

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd
Centre ID:	OSV-0003499
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Patricks Centre (Kilkenny) Ltd
Provider Nominee:	David Kieran
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Rachel McCarthy
Type of inspection	Unannounced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 23 June 2016 10:20 To: 23 June 2016 20:15

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 17: Workforce

Summary of findings from this inspection

Background to inspection

This inspection was unannounced and took place over one day. The purpose of the inspection was to implement ongoing monitoring of compliance in the centre. Previous inspections of this centre have found serious breaches of the Regulations in the areas of fire safety, rights, use of restraint and the management of alleged abuse and safeguarding.

In the recent months a new board of management had been appointed to St. Patrick's Kilkenny. The board had been in place two months at the time of the inspection.

Since the previous inspections in 2015 a number of fire safety works had been carried out in the centre in order to address significant fire safety non-compliances found by not only the Health Information and Quality Authority (HIQA) but also the regional fire officer. Previously Kilkenny County Council Fire and Rescue Service issued a closure notice on 26 August in respect of this centre due to "serious and immediate risk". In the interim, all residents were to have one to one support at night until the centre was fitted with a suitable fire detection system.

After a commitment to complete priority works were given by the provider, the court order was lifted and the provider was given a time frame to complete the necessary works. At the time of the inspection there were still some works not completed in one of the residential units. The provider gave inspectors assurances that there was a plan in place to address the outstanding works in a short time frame.

Not all aspects were reviewed in each outcome on this inspection. The main aim of this inspection was to follow up on actions given in the previous inspection and to monitor the quality of care and welfare residents were receiving in the centre.

How we gathered evidence

Inspectors visited all three residential units that made up the designated centre. As part of the inspection, inspectors met with staff in each residential unit and spoke to them about practices and their knowledge of the residents. Inspectors spoke to residents they met during the inspection taking guidance from staff as to the particular way in which residents liked to interact with others. In some instances residents did not enjoy meeting new people or the presence of unfamiliar people in their space and inspectors respected their wishes at all times. In other instances residents did not verbally communicate with the inspectors but held their hand or moved the inspectors hand to something they were looking for.

Inspectors observed practice throughout the inspection in all three residential units and made note of interactions they observed between staff and residents. Inspectors also reviewed documentation such as personal plans, risk assessments, and assessment of needs.

Description of the service

The centre was part of St Patrick's Kilkenny, which provides a range of day and residential services to children and adults with an intellectual disability. This centre was located in a congregated setting and comprised of three residential units.

One residential unit was home to 13 residents, all with high support needs and some residents that presented with behaviours that challenge. The environment was not meeting residents needs and this was evidenced by the use of key padded locked doors leading to two corridors, behind which residents lived unable to access other parts of their home.

Another residential unit comprised of three individualised dwellings which were referred to as apartments. Inspectors found this premises to be dirty and unsanitary in parts, particularly the toileting and bathing facilities. Overall, the premises presented as a bare, institutional setting which lacked any home like qualities, personalisation or decoration.

The third residential unit was home to 15 residents. Inspectors found this premises to be the most inviting and homely of all three premises inspected. Residents' bedrooms were personalised and the premises was pleasantly decorated and bright in most areas. However, the toilet and bathing facilities were communally configured and despite the presence of privacy curtains did not provide suitable facilities for residents.

Overall judgment of our findings

Inspectors found actions from the previous inspection had not been adequately addressed bringing about mostly major and moderate non-compliances in seven of the nine outcomes inspected on the day.

Major non-compliance was found in the management of health, safety and risk management relating to fire safety, management of falls and poor infection control practices. There was also major non-compliance found in relation to residents' rights primarily due to the lack of privacy supports in place for residents living in all three residential units. Outcome 11 met with major non-compliance also due to the lack of comprehensive health care assessments for residents that presented with healthcare issues and co-morbidities. Residents' nutritional supports were institutional and non-inclusive.

These findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 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):

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

Findings:

Some residents living in parts of the centre continued to experience a poor quality of life where their civil liberties were impacted on due to the configuration of their living spaces. Those residents continued to experience long periods of the day not engaged in meaningful activities or engagement. Inspectors also found residents were still experiencing inadequate privacy and dignity supports throughout the designated centre. However, the provider had made positive improvements with regards to the transparency with which residents' finances were managed.

