

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0005450
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Aileen Colley
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	28
<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 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: 04 May 2016 10:10 To: 04 May 2016 19:00

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 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This follow up inspection took place in order to assess regulatory compliance following the permanent granting of an order under Section 64 of the Health Act 2007 transferring responsibility for this designated centre from St Patrick Centre (Kilkenny) Ltd to the Health Service Executive (HSE) in October 2015. This inspection was carried out over the course of one day and assessed a total of 10 Outcomes.

This centre had been inspected in September 2015 and February 2016 following the temporary granting of this order. As part of this inspection, the inspector met with residents, the director and assistant director of services and members of staff. Documents such as personal plans, incident logs, medication administration charts and staff training records were reviewed.

Despite giving assurances in their action plan response to failings identified in the February 2016 inspection, areas of significant non compliance were still continuing. The provider had failed to address certain actions within the time-frames specified in their action plan response to the February 2016 inspection.

The centre referred to in this report is located on the campus of a congregated setting operated by St. Patrick's Centre (Kilkenny) Ltd. The designated centre discussed in this report comprises of one residential building which has three residential units interlinked by means of connecting corridors. The other part of the centre comprises of three bungalow- type buildings located in the congregated setting also. The premises has been consistently found to be majorly non compliant in all inspection reports by the Health Information and Quality Authority (HIQA) to date.

In some instances residents' needs could not be met due to lack of assistive equipment in the centre. In other instances the physical layout of residents' bedrooms impacted on their privacy. Overall the premises presented as institutional in style and was poorly maintained and decorated in areas.

Although it was noted that staff numbers had increased and instances of peer to peer aggression/abuse had decreased the inspector was not satisfied that sufficient progress had been made since the permanent order was granted. The inspector had significant concerns regarding the lack of suitable governance and management arrangements to oversee the quality and safety of care provided to residents. As a result there were direct negative outcomes for residents.

Despite providing significant additional resources the provider (HSE) had still not put sufficient arrangements in place to ensure outcomes for residents were of a high standard with tangible and observable positive outcomes for all residents. The inspector also had concerns regarding fire safety, the management of risk and healthcare assessment and provision, in particular for residents that could experience seizures associated with epilepsy.

The inspector found that the lack of effective governance and management systems had resulted in:

- Resident's rights and their privacy and dignity not being promoted at all times due to institutional practices. (Outcome 1)
- Institutional style premises which did not promote or provide residents with an opportunity to experience a standard of living similar to their peers. (Outcome 6)
- Risks being identified in health and safety due to poor risk identification and fire safety measures. (Outcome 7)
- Poor safeguarding measures in relation to restrictive practices experienced by some residents. (Outcome 8)
- Incidents of peer-to-peer abuse not being reported to the Chief Inspector as required. (Outcome 9)
- Lack of nursing assessment in residents personal plans resulting in poor healthcare risk identification. (Outcome 11)
- Medication management systems were not adequate in some instances. (Outcome 12)

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 of the report.

**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):**

No actions were required from the previous inspection.

**Findings:**

Not all aspects of this Outcome were inspected on this inspection.

The inspector found residents were still experiencing inadequate privacy and dignity supports in this centre. The inspector observed some practices occurring during the inspection which did not provide due regard for residents' privacy, dignity and support needs. Residents with higher dependency and sensory needs did not have opportunities similar to their peers.

Some residents who were more physically independent were observed during the inspection to engage in activities such as going on trips and excursions supported with the aid of a personal assistant. There was evidence to indicate this had brought about positive outcomes for those residents, for example a reduction in self injurious behaviour. However, residents with higher dependency and sensory needs did not have opportunities similar to their peers.

For example, a resident with significant visual impairment was observed to sit unoccupied for hours at a time. The resident was observed to sit against a wall on a dining room chair with a table in front of them for most of the inspection. The inspector reviewed the resident's activity planner which indicated they should have engaged in three specific activities for the day. However, the resident did not engage in any of the activities planned.

An allied health professional, who had visited the residential unit in October 2015, had also highlighted their concern in relation to the resident's notable lack of activity and engagement. This concern was documented in the minutes of multi-disciplinary team meeting for the resident mentioned. However, these resident's needs had not been adequately addressed.

