

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Lissadell
<b>Centre ID:</b>	OSV-0001897
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Saint Patrick's Centre (Kilkenny)
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	Laura O'Sullivan
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	6
<b>Number of vacancies on the date of inspection:</b>	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: 27 February 2018 10:10 To: 27 February 2018 16:20

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 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to Inspection.

This inspection was 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. Joseph's Villa 4. Subsequently, the provider reconfigured the designated centre into individualised apartments for residents whose assessed needs require individualised, single occupancy services.

The provider had applied to register this centre under Section 69 of the Health Act 2007. The purpose of this inspection was to inspect 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. 11 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, inspectors met with the recently appointed person in charge of the designated centre, nominated persons participating in management of the centre, and staff.

Inspectors also met and spoke with residents present in the centre during the inspection. Residents' specific communication repertoires meant they could not speak directly with inspectors or describe the service they were receiving. Inspectors at all times respected resident's personal choice to spend time with them or not to during the inspection.

As part of the inspection, inspectors observed practices and reviewed documentation such as risk assessments, behaviour support plans, personal plans, healthcare plans, medication management systems and schedule 5 policies. Inspectors also carried out an observational review of each of the apartments comprising the designated centre.

#### Description of the Service.

The centre comprises a one storey purpose built premises with five separate, self contained apartments. One apartment had a capacity for two residents. The centre is located in the congregated campus setting of St. Patrick's Centre, Kilkenny. The centre can accommodate up to six adult residents with varying degrees of intellectual disability and specific support needs in the management of healthcare, nutritional and specialised diets, epilepsy and behaviour support needs with associated personal risks.

Since the previous inspection a resident had transitioned from the centre to new designated centres operated by St. Patrick's Centre and located in the community. One resident currently living in the centre had transitioned from other designated centres on the campus in an effort to provide more improved living arrangements for them until they transitioned out of the centre to community residential setting homes.

This was part of St. Patrick's overall de-congregation planning which had begun earlier in 2017. St. Patrick's Centre had opened eight new designated centres since April 2017 registered by the Health Information and Quality Authority (HIQA) prior to residents moving in.

There were further 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.

Of the 11 outcomes inspected seven met with compliance or substantial compliance. Four outcomes met with moderate non-compliance.

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 in most apartments. 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 living in community residential homes. One apartment presented in a poorer state of repair than others, this however was in part to challenging behaviour presentation of the resident living in the apartment.

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 the assessment process some residents had been identified as requiring further medical investigations or treatment and this was being facilitated at the time of inspection through a person centred supportive process for those residents requiring such interventions, for example some residents were now receiving specialised diets in order to meet their nutritional needs better.

There had been a significant decrease in the use of chemical restraint in the centre. Residents' current living arrangements now provided them overall, with a more optimum living arrangement where single occupancy met their assessed needs better than sharing with a number of peers.

Improvements were required in some areas.

Staff training required improvement to ensure staff had knowledge and skills to meet residents' assessed needs, for example the management of dysphagia (compromised swallow) and management of behaviours that challenge and implementation of therapeutic response techniques in the event of a serious incident. Improvement was also required for mandatory training in the areas of fire safety and safeguarding vulnerable adults.

Inspectors issued an urgent action to the provider in response to poor management systems in place for a resident that presented with a personal risk which could occur and had most recently occurred in February 2018. Staff were not trained in a therapeutic response management technique to support the resident should such an incident arise and staffing and supervision levels in the centre were not adequate to ensure the safety of the resident at all times.

An assurance response by the provider was received by the Health Information and Quality Authority (HIQA) shortly following the inspection which outlined an increase in staffing levels within the centre, staff training in management of behaviours that challenge and specific training in a therapeutic response technique to support the resident.

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 during this inspection.

The complaints procedure was displayed in a prominent location within all apartments of the designated centre. The procedure was developed in an accessible format to ensure that all residents had an awareness of the complaints procedure and how to make a formal complaint if they wished. The document also included the contact details of persons within the centre that could assist with the complaint procedure. An up to date policy on complaints was also available within the centre.

Two complaints were documented in the complaints log. One showed evidence of resolution with documentation available to show this status. The other complaint remained open with evidence of on-going review by the person in charge. Both complaints had been submitted by staff on behalf of residents. This practice showed evidence of staff engaged in advocating on behalf of the residents.

On day of the inspection positive interactions were observed between staff and residents. Staff were observed to encourage residents to participate in a community based activity in a respectful and person centered manner. Staff respected residents personal boundaries and engaged in positive communication as part of this process. This was evidence of a positive and supportive approach for residents with autism, allowing them time to process requests and make informed decisions about their daily lives.