Previous inspection reports have documented the lack of free movement some residents experienced in some parts of the centre. Inspectors observed this was still the case on this inspection. This is further discussed in outcome 8: safeguarding and safety with regards to the use of restraint.

Inspectors found significant breaches of residents' privacy and dignity due to the layout and configuration of the premises.

Throughout the designated centre inspectors noted many residents' bedroom doors had windows. In one residential unit inspectors noted there was a window in the door of residents' shower/toilet facilities. Staff told inspectors that the windows in the bedroom doors were for night time checks but could not explain the necessity for the window in the door of the shower/toilet in one of the residential units. Inspectors were not satisfied that there was rationale for the presence of windows in residents' bedrooms and toileting/bathing facilities.

In one residential unit the bathing facilities were configured communally. For example, the bathing/showering facilities in the unit were made up of a room with two entrance/exit doors. The room contained two assisted showers, an assisted bath, a toilet and sluice all located in one room. While shower curtains were in place and staff assured inspectors residents used the facilities individually, the facility was not in line with appropriate standards to ensure privacy and dignity of residents using them.

Inspectors also noted in one residential unit, two residents shared a bedroom. At the time of inspection one of the residents was at home and would not be staying in the centre that night. An inspector however, noted there was no privacy curtain in the bedroom where the two residents shared. The sharing arrangement did not promote adequate privacy and dignity for residents similar to their peers that lived in the centre who all had individual bedrooms.

Some residents were observed spending long periods of time not engaged in any meaningful activities throughout their day. Inspectors observed residents spending long periods of time unoccupied sitting on the floor, pacing around living rooms and corridors or looking through the window of the locked door that led to their living space in one residential unit. Inspectors observed staff speak to residents in this area of the residential unit only once in the space of a two hour period.

Inspectors reviewed the changes the provider nominee had made regarding the management of residents' finances. Residents were now issued with an individualised financial bank statement in their name. This statement outlined purchases made for the resident with transactions and balances clearly indicated. Residents were issued these bank statements monthly and they were also issued to residents' families or representatives where applicable. Through the issuing of financial statements to residents and their representatives the provider was ensuring residents' finances were being managed in a open and transparent manner.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

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

Findings:

This inspection found residents' social care needs were still not consistently supported by a cohesive comprehensive assessment of need. There was evidence to indicate allied health professional assessments of residents had begun. Inspectors did also find evidence that planned supports would be in place when residents transferred between services. Some residents had been identified to move out of the congregated setting to residential services in their community. Consultation had taken place with some residents, family and staff about their transition plan and identifying the needs of the resident prior to moving into their new home.

An increase in staff numbers had resulted in some residents engaging in more activities, both in and out of the designated centre. However, as mentioned in Outcome 1 of the report, residents with higher dependency levels or those that presented with behaviours that challenge were less likely to engage in activities and were observed in some instances unoccupied for considerable periods of time.

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

Residents' personal plan information was located in numerous folders and files. For example, each resident had a daily observation folder, medical file and personal plan file. Information pertaining to residents was difficult to retrieve and in some instances the information provided was not clear. Not all recommendations and information contained in residents' personal plans had been reviewed annually or more frequently. Current information was mixed with information dated over 10 years previous. Some information contained in the plans were not relevant to residents' current support interventions and recommendations.

Residents were receiving allied health professional assessment based on a referral made by nursing staff in the centre. There was evidence that referrals had been made and residents were receiving assessments based on these. However, residents personal plans lacked evidence that multi-disciplinary reviews had taken place. For example, there were instances where residents support interventions had been drawn up by their key worker but were not supported by a recommendation made by a relevant allied health professional, for example mobility recommendations or food and liquid consistency protocols for residents with compromised swallow.

Some residents preferred their medications to be administered in specific ways for example, some residents liked to take their medication with a yogurt or a specific drink. However, this information was not documented in any meaningful way in their administration charts or personal plans so as to direct staff carrying out medication administration in the centre. Therefore, unfamiliar staff engaged in medication administration in the centre, for example could be presented with residents refusing their medication due to this lack of information particular to the resident.