Given the resident's significant sensory impairment and reliance on others to initiate activities for them, the inspector was concerned that the resident was experiencing a significantly poor standard of person centred support and brought this to the attention of the assistant director and director of services at the feedback meeting. The inspector requested systems be put in place as a matter of urgency to support the resident to ensure they were not experiencing lack of stimulation and meaning in their lives for long extended periods.

Direct observations during the inspection indicated staff interaction with residents, while pleasant and gentle in tone, was brief and generally as a result of the staff member carrying out a direct support intervention with the resident, such as helping them to eat or administering medication to them. When staff were not engaged in direct support of residents' healthcare or nutrition needs for example, they were engaged in carrying out tasks on the unit such as folding towels and tidying residents' bedrooms and writing up daily observation notes.

Privacy options for residents were poor in the centre, for example, a window was located in the door of a resident's bedroom. Some resident's bedrooms were located in the vicinity of the communal area. The location did not afford residents with adequate privacy. The door to residents' designated toilet could not be locked for privacy as the thumb turn fitted did not work.

**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. However, these were on a referral basis only which did not assure the inspector given the lack of social care assessment evidenced in residents' personal plans.

As found on the previous February 2016 inspection, 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 were less likely to engage in activities and were observed in some instances unoccupied for considerable periods of time.

The inspector reviewed a sample of residents' personal plans that had been highlighted as inadequate during the previous inspection. This was in order to ascertain if there had been any considerable improvement based on the previous actions. However, from the sample of personal plans reviewed residents' there was little evidence to indicate considered improvement had occurred.

Residents' personal plan information was still 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.

The person in charge was not on duty the day of inspection and the staff nurse allocated to the centre facilitated the inspection. However, there were numerous instances where the staff member could not retrieve information readily. Retrieval of core healthcare information for residents was not readily to hand and numerous files were searched at various times to establish information about residents. For example, the inspector requested to see a copy of a resident's most recent weight recordings. They were not readily available in either the resident's personal plan or medical file. They were located in another file some hours later.

Support plans in many instances were still not dated or accompanied by a signature. Therefore it was not possible to identify who drafted the plan, who reviewed them or if the plans were still current. This had been also found on the previous inspection February 2016.

Of the sample of plans reviewed they outlined some goals for residents to achieve. However, they were not up to date and were not of a standard that would bring about meaningful change or enrichment in residents' lives.

Goals identified for two residents appeared to be printed copies and not individualised to the resident. Goals documented for both residents included the following; 'more contact with home', 'go out for tea one evening a week', 'would like more access to money to buy 'farmer's journal' and buy items from a catalogue'. The lack of person centred, individualised goals for residents and the limited and poor standard of the actual goals established, indicated a lack of potential for residents to achieve a meaningful enriched

life experience.

Residents were receiving allied health professional assessment based on a referral, made by nursing staff in the centre. However, the inspector was not assured that this was an effective system for ensuring residents had access to appropriate multi-disciplinary support. There was little or no evidence that residents' health and social care needs had been assessed in any meaningful way to direct a referral to specific allied health professional(s) in the first instance.

The inspector found an example where allied health professionals, following their assessment of a resident, made their own referral for a resident to be reviewed by a psychiatrist rather than the referral directed by an assessment of need carried out in the centre.

**Judgment:**  
Non Compliant - Major

**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:**

The premises were not meeting the needs of residents.

While this outcome was not reviewed in full, the inspector found one residential unit of the centre significantly did not meet the needs of residents who lived there.

The building referred to consisted of three units which were interlinked by means of connecting corridors. The building was not homely and did not provide residents with a living environment similar to their peers.

Residents' bedrooms were small and did not provide sufficient space for assistive equipment or personal belongings in some instances. For example, one bedroom consisted of padded walls and floors. While staff explained that these measures were to provide for the safety of the resident, it was not demonstrated that this was an evidence-based approach. The bedroom was without a bed or wardrobe or any other space where the resident could maintain personal effects. The resident's clothes were



kept in a large cupboard on the corridor adjacent to their bedroom.

Assistive equipment, such as a hoist and specialised seating, could not be used in the room. Also, due to the layout of the room and lack of appropriate assistive equipment, staff physically lifted the resident when transferring them to their wheelchair or modified seating, for example. To do so the resident was required to kneel on the floor for a period during transfers.

The inspector observed how the transfer was carried out. The resident was assisted from their wheelchair to the floor by staff where they kneeled for a short period before being physically assisted by staff to specialised seating. This occurred in the communal room of the unit. The inspector was informed by staff that this was the same practice that occurred when the resident was transferred from their wheelchair to the shower chair requiring the resident to kneel on a towel on the tiled floor of the bathroom.

