

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Liskennett Centre
Centre ID:	OSV-0004263
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Joseph's Foundation
Lead inspector:	Kieran Murphy
Support inspector(s):	Caitriona Twomey
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
01 February 2018 15:00	01 February 2018 19:00
02 February 2018 11:00	02 February 2018 15:00

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

Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 12. Medication Management
Outcome 14: Governance and Management

Summary of findings from this inspection

Background to the inspection

This was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA). This inspection was undertaken to follow up the previous inspection in August 2017 where it was identified that significant improvement was required in relation to the implementation of restrictive practices.

Description of the service

St Joseph's Foundation provides a range of day, residential and respite services in North Cork and Limerick. The centre was a congregated setting and provided a home to 14 residents. It was based in a community setting in county Limerick. The campus also had an equestrian centre. All of the residents had high support needs and were supported individually by a high staff complement, mostly on a one-to-one basis.

The designated centre was purpose built and comprised 14 individual apartments divided into three sections:

- the community apartments which provided a home to eight residents. These apartments were all contained in an enclosed building and there was a communal dining area and kitchen available to residents. Access to the building was via a keypad code. There was also an enclosed garden available in this area where staff said that residents enjoyed barbeques.
- the farmhouse apartments. These were two apartments in the middle of landscaped grounds. It was a two-storey building with one apartment upstairs and the second downstairs. Access to the upstairs apartment was via a keypad code.

- the stables apartments which had four individual apartments which were accessed via landscaped gardens.

Each of the apartments had their own front door. All the apartments had been finished to a very high standard, with a kitchen, living, dining area, bedroom and shower facilities. A number of the apartments had restricted access with entry only via a coded keypad.

How we gathered the evidence

Over the duration of the two days of inspection nine of the residents met with the inspectors. Inspectors also met with staff during the inspection and observed their interactions with the residents. In addition inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

Overall judgment of our findings

Since the last inspection the service had recruited a number of nursing staff to support the person in charge at an operational level with the result that a nurse was available at all times during the day. This additional clinical resource had resulted in increased opportunity for staff to be adequately supported and supervised. In addition, the area manager had based himself in the centre since the last inspection and was available at all times to support and supervise staff.

However, improvement was required in relation to safeguarding and positive behaviour support which was at the level of major non-compliance:

- Recommendations from behaviour support strategies were not always being implemented. There was also inadequate guidance for staff for recurring issues and the reactive strategies identified in the behaviour support plans did not address a number of behaviours that had been previously identified by the St Joseph's service. In addition, some behaviour support plans were not being reviewed in the timeframe specified by the plans themselves (Outcome 8: Safety).
- Improvement was also required in relation to the process for approving each restriction as not all required risk assessments were in place and in particular there was not a risk assessment for the use of emergency holds ('MAPA' holds) (Outcome 8: Safety).
- In addition, improvement was required to the documentation in relation to approval and review of the restrictions as not all required sections of the decision making form were being completed. In addition, the restrictions were not being reviewed within identified timeframes (Outcome 8: Safety).
- It was noted on the last inspection that St Joseph's Foundation had commissioned an investigation report into alleged normalisation in the centre of inappropriate and unapproved physical interventions in response to incidents. There were 25 recommendations from this investigation report and while many of the actions had been implemented there were a number of actions outstanding including the availability of a code of conduct for staff and mandatory training for staff on the implementation of this code of conduct (Outcome 8: Safeguarding).

Further improvement was also required as:

- The management arrangements could not ensure effective governance, operational

management and administration of the designated centre concerned. This was a finding on the previous inspection and related to the person in charge still having responsibility for two designated centres where there were complex needs of residents across both centres. (Outcome 14: Governance and management).

- There was no evidence of a second person checking the prescription sheets as transcribed by a nurse in order to minimise the risk of error and these practices do not meet with best practice in medicines management (Outcome 12: Medicines Management).

- Following a review of incidents onsite, inspectors noted that a reportable incident relating to a safeguarding issue had not been submitted as required to HIQA. The person in charge was requested to submit a notification for this incident (Outcome 9: Notifications).

The reasons for 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 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:

Restrictive procedures were not in line with evidence based practice. It was found that recommendations from behaviour support specialists were not always being implemented. Improvement was also required to ensure the recommendations from an investigation report were being implemented including that all incidents were being reviewed and followed up appropriately

In 2017 the St Joseph's Foundation had commissioned an investigation report into alleged normalisation in the centre of inappropriate and unapproved physical interventions in response to incidents. There were 25 recommendations from this investigation report and it was noted on this inspection that many of the recommendations had been implemented including increased supervision of staff and more regular formal staff meetings. However, some recommendations were still outstanding including mandatory training for all staff on the code of conduct. It had also been recommended that staff would be familiar with resident support plans. However, during the inspection there was an incident and it was observed that staff had not followed the support plan in place.