A new working group had been developed for the transitioning of residents. This group consisted of one practice development manager and four community connectors. Inspectors spoke with a number of staff members involved in the working group about the proposed plans in place for moving residents into the community. They were informed that one house would be ready for residents shortly and the working group were in the process of identifying the residents that would be suitable and compatible based on their own personal and physical needs.

The four community connectors would be responsible for assessing each individual's social care needs and where appropriate, training in the life skills required for the living arrangements is identified for residents. There was evidence to indicate residents were being supported to explore new activities, where staff could assess residents' likes, interests and preferences. For example, a resident who had previously not engaged in activities inside of the centre had started to go out regularly with the support of staff. Feedback from staff indicated the resident enjoyed this and seemed happier, resulting in the resident engaging in activities inside the centre.

There was evidence to indicate when residents' assessments of need were completed, by the working group; transitional plans for residents would be of an appropriate standard to meet their social care needs and improve their quality of life.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

While this outcome was not reviewed in full, inspectors found two of the three residential units in the centre significantly did not meet the needs of residents that lived there. Inspectors observed, particularly in one residential unit, the premises were visibly dirty. Bathing and toileting facilities were particularly dirty and unsanitary in some residential units of the centre. There was a lack of decoration and homelike quality in other residential units.

All three residential units were visited by inspectors on this inspection. Of the three units inspected one was noticeably more clean and homely than the others. Residents' bedrooms were personalised and pleasantly decorated in this location.

The other residential units inspected did not present as homely or pleasantly decorated spaces. One of these residential units comprised of three separate, individualised dwellings for three residents. Inspectors found this residential unit to be dirty and unsanitary in some parts. For example, a bath had a significant build up of dust and soap scum in and around the edges, the sink also had soap scum and dust collections. The toilet in the bathroom had a build-up of lime-scale and urine causing significant staining and unsanitary conditions. The shower in the facility was unusable due to the build up of lime-scale in the shower head.

Inspectors reviewed the cleaning audits for the centre and found they had not been completed for a considerable period of time. There was little evidence to indicate the cleanliness of the centre was reviewed or checked on a regular basis in a consistent way.

While the inspectors did acknowledge that some residents could destroy property as part of their behaviours that challenge this did not present as an adequate explanation for the lack of cleanliness in the centre or the lack of personalisation and decoration of their bedrooms and communal spaces in other residential units where such behaviours that challenge did not present, for example.

The provider gave a commitment to ensure the centre received a deep clean by contracting a company to carry out the cleaning.

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:

The systems to promote the health and safety of residents had improved somewhat following some fire safety works having been completed. Systems for the review of accidents and incidents and identification of personal risks to residents had improved. However, inspectors were still not assured that residents' health and safety was sufficiently promoted and protected particularly in relation to falls management and

infection control.

Most priority fire safety works for the centre had been completed. For example, inspectors noted the presence in some residential units of fire rated doors fitted at key compartmentalisation points in the building which improved the fire and smoke containment systems of the centre. There were still some fire safety works outstanding which would require some residents to move from their residential unit while they were undertaken.

Inspectors reviewed fire safety training records for staff working in the centre. There were some training gaps evident. Some relief staff had not received training in fire safety.

Inspectors also reviewed fire evacuation drills for the residential unit where key padded locked doors were in place. Staff spoken with were unclear as to how evacuation drills were implemented and told inspectors that they were not carried out. However, documentation maintained in the centre indicated they had been implemented but did not specify the number of residents that had participated in the drill or how long it had taken to evacuate from the building for auditing purposes.

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

There were improvements required however. In each of the three residential units which comprised the centre, inspectors noted there were a number of residents that experienced falls regularly. Incident reports were documented for each time a resident fell. However, there were inadequate risk assessments or falls prevention measures in place for residents identified as high risk of falls. The chief inspector had been notified of a serious incident where a resident had been found having fallen and subsequently admitted to hospital for treatment of a secondary condition which could have contributed to the fall.