The inspector was concerned that the lack of assistive equipment and space for its use, in some areas of the unit, could lead to unsafe moving and handling procedures which could put residents at risk of injury. In addition this practice did not support the privacy and dignity of the resident.

A number of bedrooms and other rooms in the centre were poorly maintained in appearance. The standard of cleanliness in some areas of the centre was also poor. A bath in the residential unit was not clean. The inspector observed there was a build up of dried residue in and around the plug. While the inspector was assured that residents in the centre did not use the bath this did not demonstrate a sufficient rationale for why it was not clean.

The residential unit did not have a separate kitchen area with suitable and sufficient cooking facilities and kitchen equipment, for example a cooker/oven. Residents meals were transferred from the main kitchen located in the congregated setting.

**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 had also improved. However, the inspector was still not assured that residents' health and safety and risk management were sufficiently promoted and protected.

All priority fire safety works for the centre had been completed. For example, the inspector noted the presence of fire rated doors had been fitted at key compartmentalisation points in the building which improved the fire and smoke containment systems of the centre. All staff had undergone fire safety training.

There were still some fire safety works outstanding. For example, new mattresses with a fire rating were still not in place and were on order at the time of inspection. A large square opening in a resident's bedroom door did not afford the resident with adequate protection against smoke or fire.

The inspector reviewed a personal evacuation procedure for a resident. However, there were two different personal evacuation plans for the resident. One indicated the resident required a duvet for evacuation and the other a duvet or ski sheet. The use of a duvet for evacuation purposes was not in line with appropriate and safe fire evacuation procedures.

This concerned the inspector as the differing information across two documented evacuation procedures could lead to confusion for staff and lead to unsafe evacuation procedures being implemented during an evacuation. Given the complex needs of the resident and that a number of agency staff worked in the centre this further added to concerns.

Part of the fire safety works for the centre had been to ensure appropriate fire evacuation systems were in place for residents. The inspector did not find this was the case for all residents. Staff could not locate the ski sheet documented in the residents personal evacuation plan and informed the inspector that the evacuation procedure must be to use a duvet as there was no ski sheet available.

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.

Since the previous inspection systems for the review of incidents and accidents had begun. The health and safety officer for the service reviewed incidents and accidents daily and submitted a report to the senior management team at least once a week. This process was to facilitate senior management in identifying trends and themes for each designated centre in the congregated setting in order to inform decisions regarding resources required for each centre. A quality and safety committee had also been established which had risk, accidents and incidents as a fixed agenda item. This was an improvement in the management and oversight of risk, accidents and incidents in the centre.

However, corrective actions in response to accidents and incidents did not always address the actual risk in a comprehensive way. For example, an incident had been recorded whereby a resident locked themselves into the bathroom and had turned on the shower. They had turned the temperature of the shower up high and had held the shower head against their chest resulting in a red mark. The privacy lock on the bathroom door was removed as the action taken to address the risk posed by the incident.

While action had been taken it had not addressed the specific risk to the resident which was risk of a scald and the removal of the bathroom lock impacted on the privacy for residents using the bathroom as they could no longer lock the door. The risk for residents receiving a scald was not comprehensively addressed.

While systems were in place for the overview of incidents and accidents had improved the inspector was not assured that the information collated would be entirely accurate as some incident forms reviewed indicated risks to residents had not been accurately or appropriately recorded.

In one instance a medication management incident had been identified as a resident engaging in behaviours that challenge. This is further discussed in Outcome 12.

Some incidents that had been recorded on the electronic system could not be reviewed fully as there were issues with accessing all information that had been logged at the time. The inspector found in these instances the only information available was a description of the incident, no actions taken were detailed.

The assistant director of services informed the inspector that the organisation would need to contact the technology company they had procured the equipment from and request to access the information regarding the incidents. This could take some time as the organisation were no longer in a contract with the company.

Infection control systems, while in place, were not carried out to an adequate standard. The cleanliness of the centre in some parts was not adequate in particular resident's toileting and bathing facilities. Some assistive equipment was stored in the shower, toilet area and on the day of inspection was pushed beside toilet. Paper hand towels were located in the residents' designated toilet for hand drying purposes. However, the inspector could not use them to dry hands as they were stuck in the dispensing container. This impacted on residents being able to engage in good hand hygiene. The health information and quality authority had received a notification of an outbreak of infectious disease from the centre in the months previous to the inspection.

