using an 'OK Health Check' assessment tool.

As mentioned in previous inspection reports for St. Patrick's Centre campus designated centres, residents' access to and assessment by allied health professionals had improved significantly in the last year. Each resident was afforded a monthly allied health professional review whereby each resident's support needs were discussed and reviewed by the relevant allied health professionals associated with their care. This systematic and thorough review of each resident was reflecting positive and improved healthcare outcomes for residents.

As outlined in outcome 6; Safe and Suitable premises, kitchen facilities in Greenfields designated centre were not adequate and therefore residents' main meals could not be prepared in the centre. Pureed consistency meals were prepared in another centre and were delivered in individualized frozen meal portions and heated up in the centre. While

it was evident that the meals were provided in the correct consistency for residents and molded in a presentable way, this meal provision was not an optimum or sustainable way for providing for residents' nutritional needs or food preferences.

Meals provided were in line with consistency recommendations from residents' speech and language therapist (SALT) and/or dietitian. Guidelines in relation to food and nutrition were available within each kitchenette of the centre to ensure staff had access to these plans for guidance when preparing drinks and providing meals.

Residents at nutritional risk were assessed on a frequent basis by their dietician and recommendations implemented. The provider had also resourced the centre with a weighing scales which could accommodate resident's mobility aids. This was an improvement from the previous inspection and ensured residents' nutritional risk could be monitored correctly and in line with recommendations by their dietician and their nutrition support plans.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

Systems in relation to medication management were reviewed by the inspector. Over-all these were found to be safe.

Equipment was available for crushing of medications as required and guidelines were available for staff in the administration of medications via a PEG tube (percutaneous endoscopic gastrostomy).

Medication administration sheets were clear with medication clearly identifiable from document. A signature bank was available of all nurses who currently administered medications within the centre. A medication fridge was available within the centre and daily temperature checks were documented and up-to-date.

Both internal and external audits had recently been completed by staff nurses and project lead. Action plans were developed as part of these audits with evidence of leaning and follow through of actions. Findings on this inspection and also in the most recent medication audit of the centre, indicated improvement was required in relation to

the ordering and return of medications. A large quantity of medications were maintained in the centre. It was not demonstrated that there was a rationale or requirement for the volume of medications, in particular liquid medications, stored in the centre.

At the time of inspection, the logging of medications, when they were delivered, took a considerable period of time and the inspector was informed that nurses could spend a number of hours logging medications when they were supplied to the centre. This process required review to ensure residents' needs were not impacted upon due to excessive time spent by nursing staff logging and tracking large quantities of medications which did not appear to meet the assessed medication needs of residents.

Logs maintained contained a number of errors in calculations in a sample reviewed. Therefore, medication logs were not as effective as they could be for the purpose of reviewing a medication error or medication mismanagement.

Improvements were also required for the system of returning out of date or no longer required medications to the pharmacy. The medication returns box was not of an adequate size to fit bottles of liquid medications and therefore, in the instance where liquid medications in excess stock, they could not be stored in the receptacle as part of the organisation's medication policy and procedures.

Overall, medication ordering and return of medication systems required improvements.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Improved senior management governance systems in Saint Patrick's Centre were evident. Internal assurance processes were ongoing and carried out on a regular basis. However, there were some improvements required to ensure quality assurance systems occurred operationally within the centre.

Since the previous inspection a new person in charge had been appointed who met the requirements of regulation 14 and its associated sub-regulations relating to management experience and qualifications. However, at the time of inspection they were on leave. In their absence the team leader was responsible for the centre and to support them in their role a clinical nurse manager 1 (CNM 1) was also in place during the absence of the person in charge. The team leader was a qualified social care worker and had recently completed a management qualification.

The role of the CNM 1, in the absence of the person in charge, was to provide nursing oversight to the centre in compliment to the social care skills and experience of the team leader. The person in charge reported to a community services co-ordinator manager. They knew residents and their families very well. The community services co-ordinator reported to the director of services.

The appointed community services co-ordinator also had relevant management experience and had a good understanding of regulation and monitoring centres for compliance with the standards and regulations.

Unannounced visits and audits by persons nominated 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. A recent six monthly audit had been carried out prior to the inspection. The audit was found to be informative and detailed with an associated action plan and persons responsible identified. At the time of inspection the team leader for the centre were working on the audit findings.

Systems to assess the quality and safety of care in St. Patrick's Service has improved greatly in the previous year with the appointment of a 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, for example.

Personnel from the management team for Saint Patrick's Centre carried out audits within the centre. While this was evidence of the provider's effective oversight of designated centres, the provider had not developed quality audit systems for the person in charge and team leader to implement on a day-to-day basis locally in the designated centre.

The provider was required to review the designated centre's operational management auditing system to ensure the person in charge and team leader consistently engaged in reviewing the quality of service provided to residents in addition to the provider's quality oversight system which was currently in place. this was to ensure the quality and safety of care, provided in the centre, was consistently and effectively monitored by all levels of management for the centre.