Inspectors found inadequate review and analysis in place to ascertain what caused residents to fall frequently and what supports should be in place for them to prevent the falls from occurring or ensuring they were supervised or supported adequately to prevent them. For example, a resident that spent most of their time in bed, by their own choice, had experienced a number of falls, some of which were when they were using the toilet facilities which was one of the only times they left their bed.

There was evidence however, of improved personal risk assessments in place for some residents. Where specific risks for residents were identified a personal risk assessment

had been carried out which identified the risk, control measures in place to mitigate the risk and the level of risk had been assessed using a risk analysis matrix which identified the likelihood the risk would occur and the consequences to the resident.

Infection control systems, while in place, were not carried out to an adequate standard. HIQA had received a notification of an outbreak of infectious disease from the centre in the months previous to the inspection. Some parts of the premises were visibly unclean and there was a lack of adequate hand washing facilities available throughout the centre despite staff engaging in intimate personal care practices to support residents.

Some examples of poor infection control observed by inspectors included:

- Some bathing/toileting facilities did not have hand washing soap or hand drying facilities in place for residents or staff to use.
- There was no hand washing soap, hand drying facilities or alcohol hand gel available at the hand washing sink of the sluice in one of the residential units.
- Inspectors observed dried brown staining on the side of a mattress, the wall and skirting board in a resident's bedroom which inspectors were informed was most probably vomit.

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:

There had been improvements in the detection, management and response to allegations of abuse in the centre since previous inspections. There was also evidence of improvement in staff training in the management of behaviours that challenge and de-escalation techniques. However, some residents still experienced prolonged periods of environmentally imposed restrictions to manage behaviours that challenge.

A number of designated persons for the organisation had been trained since the previous inspection. The person in charge of the centre had received the training and carried out vulnerable adult training to staff working in the organisation. Inspectors also noted that there had been an improvement in the overall response to allegations of abuse. Preliminary screening of allegations had begun to take place and inspectors noted there was more consistent follow up to allegations of abuse than there had been previously. This was mostly in part to the appointment of designated persons implementing the national vulnerable adult safeguarding policy in the centre.

Another positive improvement was the presence of a social worker for the centre. One of their roles was to assess allegations of abuse and review any preliminary screenings of allegations to ensure designated persons were implementing the correct procedures.

Staff training indicated all staff had received training in the management of behaviours that challenge and de-escalation techniques. During the course of the inspection, inspectors observed in one residential unit, staff successfully de-escalate and support a resident who presented with the potential to engage in behaviours that challenge. They were observed to speak to the resident in a caring a supportive way ensuring their privacy and dignity was maintained at all times.

However, there were improvements required regarding the management of restrictive practices, in particular environmental restraint. One residential unit in the centre comprised of a number of corridors that are accessed via a coded door. These corridors lead to the main shared communal space in the building. Inspectors observed residents locked behind the doors of these corridors preventing them from moving freely throughout their living space. The rationale for the restrictions was that some residents could abscond from the premises or make their way to the kitchen and eat edible and inedible substances if not supervised.

While a personal risk was present for those residents it was evident that the environment they were living in was not suiting their specific needs. This resulted in residents experiencing prolonged environmental restrictions which were not the least restrictive and did not demonstrate that all alternatives had been trialled. Residents living in this unit experienced a much poorer quality of life than their peers living in the other residential units of the centre.

The provider nominee had previously indicated to HIQA that these locks were to be removed by 30 November 2015. However, these locks were still in place during this inspection.

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:

It was not demonstrated that residents were consistently provided with appropriate healthcare reviews and adequate healthcare support planning. There was a lack of comprehensive evidence based nursing assessment for residents that presented with healthcare issues. Institutional practices were evident in the manner in which residents' meals were prepared.

The inspector found there was still a lack of assessment of residents' needs in order to inform clear plans of care with prescribed interventions. In some instances, where residents, had identified health issues, appropriate interventions were still not provided. A sample of resident medical information and related documents was reviewed. It was observed that such documentation was still poorly organised with information dating back over a decade stored with more recent information.