**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):**

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

**Findings:**

Systems for the protection of vulnerable residents were in place. However, improvements were still required in relation to the identification and management of restrictive practices.

Since the previous inspection the number of incidents of peer to peer abuse incidents had reduced. The increased number of staff in the centre and allocation of personal assistants for some residents had also brought about positive tangible changes for residents. There had been a reduction in the number of times residents engaged in self injurious behaviour. For one resident there was evidence to indicate a wound was gradually healing as a result of the reduced number of incidents where they engaged in self injurious behaviour.

Review of staff training records indicated all staff had received safeguarding vulnerable adults training. An action from the previous report related to inadequate staff training in the management of behaviours that challenge. The timeline for action plan response had not passed at the time of inspection. However, on reviewing the training records for the centre the inspector did note most staff had received training in behaviours that challenge response techniques. Further training in positive behaviour support was due to take place.

A sample of behaviour supports plans for residents indicated they had been updated in the months prior to this inspection and contained relevant information such as describing the behaviours of concerns for residents, predictors of such behaviours and the strategies to be adopted to respond to such behaviours.

However, the inspector observed one instance where a resident experienced prolonged environmental restriction during the course of the inspection. As outlined in Outcome 1 of this report the inspector observed a resident sit for hours unoccupied. The inspector noted that the resident's personal freedom was limited due to where they were positioned in the unit. The resident sat on a wooden chair against a wall with a bare table in front of them for hours. The resident could mobilise but was unsteady and required assistance.

The inspector was concerned the arrangement of furniture placed in front of the resident was to limit their movements and presented as an environmental restraint which they experienced for hours at a time. This restrictive practice had also been observed by an allied health professional in October 2015 and had been highlighted at an allied health professional meeting. However, as the inspector observed, the practice had not changed since then.

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

**Findings:**  
Review of accidents and incidents indicated there had been some instances of peer to peer abuse which had not been notified to the Chief Inspector.

For example, a resident was slapped across the face by another resident, in another incident a resident bit another on the arm leaving a red mark 2-3 centimetres in size. This information is required to be promptly notified to the Chief Inspector.

**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. Institutional practices were evident in the manner in which residents' meals were prepared and mealtimes observed were not provided in a way which ensured they were pleasant occasions. The actions from the previous inspection had not been adequately addressed.

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 several decades stored with more recent information.

Some annual health reviews had been carried out for residents in the centre. The inspector saw one such annual health review had been carried out in January 2015. The inspector could not find evidence that an up to date annual health review had taken place for 2016 to inform healthcare interventions for residents.

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.

The inspector followed up on a healthcare issue that had been identified on the previous inspection relating to skin breakdown. The inspector found that there was a failure to address the matter since the previous inspection in February 2016. An evidence based approach to management of this health care need was not demonstrated. In the resident's personal plan it was documented that they had a Grade 2 pressure ulcer dated 25 February 2016. However, there had been no further assessment of the resident's risk for developing pressure ulcers. The inspector found evidence of a blank pressure ulcer risk assessment maintained in the resident's personal plan. There was no evidence that a pressure ulcer risk assessment had been completed since since the pressure ulcer was identified 25 February 2016.

The inspector was informed that the resident had been seen by a tissue viability nurse and requested to see the notes of the review. However, on reading the notes it was documented the tissue viability nurse had arrived to the residential unit to see another resident and while there had been asked to review the resident. A note had been made in the resident's medical file by a staff nurse on the unit, not the assessing tissue viability nurse, indicating there were no issues. The inspector was not satisfied the resident had been reviewed in line with policies and procedures regarding residents' healthcare whereby an individual referral is made to the relevant allied health professional.

The resident had also been recommended a pressure relieving cushion which was to be used when they were seated to prevent pressure ulcer breakdown. The inspector did not see the cushion in use during the inspection and observed the resident sitting for an extensive period of time without moving. This posed a risk for pressure ulcers to occur due to persistent pressure to areas of their body from sitting in one position.

A number of residents in the centre could experience seizures related to epilepsy. While these residents were regularly reviewed by their medical practitioners, care plans still did not guide staff in sufficient detail. Epilepsy care plans indicated emergency rescue medication was to be used. However, they did not outline what steps staff were to take should the resident not respond to the treatment, for example when to call emergency services.