There was evidence of minutes of ongoing residents meetings. A number of topics were discussed during these meetings including activities, menus for coming week and future

goals. Also in place was a document for staff on how to carry out residents' meetings which included guidance on the use of objects of reference and other communication aids to facilitate the meeting, if a resident did not want to participate in the meeting their choice was respected.

**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:**

There was evidence to indicate allied health professional assessments of residents were ongoing and support planning to implement their recommendations were 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. Improvement was required with regards to person centred planning.

Inspectors 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 a residents' needs and support planning was reviewed through a multi-disciplinary allied health professional process. This was evidence of comprehensive review of residents' needs.

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.



While residents presented with personal challenges in relation to living with peers, they still engaged in activities both within and outside of the centre and were afforded opportunities to meet their peers and engage in their local community as much as possible. Activities residents engaged in were led by them in the most part and inspectors observed staff work in a patient, respectful and person centred way to encourage residents to engage in activities at their own pace.

Person centred planning however still required improvement. Overall, there was a lack of person centred planning with residents and associated goal setting with action plans to achieve goals identified and timelines by when goals should be reviewed and who was responsible for the implementation of the actions 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):**

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

Since the previous inspection, the designated centre had been reconfigured to provide residents with individualised apartments where it had been determined that they required single occupancy living arrangements to meet their assessed needs. One apartment provided occupancy for two residents and presented as a compact but homely space which the residents appeared to enjoy living in.

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 improvements were noticeable throughout, the premises was still institutional in

presentation.

Walls in some apartments were bare breeze block walls which had been painted. Residents had limited access to outdoors and could only leave the premises with a member of staff. Communal living room spaces lacked a homely aesthetic and kitchen areas were somewhat limited in space.

Some apartments presented as more homely than others. This, in part, was due to the assessed needs of some residents whereby they engaged in destructive behaviours in their home. For example, all cladding in the residents' bathroom had been removed by them and wardrobes had been removed. It was also noted that ventilation and light in some apartments was poor despite the refurbishment carried out by the provider.

Cooking facilities within all apartments were inadequate which meant residents meals could not be prepared or cooked in their home. Residents meals were prepared in another designated centre within the campus setting.

While it was demonstrated the provider had made concerted efforts to improve residents' living arrangements the centre could not provide residents with an optimum living environment similar to their peers in community residential homes.

**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 in most areas. overall. However, a personal risk for a resident did not have adequate risk mitigation management systems in place.

Fire safety works improvement works were carried out since previous inspection had been completed by this 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. Some residents, though ambulant, required additional supports for evacuation purposes, these were documented in their personal evacuation planning.

An up-to-date health and safety statement had been completed and a risk register was in place which detailed the risks and control measures specific to the centre and residents' personal risks also. There was evidence which demonstrated the person in charge's understanding and competence in carrying out and analysing risks both environmental and personal risks for residents. However, improvement was required in relation to personal risk management systems within the centre.

Where residents displayed significant risk of personal harm as a result of behaviours that challenge, risk mitigation management systems in place were not effective. This is further discussed in outcome 8; Safeguarding and Safety.

There was a policy on infection control. Cleaning schedules were in place and completed by staff on an on-going basis. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces.

**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):**

No actions were required from the previous inspection.

**Findings:**

The provider had put in place measures to ensure residents were safeguarded and protected from all forms of abuse. However, improvements were required to ensure staff were appropriately guided by policies and procedures and adequately trained in safeguarding vulnerable adults. Improvements were also required with regards to the identification and monitoring of restrictive practices. Inspectors identified a personal risk for a resident that required specific and targeted behaviour support assessments, planning and recommendations to ensure staff could adequately support the resident to prevent personal risks to the resident posed by their behaviour.

The provider had developed systems within Saint Patrick's Centre to implement the National safeguarding vulnerable adults policy. The policy was a printed copy of the HSE safeguarding vulnerable adults policy only. While this was acceptable in the main, the policy did not contain additional local procedural guidance for staff on how to implement the National policy within Saint Patrick's Centre designated centres. For example, the policy did not give 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 required to ensure staff were fully informed of how to implement National policy within Saint Patrick's Centre.

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

Not all staff had received up to date training in the area of safeguarding vulnerable adults.

Personal and intimate care plans had been developed for each resident. These plans were clear and gave guidance for staff on the individual needs for residents. They took into account the individual needs of the residents and were person centred in their approach.