A number of residents had complex medical needs and co-morbidities however, there was still little evidence that a comprehensive nursing assessment had been carried out in order to facilitate clear and consistent care plans. Where support interventions were documented, for example modified consistency fluid plans for residents with compromised swallowing, support plans had been drafted by the resident's key worker but were not supported with recommendations by a relevant professional such as a speech and language therapist (SALT). Therefore, it was unclear if the plans were in line with evidence based practice. There was no evidence that such support plans had been reviewed by a relevant allied health professional to ensure they were appropriate or supporting the residents needs adequately.

A number of residents in the centre could experience seizures related to epilepsy. Inspectors found evidence that these residents were regularly reviewed by their medical practitioners and consultant neurologists as required. There was also evidence to indicate a number of referrals had been made to allied health professionals to review residents' needs.

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

Inspectors were informed that residents' meals were prepared in some units on a Wednesday as an activity. Feedback from staff indicated that residents really enjoyed this. For example, inspectors were informed that one resident that required a specific diet enjoyed meal preparation on Wednesdays because their meals were different on

those days. Most other days the resident's dinner was mashed potato with mince which an inspector observed the resident to eat on the day of inspection.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management

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

Theme:
Health and Development

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

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

Findings:

From a sample of medication administration charts reviewed inspectors found entries to be up-to-date and accurate. Medication administration by a member of staff was observed during the inspection and deemed to be appropriate and safe. Residents medications were securely stored in all three residential units that made up the designated centre.

Residents requiring crushed or liquid medications were appropriately prescribed them and they were documented clearly on their medication administration charts.

Some residents preferred their medications to be administered in specific ways for example, some residents liked to take their medication with a yogurt or a specific drink. However, this information was not documented in any meaningful way in their administration charts or personal plans so as to direct staff carrying out medication administration in the centre. This is further discussed in Outcome 5.

Prior to the inspection the assistant director of services had carried out an audit of medication practices in the centre.

Judgment:
Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Previous inspections of the centre found systems of governance and management were not sufficient to ensure residents received a safe service and quality care. On this follow up inspection, it was found that this continued to be the case.

The provider had still not implemented adequate procedures for monitoring the quality of care provided to residents. Systems were not in place to gather and analyse information which could be used to validate the quality and safety of care provided to residents. As a result, direct negative outcomes were observed for some residents, as outlined in Outcome 1 (Rights, Dignity and Consultation), Outcome 5 (Social Care Needs), Outcome 8 (Safeguarding and Safety), for example.

Unannounced visits and audits by the provider, which are a requirement under Regulation 23, to gather information and assess the quality and safety of care had not been carried out. Inspectors requested documented evidence of an unannounced visit to the centre by the provider. However, a report was not available. An annual review of the quality of service was also unavailable on the day of inspection.

Systems to assess the quality and safety of care at the centre level were not adequate. Systems for auditing and checking the quality of care had still not been developed and implemented to a sufficient degree. Some in-house audits had been implemented by the person in charge. However, they were not of a sufficient quality or frequency to ensure consistency in standards across residential units making up the centre. For example, while infection control and cleaning audits templates were in place, inspectors found varying degrees of cleanliness across all three residential units with some presenting as clean and others visibly dirty and unsanitary in some parts.

Residents experiencing falls was a risk issue that was present across all residential units in the centre. Falls incidents had not been analysed in any meaningful way to bring about a reduction in the risk of residents experiencing falls or analyse why they were happening. This indicated that, while an audit system was in place, it was not effectively influencing or improving practice and ultimately improving outcomes for residents.

There were however improved systems in place to review accidents and incident reports in order to improve safety arrangements for residents. Incidents/accidents and risk were now a fixed agenda item on the newly established quality and safety committee. This was a positive step towards a more comprehensive overview of risk management in the service and designated centre.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

There had been an improvement in staff numbers and training. Systems for staff induction, probation and supervision had improved but there were still some gaps. However, there was evidence that the new staff induction and probation process was not being implemented appropriately by the person in charge.