Not all staff working in the centre had received training in the administration of rescue medication to control seizures. At the time of inspection only a nurse could administer the medication. On the day of inspection, one nurse was on duty for the 28 residents living in the centre which comprised of a number of residential units located on the campus of the congregated setting. This often occurred as was evidenced from reviewing duty rosters for the previous week.

This meant there could be a delay in a resident receiving emergency medication if the nurse on duty was not in the unit the resident lived in when they experienced a seizure. The inspector was concerned this posed a healthcare risk to residents and discussed this issue with the director of services who assured the inspector training in emergency medication administration was to take place shortly after the inspection.

Mealtimes observed during the inspection were not always supportive to residents' needs. The inspector observed household staff hoovering the communal area while a resident, with significant visual impairment, was supported to eat their breakfast. The resident's mealtime experience was continuously disrupted by the noise of hoovering and the banging of furniture and doors in the area. Given the resident's significant sensory visual impairment, due regard was not afforded to them to ensure their mealtime was a pleasant, supportive experience

Institutional practice regarding preparation and serving of residents' meals was also 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.

**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:**

The actions from the previous inspection had been addressed.

The inspector reviewed a sample of medication administration charts and found PRN (as required) medications now indicated the maximum dose to be administered in 24 hours. Discontinued medication was now signed off as discontinued by the prescribing medical professional.

However, there were still some improvements required. Some documentation errors were on administration charts. From a sample of five administration charts reviewed all had errors where the date the medication was administered had not been entered.

As mentioned in Outcome 7, a medication management error had been documented as a resident engaging in behaviours that challenge. An incident had occurred where a resident had been administered their medication. Five minutes later the resident walked over to staff and pointed to their nose where staff noticed a tablet was stuck in their nostril. The incident was documented as the resident engaging in behaviours that challenge rather than a medication management incident. This resulted in the incident not being appropriately investigated which resulted in no changes made in staff practice regarding the administration of medication to the resident.

**Judgment:**

Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The previous inspection in February 2016 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 new governance structures, implemented since the transfer of the centre to the HSE, had resulted in some improvements. There were increased numbers of staff and this resulted in an increased level of support for those residents assessed as requiring one to one support. This had a direct positive impact on the quality of life of some residents who were supported with individual activity programmes. The number of residents in the centre had been reduced through the provision of alternative accommodation and staff reported that this reduced peer to peer assaults in the centre. The carrying out of initial fire safety works had removed the immediate risks in relation to fire.

However, the new 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 11 (Healthcare Needs).

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 still not been carried out.

The inspector requested, documentation and evidence of an unannounced visit to the centre by the provider which was indicated to have taken place in 12 April 2016, in accordance with Regulation 23. However, the report related to the visit was not available and had not been given to the director, assistant director of services or person in charge. At the close of inspection the inspector was informed the provider nominee had contacted the director of services in relation to their visit but there was no report on the quality of service. A quality audit had not taken place.

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. For example, in-house audits of medication management had been carried out however, the inspector found on the day of inspection there were still a number of documentation errors regarding dates of when medications were administered. This indicated audits, while carried out were not influencing or improving practice sufficiently.

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. On the day of inspection the first committee meeting took place. This was a positive step towards a more comprehensive overview of risk management in the service and designated centre.

While the centre was managed by a suitably qualified and experienced person in charge, inspector found limited evidence that actions from the previous inspection, which were the responsibility of the person in charge, had been addressed in a comprehensive way. Residents' personal plans still did not evidence comprehensive assessment of needs and

there was a lack of evidence of nursing assessments with regards to residents' healthcare needs in the sample of personal plans reviewed by the inspector.

**Judgment:**

Non Compliant - Moderate

**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:**

There had been an improvement in staff numbers but some training gaps were still present at the time of inspection. Systems for staff induction, probation and supervision had improved but there were still some gaps.

The staff members present during this inspection were observed to engage in a positive and caring way with residents, however as already mentioned in Outcome 1, these interactions were short and usually directed by staff carrying out direct support interventions with residents. Since the previous inspection the staff to resident ratio had improved resulting in some residents, particularly more physically independent residents, having one-to-one support which was facilitating those residents experiencing increased access and participation in activities outside of the centre.