Judgment:
Substantially Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

At the time of inspection the person in charge was absent for a period longer than 28 days.

The provider had notified the Chief Inspector of this absence in line with requirements of the regulations.

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:

While the provider had made arrangements to ensure a stable and effective workforce some improvement was required.

Supervision meetings for staff had begun in recent months and were of a good standard. All staff had received mandatory training. Some improvement was required in relation to training to meet residents' specific assessed needs in relation to seizures related to epilepsy. Actions from the previous inspection in relation to dysphagia training for all staff had been addressed. Staffing levels in the centre were not in line with the whole time equivalents set out in the statement of purpose for the centre.

A planned and actual rota were maintained, updated and available in the centre. Staffing numbers in the centre were not in line with the whole-time-equivalent staffing ratio as set out in the statement of purpose for the centre. As a result there were occasions when residents could not engage in activities outside of the centre, for example. Therefore, staffing arrangements required review by the provider.

All mandatory training for staff was up-to-date with refresher dates booked and maintained in the centre. Some improvement was required to ensure staff could meet the assessed needs of residents in relation to administration of emergency medication for the management of seizures associated with epilepsy and oxygen therapy. This was required to ensure all staff could support residents to engage in activities outside of the centre and to ensure their support was not only reliant on specifically trained staff being on duty a particular day.

Staff supervision systems were reviewed as part of the inspection. It was evidenced that the team leader for the centre had taken a considered initiative and had devised a supervision meeting schedule for the coming year and this was available for review during the inspection.

A sample of staff supervisions that had been completed were reviewed. They demonstrated the team leader's competence in carrying out effective and supervision meetings with staff. There was also evidence that both the team leader and the CNM 1 for the centre had received a supervision meeting with their manager, the community services co-ordinator.

A sample of staff files were not reviewed during this inspection.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

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

Findings:

As per the matters set out within Schedule 4 of the regulations, improvement was required in the logging of complaints and documenting of how they were responded to, any investigation that occurred and the satisfaction of the complainant with the outcome of the complaint.

Judgment:

Substantially 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
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Saint Patrick's Centre (Kilkenny)
Centre ID:	OSV-0001893
Date of Inspection:	22 March 2018
Date of response:	10 May 2018

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:

Person centred planning required improvement.

1. Action Required:

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

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

responsible for pursuing objectives in the plan within agreed timescales.

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

1. Visionary Meetings to be scheduled for all people we support in conjunction with the PIC & Community Transition Coordinators Team by the 25th May 2018.
2. Each person will have a visionary meeting by the 31st July 2018.
3. Individual Meetings for each person will clearly define review timelines & monitoring mechanisms.
4. PIC will ensure each person has individual goals that are audited on a bimonthly basis.
5. PIC will ensure that each keyworker will hold responsibility for the persons goals, timelines & that recording systems are in place.
6. Support for each identified goal will be evidenced with 'conditions for success' forms and progress will be monitored by the PIC and team leader.

Proposed Timescale: 31/07/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The presentation, location and layout of the centre was institutional in nature and did not provide residents with the most optimum living environment similar to their peers living in community residential settings.

2. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

St. Patrick's Centre de congregation plan will see all the people we support transition to the community by the year end 2018. Senior Management & Operations Manager is responsible for the delivery of this plan.

St. Patricks Centre recognises that the premises are not comparable to community homes and therefore has accelerated its de-congregation plan.

Proposed Timescale: 31/12/2018

Theme: Effective Services

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

Residents meals could not be prepared in the centre as kitchen facilities were not adequate to cook and prepare residents meals.

3. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

St. Patrick's Centre de-congregation plan will see all the people we support transition to the community by the year end 2018. Senior Management & Operations Manager is responsible for the delivery of this plan.

Slow cookers, steamers & George Forman have to be purchased to prepare & cook meals in Greenfields by the 31st May 2018.

The dietician will support this advancement through guidance and advice and there will be ongoing review of all person's nutritional intake.

The Team Leaders will request support from dietician by 30th May 2018 in order to advance this issue.

Proposed Timescale: 31/05/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Overall, assessment of hazards and personal risks, their analysis and associated control measures required improvement to ensure risks and hazards in the centre were monitored in a consistent and accurate way.

While many residents used bed rails it was not demonstrated that appropriate systems were in place to ensure they were safely used.

4. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

1. Risk Management Training-conducted at localised level. All Staff to attend this training by the 10th June 2018.
2. PIC will review all risk assessments.
3. Bed Rail specific risk assessments to be put in place for all relevant people we support.
4. Ongoing review & monitoring of risk assessments by the PIC.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

Fire drills were required to occur more frequently. This was to ensure all residents living in the centre had participated in a fire drill and to ensure fire evacuation systems, including resources to support the drills, were assessed for their adequacy on a more frequent basis.

5. Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

1. PIC to schedule monthly daytime fire drills & ensure fire drills are completed.
2. Each supported person will be involved in all fire drills and in the event they are away during planned drill another drill will be planned to include them.
3. There will be a simulated night time fire drill during each quarter, this will be planned in a schedule.
4. The individual presentation of each person will be documented on the fire drill form to inform their individual PEEPS.

Proposed Timescale: 31/05/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

A restraint register was not in place.

6. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

1. Restrictive Practice register to be completed for the centre identifying each restriction in place for the centre.
2. Rationale for use of restrictive practice to be documented for each person we support as required.
3. Each restriction will be risk assessed to review level of risk and have a documented 'Restoration of rights plan' in place which will be reviewed 3/monthly.
4. Restrictive Practice Pathway will guide the management of all restrictions as per SPC policy.
5. Quarterly Restrictive Practice audits to be carried out by the PIC.

Proposed Timescale: 30/06/2018

Theme: Safe Services

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

Safeguarding plans did not clearly define what resident's safeguarding risk was and how it was managed.

7. 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:

1. Safeguarding workshops have been organised with Team Leaders/ PIC's by the Social Workers.
2. Safeguarding workshops to be carried out with staff team in Greenfields.
3. Safeguarding as an agenda item at Team Meetings on a monthly basis.
4. Each safeguarding plan to be reviewed by the PIC to identify clearly the identified risk and the management of same.

Proposed Timescale: 31/05/2018

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:

The system for providing pureed consistency meals required review.

8. Action Required:

Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

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

1. Nutritional Breakfast & evening meal provided in the designated centre.
2. Slow cookers, steamers & George Forman have to be purchased to prepare & cook main meal in Greenfields by the 31st May 2018.
3. Dysphasia chefs have been engaged to support the preparation and presentation of pureed meals. The PIC will contact the training dept to fast track training for the staff team.

Proposed Timescale: 31/05/2018

Outcome 12. Medication Management

Theme: Health and Development

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

Improvements to the ordering system for residents medication required improvement to ensure excess volumes of medication were not stored in the centre unnecessarily.

9. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

1. Excess stock has been returned to the pharmacy, following meeting with Pharmacist as per St. Patrick's Medication Policy.
2. Ordering & Stock control documentation under review with Medication Coordinator.
3. A staff member has been delegated responsibility for Medication Ordering & Stocking in Greenfields.
4. This area will be closely reviewed and monitored by the PIC through monthly medication management auditing.

Proposed Timescale: 31/05/2018

Theme: Health and Development

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

Systems for the correct storage of out of date or 'return medications' required improvement.

10. Action Required:

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

1. Excess stock has been returned to the pharmacy, following meeting with Pharmacist as per St. Patrick's Medication Policy.
2. Ordering & Stock control documentation under review with Medication Coordinator.
3. A staff member has been delegated responsibility for Medication Ordering & Stocking in Greenfields.

4. This area will be closely reviewed and monitored by the PIC through monthly medication management auditing.
5. Purchase a suitable Medication Return box to allow safe storage of out of date / return medication in a labelled locked press in the centre.
6. This area will be closely reviewed and monitored by the PIC through monthly medication management auditing.

Proposed Timescale: 31/05/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The provider was required to review the designated centre's operational management auditing system to ensure the person in charge and team leader consistently engaged in reviewing the quality of service provided to residents in addition to the provider's quality oversight system currently in place.

11. 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:

1. The CSM's & Team Leader's to meet and agree an appropriate audit schedule to monitor optimal quality of services to the people we support.
2. This schedule will be available in the centre to guide the auditing process.

Proposed Timescale: 31/05/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffing numbers in the centre were not in line with the whole-time-equivalent staffing ratios set out in the statement of purpose for the centre and required review.

12. Action Required:

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

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

1. Recruitment process currently in place.
2. PIC & CSM include as an agenda item at all monthly supervision.
3. Staffing requirements & needs highlighted at HR Business Meetings held monthly.
4. A full review of staffing profile and WTE needed for the centre will be undertaken by the CSM/corporate manager to identify appropriate staffing requirements

Proposed Timescale: 30/06/2018

Theme: Responsive Workforce

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

Improvement was required for staff training specific to meet the needs of residents, for example the administration of oxygen and emergency medication for the management of seizures relating to epilepsy.

13. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

1. PIC has identified the staffs that require Oxygen & Emergency Medication for the management of seizures relating to Epilepsy.
2. PIC to ensure relevant staff can attend the training as per training schedule.
3. These training requirements have been highlighted to the Training coordinator.
4. Staff training needs will be reviewed monthly by PIC.

Proposed Timescale: 31/07/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

Improvement was required in the logging of complaints and documenting how they were responded to, any investigation that occurred and the satisfaction of the complainant with the outcome of the complaint.

14. Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

1. Presentation of St. Patrick's Complaint Policy to be delivered to all the staff at Team Meetings, emphasising the importance of logging of complaints & documenting how we respond & the outcome of the complaint.
2. PIC to complete Complaints Audit monthly.
3. Complaints to be an Agenda item for discussion bi-monthly.

Proposed Timescale: 30/06/2018