The staff members present during this inspection were observed to engage in a positive and caring way with residents. Since the previous inspection the staff to resident ratio had improved resulting in residents having one-to-one support facilitating those residents experiencing increased access and participation in activities outside of the centre. All staff had received training in the management of behaviours that challenge and de-escalation techniques. The director of services informed inspectors that the organisation planned to introduce further training in a different model of behaviours that challenge management which focused on de-escalation techniques and low arousal. A number of staff within the organisation had been trained in this new behaviour management and support model and would carry out training within the organisation when their training was complete.

A staff supervision system had yet to be fully implemented at the time of inspection. Since the previous inspection supervision meetings and an induction process had begun for new staff. However, not all new staff that had started working in the centre since December 2015 had received a probation meeting with the person in charge in their first six months of working in the centre. Therefore inspectors found that the system of supervision of staff required improvement.

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 St Patricks Centre (Kilkenny) Ltd
Centre ID:	OSV-0003499
Date of Inspection:	23 June 2016
Date of response:	16 August 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Some residents living in parts of the centre continued to experience a poor quality of life where their civil liberties were impacted on due to the configuration of their living spaces.

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

1. Action Required:

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

Individualised Daily Plans will be implemented for each resident.

Four (4) residents had been scheduled to move into their new community based home on 15/08/16. This move has now been deferred and would have eliminated the last remaining shared bedroom. Ongoing strenuous efforts will continue to secure more appropriate accommodation for all residents.

Risk assessments will be conducted to determine if coded door locks can be removed from the doors concerned.

Proposed Timescale: 26/08/2016

Theme: Individualised Supports and Care

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

Residents were still experiencing inadequate privacy and dignity supports in this centre.

2. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Opaque Adhesive sheeting will be fitted to windows in all Bedroom and Bathroom doors.

Bath and Shower rooms will continue to be used individually.

A curtain / screen will be made available in the shared bedroom.

Proposed Timescale: 26/08/2016

Theme: Individualised Supports and Care

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

Some residents continued to experience long periods of the day not engaged in meaningful activities or engagement.

3. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

A full review of all individual activity timetables will be conducted by the PIC in conjunction with relevant members of the MDT.

Following this review all activity timetables will be updated to ensure that they reflect resident's interests, capacities and developmental needs.

All staff will receive training in the role of the Keyworker based on the new Keyworker Policy introduced in July 2016.

Individualised Daily Plans will be implemented for each resident.

A monitoring and compliance checklist will be introduced to ensure residents are supported to engage in their individual activity timetables.

The Practice Development Manager will continue to working with management and staff to foster a supportive atmosphere in all residential units that promotes positive and ongoing engagement between staff and residents.

Proposed Timescale: 30/09/2016

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:

Residents personal plans lacked evidence that multi-disciplinary reviews had taken place. For example, there were instances where residents support interventions had been drawn up by their key worker but were not supported by a recommendation made by a relevant allied health professional, for example mobility recommendations or food and liquid consistency protocols for residents with compromised swallow.

4. Action Required:

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:

"In House" Monthly Clinical reviews will be scheduled to ensure all residents have their clinical needs assessed on a regular basis. Particular emphasis will focus on OT, SALT and Dietician referrals. The outcomes of these reviews will determine referrals to relevant allied health professionals. Recommendations from allied health professionals will in turn inform the in-house clinical reviews.

Monitoring and compliance checklists will be introduced to ensure recommendations from allied health professionals are implemented.

Weekly audits of these checklists will be conducted by the PIC and submitted to the line manager (Assistant Director of Services).

Ongoing support from the HSE Regional Practice Development Co-ordinator for Intellectual Disability Services / Quality Advisor (National Quality Improvement Programme) will continue particularly with respect to best practice regarding assessment tools and in the changing role of the nurse supporting residents in community based services.

The "Ok Health Check" will be completed by the assigned Keyworker with support from a registered nurse for all residents.

Proposed Timescale: 18/09/2016

Theme: Effective Services

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

Not all recommendations and information contained in residents' personal plans had been reviewed annually or more frequently. Current information was mixed with information dated over 10 years previous. Some information contained in the plans were not relevant to residents' current support interventions and recommendations.

5. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

The current information/documentation system which includes the daily recording file, the personal file and medication file is being refined and will be reduced to a personal and medical file only.