One of the recommendations from the investigation report was that there would be regular audits of incidents occurring in the centre. Inspectors reviewed records of incidents covering the period August 2017 to February 2018 for the area described as the communal area of the centre. There were 38 reported incidents which included six incidents of errors in medicines management with seven incidents relating to residents hitting or attempting to hit staff. While incidents were being managed in a timely manner, improvement was required to ensure that all incidents were being reviewed and

followed up appropriately. The St Joseph's service had completed an annual review of quality and safety of care in the centre for 2017 and this review had also identified that improvement was required to ensure that learning from incidents was shared to inform staff practice.

It is a requirement of the regulations that all serious adverse incidents, including safeguarding issues are reported to HIQA. Eight such incidents had been submitted to the Chief Inspector since the previous inspection. Documentation in relation to these incidents were reviewed during the inspection and it was found that all incidents had been followed up as per the organisation's safeguarding guidelines.

There was a specialist in behavioural support available to residents. Where required, residents had positive behavioural support strategies in place that provided a comprehensive background to guide staff. However, many of the recommendations from these support strategies were not being implemented. For example, it was clearly outlined that staff working with one resident needed training to communicate and interact with the resident. However, not all staff had received this communication training. In addition, the support plan outlined that the resident required more opportunities to do daily activities more independently and that the resident would benefit from increased activities in the community, including swimming. However, according to documentation seen by inspectors and conversations with senior staff members these recommendations were not being implemented. In other behaviour support plans seen by inspectors, there was inadequate guidance for staff for recurring issues and the reactive strategies identified in the plans did not address a number of behaviours that had been previously identified by the St Joseph's service. In addition, some behaviour support plans were not being reviewed in the timeframe specified by the plans themselves.

Since the last inspection the St Joseph's Foundation had reviewed their policy and guidelines on the use of restrictive interventions and the organisation aspired to a restriction free environment. The St Joseph's Foundation was obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in December 2017 that chemical restraint had been used on 19 occasions and that eight emergency holds ('MAPA' holds) had been used in the three months from July to September 2017. It was noted that since the last inspection there had been a reduction of environmental restrictions throughout the centre including the removal of keypads on entry to the communal area of the centre and locks from presses in the kitchen area.

For each restriction identified there was a restrictive intervention assessment and decision-making form that was to be approved and reviewed on at least a three-monthly basis by the multidisciplinary team. However, improvement was required in relation to the process for approving each restriction as not all required risk assessments were in place and in particular there was no risk assessment for the use of emergency holds ('MAPA' holds). In addition, improvement was required to the documentation in relation to approval and review of the restrictions as not all required sections of the decision making form were being completed. In addition, the restrictions were not being reviewed within identified timeframes.

Inspectors noted that some residents were prescribed 'as required' medicines to be used to relieve agitation or anxiety. While there were protocols in place for agitation, anxiety for residents that required it, the protocols had not always been signed off by a suitably qualified person. For residents that received these 'as required' medicines the continual monitoring of the resident and effect of the medicine was not always documented. This was also a finding on the previous inspection. In addition, medicines identified as chemical restraint in the St Joseph's restrictive practice policy were not always being reviewed as directed by the decision making process identified in the service restrictive practice policy.

Judgment:
Non Compliant - Major

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:
It is a requirement that all serious adverse incidents were reported to HIQA within three working days of the incident. On the last inspection a notification had not been submitted due to an administrative error but was subsequently submitted. Since the last inspection a record of all incidents occurring had been maintained and all notifications had been sent to HIQA as required.
However, following a review of incidents onsite, inspectors noted that a reportable incident relating to a safeguarding issue had not been submitted. The person in charge was requested to submit a notification for this incident.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:
Health and Development

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

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

Findings:

A single aspect of this outcome was reviewed on inspection.

The medicine prescriptions were transcribed by the person in charge who was a registered nurse. Transcribing is the act of transferring a medication order from the original prescription to the current medication administration record; prescription sheet. However, there was no evidence of a second person checking the prescription transcribed in order to minimise the risk of error and these practices did not meet with best practice in medicines management.

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):

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

Findings:

The management arrangements could not ensure effective governance, operational management and administration of the designated centre concerned.

The person in charge was a registered nurse in intellectual disability, had had been appointed as person in charge of this centre in May 2017 and had worked for St Joseph's Foundation for over ten years. However, she was also the person in charge for another designated centre. As on the previous inspection, this was a significant workload for the person in charge in circumstances where there were complex needs of residents across both centres.