A restraint register was in a place within the centre which detailed current identified restrictive practices within the centre. There was evidence of on-going review and updating of this register by the person in charge. An individualised assessment tool had been completed for each resident to assess if a current practice was restrictive in nature. A rationale was in place if a practice was deemed restrictive including specific control measures and management practices to ensure its safe and correct implementation. The use of chemical restraint had reduced significantly since the previous inspection. This was deemed attributable to the reconfigured premises which supported residents to live in a single occupancy arrangement which better met their assessed needs. However, improvement was required.

To manage a serious personal risk for a resident living in the centre required the infrequent but required use of physical restraint to ensure their personal safety in the event of a serious incident occurring. On review of systems in place to manage this risk inspectors were not assured the provider had instated adequate support mechanisms to manage the risk.

Not all staff had received training in the management of behaviours that challenge and therapeutic restrictive practice methods to support the resident in the event of such an incident. Behaviour support planning recommendations indicated staff were to contact An Garda Shiochána should a serious incident occur again. The rationale for this was due to staff not having the necessary training in therapeutic behaviour supports to manage such an incident. This was not adequate and demonstrated the resident's behaviour support needs could not be managed in the centre in a safe and effective

way.

In response to these findings, inspectors issued the provider an urgent action which required the provider to review and current supports in place and implement measures to ensure the personal safety of the resident at all times. Following the inspection the provider provided correspondence to HIQA in how they would improve support systems to manage the risk which included increasing staffing resources for the centre, improved electronic alert response systems and staff training in specific restrictive practice methods to be used in the event of a serious incident occurring.

The provider was required to continue to implement comprehensive and robust measures to ensure the resident was safely and adequately supported at all times to ensure their personal safety. Based on assurances received from the provider shortly following the inspection this outcome was found to be moderately non compliant.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Some notification of incidents, as required by the regulations, had not been submitted with the required timelines set out in the regulations.

**Judgment:**

Substantially Compliant

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

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

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

**Findings:**

Improvements in the overall comprehensive medical and allied health professional assessment of residents' healthcare had occurred and were still on-going.

All residents had their own General Practitioner (GP) and had received an annual health check with them. 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.

There was guidance for staff to support resident's healthcare need through the use of health care plans. For example a stoma care plan reviewed, gave staff guidelines for the management and associated infection control procedures. An associated risk assessment elaborated the current control measures in place. To further this support staff, the person in charge had requested stoma specific training for staff. Similar care plans had been developed for health care needs such as epilepsy management and nutrition support.

Not all apartments within the centre had adequate cooking facilities, for example, cooking hobs or ovens. A non compliance relating to this is assigned to outcome 6; safe and suitable premises.

Systems were in place however, to support the nutritional needs of the residents. Residents meals were prepared in another designated centre and supplied to the centre. Control measures were in place to ensure the food was maintained at a required temperature. Slow cookers and alternative cooking utensils had been purchased to encourage residents where appropriate to choose and prepare their own meals. A daily food safety and kitchen hygiene check was implemented by the person in charge and staff members on an on-going basis.

Where residents were prescribed specific specialised diets by their dietician, guidelines were in place for staff to follow in order to support residents.

**Judgment:**

Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Systems in relation to medication management were reviewed by inspectors. these were found to be efficient an safe.

Good practice was observed in the storage, disposal and supply of medications. Medication administration sheets were clear with medications prescribed clearly documented. A signature bank was availed for all staff authorised to administer medications within the centre, only nursing staff and staff that had completed training in the safe administration of medication could administered medication.

An external audit had been completed by a medication project lead in February 2018. As part of this audit a medication error was identified. Following the identification of this error a detailed action learning analysis had been completed by the person in charge. This was a detailed analysis of the error including what went wrong, why it occurred an what earning cold be had from the error. A second error examined should extensive review and learning.

A standard operating procedure was in place to give clear guidance for staff in the area of administration of medication. PRN medication (as required) protocols provided specific criteria and guidance for staff including how resident communicated pain, for example.

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

A statement of purpose was made available to inspectors as part of the inspection.

Overall, this document was in line with information required under Schedule 1. However some review was required.

The Statement of Purpose however, did not give accurate details of current whole time equivalent staffing current available within the centre.

Also the document did not take into account the temporary admission of residents to the centre as part of the de-congregation process currently being undertaken by St. Patrick's centre.

The provider was also required to revise the statement of purpose outlining improved risk management systems in place to support a resident and their specific personal risk presentation.

**Judgment:**

Substantially 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):**

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 comprehensive governance and management 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.

Lines of authority, accountability and reporting structures for management of the centre were clearly delineated.