All files are currently being audited to ensure they only contain reports/information etc relevant to current support needs.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Some residents preferred their medications to be administered in specific ways for example, some residents liked to take their medication with a yogurt or a specific drink.

However, this information was not documented in any meaningful way in their administration charts or personal plans so as to direct staff carrying out medication administration in the centre.

6. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

All personal medication plans will be reviewed and updated to ensure that individual preferences are noted to inform all staff as to the preferred and agreed method of medication administration for each resident.

Proposed Timescale: 26/08/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Inspectors observed, particularly in one residential unit, the premises were visibly dirty. Bathing and toileting facilities were particularly dirty and unsanitary in some residential units of the centre.

There was a lack of decoration and homelike quality in some residential units of the centre.

7. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

A deep clean of the residential unit has been completed in the days following the inspection.

The PIC will conduct daily audits to ensure cleaning schedules are adhered to.

Staff (Keyworkers) are being expected and supported to personalise and make homely in particular resident's bedrooms.

Proposed Timescale: 30/06/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Inspectors found inadequate review and analysis in place to ascertain what caused residents to fall frequently and what supports should be in place for them to prevent the falls from occurring or ensuring they were supervised or supported adequately to prevent them.

8. 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:

The individual resident referred to in the inspection report who had a number of falls and who had been hospitalised recently now has an updated individualised support plan designed to minimise the risk of falls.

The dietician has recently commenced research in the centre into the possible link between falls and a lack of vitamin D for residents.

The physiotherapist is establishing a falls pathway. The purpose of the pathway is to provide a quality evidence based falls prevention approach. The ultimate aim is to identify those residents at risk of falling and reduce incidence and resultant injury by identifying risk factors and implementing appropriate preventive measures.

A new Policy on the Prevention of Slips, Trips & Falls is being devised.

A new IT based Risk Management System is currently being drafted in conjunction with a neighbouring Service provide - SOS. In the interim, the current paper based system will continue to be used.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Infection control systems, while in place, were not carried out to an adequate standard.

9. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

Current Infection Control Systems will be reviewed and updated to ensure they are consistent with the Standards for the Prevention and Control of Healthcare Associated Infections 2009.

The PIC will ensure access to water, soap and hand drying facilities in all appropriate areas.

The PIC will monitor and audit the centre's current Infection Control Systems to ensure compliance and report the findings to their line manager (ADOS) on a weekly basis.

Infection Control Training is provided to staff in the centre and we will ensure that all staff participate in same. To date 22 staff have their infection control training done. Of the remaining staff to be trained we have three on Maternity Leave, three on long term sick leave, seven that are new to the service. Remaining staff will be participating in training in the coming weeks to meet timescale below.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

There were still some fire safety works outstanding.

10. Action Required:

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

Fire compliance work is ongoing. Schedule A Works are complete.

To enable further fire works to the existing building, vacant possession is required and this will only occur residents from Side One of the centre move to a community house which is currently pending registration. Further funding is also required to progress this work.

Fire fighting equipment is compliant.

All new bedding and furnishings are purchased on the HSE platform and are fire compliant.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Staff spoken with were unclear as to how evacuation drills were implemented and told inspectors that they were not carried out.

Documentation maintained in the centre indicated they had been implemented but did not specify the number of residents that had participated in the drill or how long it had taken to evacuate from the building for auditing purposes.

11. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

Staff nurse spoken to during the inspection had completed fire safety training Level 1. They will be undertaking Level 2 training in September.

The PIC will ensure that all staff are involved in scheduled fire evacuations.

The number and identity of residents and staff that participate in fire drill and the time taken for evacuation will be documented in a revised recording sheet.

Proposed Timescale: 26/08/2016

Theme: Effective Services

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

Inspectors reviewed fire safety training records for staff working in the centre. There were some training gaps evident. Some relief staff had not received training in fire safety.

12. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Training in Fire Safety is mandatory for all staff in the organisation. At the time of the inspection all staff (60) are up to date in their training for Fire Safety Level 1. Currently 27 staff of these staff are up to date for Fire Safety Level 2. A further four staff are participating in Level 2 training on Friday 19th August.