Since the last inspection the service had recruited a number of nursing staff to support the person in charge at an operational level with the result that a nurse was available at all times during the day. This additional clinical resource had resulted in increased opportunity for staff to be adequately supported and supervised. In addition, the area

manager had based himself in the centre since the last inspection and was available at all times to support and supervise staff. The area manager outlined that there would be changes to the staff rota with the provision of "awake" staff at night at all times to support residents, particularly in the event of an emergency.

An annual review of the quality and safety of care provided by the centre had been completed for 2017. A number of issues identified on this inspection had also been identified in the annual review including:

- supporting staff in understanding and implementing support plans
- restrictive practices
- training for social care leaders in supervision
- review and update person centred plans.

The provider had ensured that an unannounced visit had been completed that reviewed the quality and safety of care and support in the centre. However, there had only been one in the previous 12 months and not two as required by the regulations and so effective oversight of care and support of residents was not demonstrated.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Joseph's Foundation
Centre ID:	OSV-0004263
Date of Inspection:	01 & 02 February 2018
Date of response:	21 March 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 08: Safeguarding and Safety

Theme: Safe Services

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

Recommendations from behaviour support strategies were not always being implemented. There was also inadequate guidance for staff for recurring issues and the reactive strategies identified in the behaviour support plans did not address a number of behaviours that had been previously identified by the St Joseph's service. In addition, some behaviour support plans were not being reviewed in the timeframe specified by

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

the plans themselves.

1. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

- Team meetings will be organised to inform staff on all behavioural plans in place in the designated centre and to provide support to staff to enable them to fully understand and implement all plans.
- Training on Autism, behaviour support, implementation of behaviour support plans, key working, and Movement method has been designed and customised for the designated centre. Training days are organised for 24th April & 1st May.
- All behaviour support plans will be reviewed in line with the specified timeframes.

Proposed Timescale:

1. 28th March 2018
2. 24th April and 1st May 2018
3. 30th April 2018

Proposed Timescale: 01/05/2018

Theme: Safe Services

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

Improvement was required in relation to the process for approving each restriction as not all required risk assessments were in place and in particular there was not a risk assessment for the use of emergency holds ('MAPA' holds). In addition, improvement was required to the documentation in relation to approval and review of the restrictions as not all required sections of the decision making form were being completed. In addition, the restrictions were not being reviewed within identified timeframes.

2. Action Required:

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

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

- Risk assessment has been completed in relation to the use of emergency (MAPA) holds.
- The completion of documentation regarding restrictive procedures and in particular the need to include clearer relevant discussion regarding same was discussed at Person in Charge meeting 15/3/18. This was to ensure general learning for all designated centres.
- Restrictions will be reviewed within identified timeframes.

- Complete 15/03/2018
- Complete 15/03/2018
- 15/04/2018

Proposed Timescale: 15/04/2018

Theme: Safe Services

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

All recommendations were not being implemented following an investigation report into alleged normalisation in the centre of inappropriate and unapproved physical interventions in response to incidents.

3. Action Required:

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

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

- 1.Recommendation from report in relation to the introduction of a written Code of Conduct has been implemented and the Code of Conduct has been distributed to all staff in 2017.
- 2.Training programme relating to the Code of Conduct / Code of Practice has been developed and mandatory training will be provided to all staff in 2018.
- 3.Person in Charge to review incidents on a weekly basis and bring learning to team meetings. This is a set agenda item at all team meetings.

Proposed Timescale:

- 1.Complete 31st March 2017.
- 2.June 2018.
- 3.Complete and ongoing

Proposed Timescale: 30/06/2018

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:

Following a review of incidents onsite, inspectors noted that a reportable incident relating to a safeguarding issue had not been submitted as required to HIQA. The person in charge was requested to submit a notification for this incident.

4. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector

within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

Incident reported through organisation policy & procedure. Going forward all alleged incidents will be notified as per guidance.

Proposed Timescale: 21/03/2018

Outcome 12. Medication Management

Theme: Health and Development

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

There was no evidence of a second person checking the prescription transcribed in order to minimise the risk of error and these practices did not meet with best practice in medicines management.

5. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

Staff rewriting medication Kardex's will sign same and have a second staff member check and initial the Kardex prior to sending it to GP for his/her signature, to minimise the risk of medication errors and to comply with best practice.

Proposed Timescale: 16/03/2018

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:

14(4) The management arrangements could not ensure effective governance, operational management and administration of the designated centre concerned.

6. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

- Paperwork for the Person in Charge is in the process of being submitted to HIQA.

Proposed Timescale: 31/03/2018

Theme: Leadership, Governance and Management

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

There had only been one unannounced visit to review the quality and safety of care and support in the centre in the previous 12 months and not two as required by the regulations.

7. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

Two six monthly reviews are scheduled for 2018.

Proposed Timescale:

1.April and August 2018

Proposed Timescale: 31/08/2018