The person in charge was supported in his role by a community services co-ordinator



who also had relevant management experience and a good understanding of regulation and monitoring centres for compliance with the standards and regulations. The person in charge was responsible for this designated centre and a recently opened community residential centre. They outlined to inspectors how they managed the two locations and provided supervision and oversight to both areas.

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 sample of six monthly provider led audits were reviewed. They were found to be informative and detailed with an associated action plan and persons responsible identified. At the time of inspection the person in charge 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 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

While it was demonstrated that staff working in the centre knew the residents and their assessed needs well improvements were required.

Improvements were required with regard to staff training within the centre. A significant number of staff required mandatory training in the area of fire safety, safeguarding vulnerable adults and therapeutic management of behaviours that challenge. Further training was required to assist staff in supporting residents requiring specific specialised diets and dysphagia management (compromised swallow which may lead to a risk of choking). It was identified by the person in charge during the course of the inspection, that releasing of staff to attend training was difficult due to the one to one staffing ratio requirements for residents in most instances.

However, while it was acknowledged that this was a contributing factor, the provider was required to ensure staff had necessary training in order to support the complex needs of residents living in this centre.

Staffing numbers within the centre were not in line with the whole-time equivalent staffing ratio as set out within the statement of purpose for the centre. Supervision arrangements for some residents presenting with specific personal risks were not adequate. As part of the urgent action issued to the provider during the course of the inspection, the provider was required to review current staff arrangements.

Following the inspection assurances were received from the provider that a suite of training had begun in the centre and increased staffing had been instated in the centre to ensure greater supervision levels for residents requiring specific supports. Based on the assurances received the non compliance for this outcome was deemed moderately non compliant.

Staff files were not reviewed as part of this inspection.

**Judgment:**

Non Compliant - Moderate

**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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Saint Patrick's Centre (Kilkenny)
<b>Centre ID:</b>	OSV-0001897
<b>Date of Inspection:</b>	27 February 2018
<b>Date of response:</b>	17 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. Overall, there was a lack of person centred planning with residents and associated goal setting with action plans to achieve goals identified and timelines by when goals should be reviewed and who was responsible for the implementation of the actions identified.

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

**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 responsible for pursuing objectives in the plan within agreed timescales.

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

1. Each Resident will have a Visioning Meeting by 31/05/2018.
2. These Visioning meetings will be scheduled by the PIC, before May 21st 2018
3. Individual Meetings will identify goals for each Resident, along with clearly documented timelines and monitoring mechanisms. PIC will ensure that each Resident has clearly identified goals and action plans, which will be monitored monthly by the PIC.
4. Keyworkers will be responsible for documenting goals, timelines and recording mechanisms.
5. Monitoring of goals and action will take place during Quality Conversations meeting and evidenced through 'Conditions for Success' forms

**Proposed Timescale:** 01/06/2018

**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:**

Cooking facilities in residents' apartments were inadequate and meant residents meals could not be prepared in the centre.

Ventilation and lighting in some apartments was not adequate.

**2. 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:**

Slow cookers, steamers and George Foreman grills will be in place in each apartment by 31st of May 2018.

Battery operated lighting will be purchased and installed to provide more lighting in areas that require same.

**Proposed Timescale:** 31/05/2018

**Theme:** Effective Services

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

Some parts of the premises were not in a good state of repair.

**3. Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

St Patrick's Centre de-congregation plan (approved by the BOM and shared with the regulator and Commissioner) will see all persons we support transition to the Community by year end 2018. The Operations Manager and Senior Management Team are responsible for execution and delivery on this plan.

Any identified immediate environmental Health and Safety concerns will be addressed by the Maintenance Team. 31/05/2018.

**Proposed Timescale:** 31/12/2018

**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.

**4. 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 (approved by the BOM and shared with the regulator and Commissioner) will see all persons we support transition to the Community by year end 2018. The Operations Manager and Senior Management Team are responsible for execution and delivery on this plan.

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

**Proposed Timescale:** 31/12/2018

**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:**

Some personal risks for residents did not have adequate risk mitigation and

management systems in place.

**5. Action Required:**

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

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

All Behaviour support plans will be reviewed by 31/5//2018 with ongoing monitoring and review systems in place. The PIC will schedule monthly recorded behaviour meetings for each person supported, where behaviours and associated incident forms will be graphed and analysed.

All person(s) behaviour that challenge risk assessments will be reviewed by 31/5/2018. There is an emergency response system in place with support from neighbouring houses. A review meeting for this is scheduled for 23/5/2018

**Proposed Timescale:** 31/05/2018

**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:**

Staff did not have necessary training in the therapeutic management of behaviours that challenge. This was required to support all residents living in the centre and specifically for one resident whose behavior posed significant personal risks from time to time.