Remaining staff will be trained in the coming months. Two further training dates are scheduled for 30th September and 28th of October.

Proposed Timescale: 28/10/2016

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:

There were improvements required regarding the management of restrictive practices, in particular environmental restraint.

13. 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:

The Behaviour Support Plans for the residents currently living within "coded" door arrangements will be reviewed as a priority with the MDT to determine if there are alternative arrangements that would support the residents concerned, are the least restrictive alternatives and protect their safety and the safety of their fellow residents.

Risk assessments will be conducted to determine if the remaining coded door locks can be removed.

Proposed Timescale: 30/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

A comprehensive evidence based nursing assessment had not been completed for residents that presented with complex healthcare needs and co-morbidities.

Where support interventions were documented the support plans had been drafted by the resident's key worker but were not supported by recommendation by a relevant allied health professional. Therefore, it was unclear if the plans were in line with evidence based practice.

There was no evidence that such support plans had been reviewed by a relevant allied health professional to ensure they were appropriate or supporting the residents needs adequately.

14. 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:

"In House" Monthly Clinical reviews will be scheduled to ensure all residents have their clinical needs assessed on a regular basis. The outcomes of these reviews will determine referrals to relevant allied health professionals – Particular emphasis will be given to OT, SALT and Dietician. Recommendations from allied health professionals will in turn inform the in-house clinical reviews. All interventions will be evidence based and documented accordingly.

Monitoring and compliance checklists will be introduced to ensure recommendations from allied health professionals are implemented.

Weekly audits of these checklists will be conducted by the PIC and submitted to the line manager (Assistant Director of Services).

The Regional Practice Development Co-ordinator for Intellectual Disability Services who is a Quality Advisor and member of the National Quality Improvement Programme has recently commenced working with and advising members of the nurse management team in relation to best practice regarding assessment tools and in the role of the nurse in supporting residents in community based services.

The "Ok Health Check" will be completed on all residents by assigned Keyworkers, supported by registered nurses.

Proposed Timescale: 30/09/2016

Theme: Health and Development

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

Institutional practice regarding preparation and serving of residents' meals was observed during the inspection. Residents' meals were prepared in a centralised kitchen away from the centre and brought to the unit in heated containers.

15. Action Required:

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

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

Meals are now prepared two evening per week on one of the units. Dependency on the centralised kitchen will gradually reduce and cease when people transition to new homes. In the interim an increase in food preparation across the centre will be encouraged, whereby residents will be supported to buy, prepare and cook their own meals as much as possible.

Meals will routinely be prepared three evenings per week.

Proposed Timescale: 30/09/2016

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 not in place to oversee the quality and safety of care and to ensure that care was sufficiently monitored.

Systems to assess the quality and safety of care at the centre level were not adequate. Systems for auditing and checking the quality of care had still not been developed and implemented to a sufficient degree.

16. 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 PIC will liaise with the newly appointed Quality and Standards Co-ordinator to review system in place and implement revised internal auditing systems.

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

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

The inspector requested documentation and evidence of an unannounced visit to the centre by the provider, however there was none available on the day of inspection.

17. Action Required:

Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

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

Routine unannounced managerial audit visits will be initiated.

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

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

An annual review of the quality of service was unavailable on the day of inspection.

18. Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

An Annual Review of Quality & Safety of Care in the centre will be conducted by the Provider and/or the Director of Services by the end of September.

Six monthly and annual audits regarding quality and safety will be scheduled.

Proposed Timescale: 30/08/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

A staff supervision system had yet to be fully implemented at the time of inspection. Since the previous inspection supervision meetings and an induction process had begun for new staff. However, not all new staff that had started working in the centre since December 2015 had received a probation meeting with the person in charge in their first six months of working in the centre.

19. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

Probation reviews have been conducted with new staff. Four staff probations are outstanding and these have been scheduled to take place over the coming week.

Staff supervision sessions have commenced and are underway. Twenty (20) staff have had supervision sessions to date and all others are scheduled and will be complete by the end of September 2016.

Proposed Timescale: 30/09/2016