**6. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Six staff have completed full Studio 3 training (5/3/2018) and (28/3/2018). Three staff are scheduled to attend Studio 3 training (3 day course) on 22/5/2018 The PIC has identified that the remaining staff within this centre are given priority for next training dates in Studio 3. The PIC is currently awaiting training dates for June and July 2018 for the remaining staff to attend.

A Counselling Psychologist who is employed by Studio 3 Clinical Services Ltd. has visited the centre to meet with one resident, his family and his staff team on 28/3/2018. Recommendations are being implemented on an ongoing basis and will be reviewed at scheduled monthly behaviour meetings.

Another supported person has also been referred to the Studio 3 Clinical services also to provide support and guidance to the staff team.

**Proposed Timescale:** 31/07/2018

**Theme:** Safe Services

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

Not all staff had received up-to date training in safeguarding vulnerable adults

**7. Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Since the inspection, all staff in the Centre have now completed Safeguarding Vulnerable adults training.

**Proposed Timescale:** 17/05/2018

**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 each residents safeguarding risk was.

**8. 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:**

Since the inspection the PIC has met with the Social Worker to review all safeguarding plans.

All incidents are now logged on the new online incident and accident reporting system (DMS). These incidents are reviewed by the PIC, CSM and Health and Safety Department. If there is any allegation or suspicion of abuse, an internal notification is submitted to the Social Worker who will then implement an interim safeguarding plan.

1. PIC will arrange a meeting with the Social Worker (Designated Safeguarding Officer) to review all recorded Accidents / Incidents to the end of April 2018 and identify any amendments to Safeguarding Plans which may be indicated. This review will have been conducted by 31/05/2018. Any amendments / introduction of new Safeguarding Plan/s will be completed by the end of June 2018. Each safeguarding plan has been reviewed by the PIC to clearly identified the risk and the management of same.



**Proposed Timescale:** 30/06/2018

**Theme:** Safe Services

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

The safeguarding vulnerable adults policy did not give organization or centre specific guidelines for staff to follow

**9. Action Required:**

Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

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

The safeguarding policy has been reviewed to include Centre Specific guidelines for staff. (please see attached)

The PIC ensure all staff are aware of centre specific guidelines at next team meeting. Each staff will read and sign the SPC safeguarding procedure.

**Proposed Timescale:** 10/06/2018

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

Some notification of incidents, as required by the regulations, had not been submitted with the required timelines set out in the regulations.

**10. Action Required:**

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

Since the inspection NF 39's have been submitted within the agreed time frame with all relevant information included.

The requirement in relation to submission of NFO's is now on the agenda for staff meetings within the Centre.

**Proposed Timescale:** 17/05/2018

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not accurately show current whole time equivalent staffing within the centre.

The statement of purpose did not take into account the temporary admission of residents.

The provider was required to revise the statement of purpose to include risk management measures in place to support a resident living in the centre and the management of their specific personal risk presentation.

**11. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:**

A full review of the centre SOP is currently being reviewed to include WTE staffing levels and capacity for temporary admission/s.

**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.

**12. 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 PIC will arrange to meet with the Quality Assurance Manager and agree an appropriate audit schedule to monitor optimal quality of services to residents.
- 2.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.
- 3.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 levels were not in line with the whole time equivalent staffing ratios set out within the statement of purpose.

#### **13. 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. The Statement of Purpose will be reviewed to include Whole Time Equivalent staffing levels. Staffing requirements & needs highlighted at HR Business Meetings held monthly.

2. 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 in mandatory training and further training specific to meet the needs of residents.

#### **14. 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:**

The PIC has identified training needs for each individual staff member and has forwarded same to the training department.

Since the inspection, all staff in the Centre have now completed mandatory Safeguarding Vulnerable adults training.

Studio 3 training is planned for the remaining staff within the Centre. (Awaiting dates for June and July).

Roster review process has commenced with staff teams. This will ensure that staff training will be built in to staff rosters to afford staff to attend same.

**Proposed Timescale:** 31/07/2018

**Theme:** Responsive Workforce

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

Not all staff working within the centre had received a supervision meeting with the PIC

**15. 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:**

A supervision schedule is now in place for all staff working within the centre. Since the inspection, as second team leader has commenced working in the designated centre and will now share supervision responsibilities in the centre.

All staff will have a supervision meeting by the below time frame.

**Proposed Timescale:** 15/06/2018