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 February 2016 had received an induction. For example, the nurse on duty in the centre the day of inspection had not received an induction but had a completed probation report. While other staff in the unit had received an induction it had only been one and a half a days where they observed staff carry out their duties. With regards to another longer standing member of staff on duty the day of inspection there was no documentation to indicate they had participated in supervision meetings.

The inspector reviewed training records for staff working in the designated centre. As discussed in outcome 11 of this report, not all staff had received training in administration of rescue medication to treat seizures caused by epilepsy. Due to the lack

of staff trained in administering the rescue medication some residents could leave the unit without a nurse present. This seriously curtailed residents' opportunities to participate in activities away from the centre impacting on their quality of life.

**Judgment:**  
Non Compliant - Major

### **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

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 Health Service Executive
<b>Centre ID:</b>	OSV-0005450
<b>Date of Inspection:</b>	04 May 2016
<b>Date of response:</b>	30 May 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:**

Privacy options for residents were poor in the centre, for example, a large window was located in the door of a resident's bedroom.

While sitting in the communal area it was possible to look directly into another resident's bedroom when their bedroom door was open.

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

In one of the residential units the resident's toilet door could not be locked for privacy as the thumb turn fitted did not work.

**1. 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:**

Risk assessment regarding the need for the "large window" was conducted. Recommendations following same was to replace the existing door (with window) with a windowless door. Current window opening was covered temporarily with plywood on 20.5.16.

All residents will have their care plan reviewed to ensure that their dignity is respected at all times. This will be done as part of the overall review as outlined in relevant sections later in the document (outcome 5 and 11).

Service user's preference for open door is / has been documented in personal plan. Staff have been briefed by PIC on the importance of maintaining service user's privacy and dignity at all times (24 .5.16). This will be included in all team meetings, and highlighted on the agenda on service user's meetings

Bathroom doors were reviewed by PIC and maintenance staff on 20/05/16. Thumb turn locks have been ordered and will be installed by 30/6/16.

Maintenance audits will be carried out monthly that will ensure environment issues such as this are highlighted and fixed quickly to ensure the privacy and dignity of residents.

**Proposed Timescale:** 30/06/2016

**Theme:** Individualised Supports and Care

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

Residents with higher dependency and sensory needs did not have opportunities similar to their peers. A resident with significant visual impairment was observed to sit against a wall on a dining room chair with a table in front of them for most of the inspection.

**2. 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:**

The provider nominee has reviewed this action plan with the management team and the PIC from an overall environment perspective as well as addressing the identified resident's needs.

A review conducted by nursing staff (13/10/15) indicates reasons for seating preference. This is documented in the residents care plan.

A Psychology Referral was made on (25/05/16) seeking an assessment as to reasons for the residents perceived preference for sitting with the table pulled in front of him.

Referrals have been sent to OT (22/2/16 & 25/02/16 & 20/5/16) for full OT assessment re alternative seating and for support to provide meaningful activities. Awaiting appointment.

The Urgency of this referral will be highlighted by PIC, DOS and HSE on OT return from A/L (31/5/16).

While awaiting appointments we are offering more choices in service users daily activities.

The outcome from recent personal outcome review indicates the need to personalise the resident's table to include sensory stimulation items such as sand tray, water based activities, tactile mat.

Daily Schedule has also been reviewed and updated on 24/5/16 to include a choice of activities based on the residents preferences.

Behaviour Support Plan was last reviewed 23/11/15. This is being implemented and monitored by the PIC and DOS and will be reviewed again by 30/6/16.

**Proposed Timescale: 30/06/2016**

**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 required a comprehensive social care needs assessment to establish their overall needs. The evidence indicated residents' needs may not always receive an assessment by the appropriate allied health professional if assessment was reliant on a referral system from staff working in the centre as was in place at the time of inspection.

**3. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

It is acknowledged that the social care needs of the residents are key to each persons care plan.

- Each service user will be involved in a comprehensive assessment supported by family members, keyworkers and appropriate staff team members. Currently residents in the centre have their needs assessed and their personal plan informed by the Personal Outcomes Measures Process, a Supports Intensity Scale Assessment and the A1 Health Check. A new Transition Toolkit (incorporating a social care needs assessment) has been developed rooted in the Theory of Practice of Social Role Valorisation; Its purpose is to gain in depth insight in each individual needs, will and preferences to inform transition planning and future service planning.

There are 28 residents and the social care needs of 7 residents will be done per week between 30th May and 30th June 2016. The PIC will ensure that this is actioned. Residents social care needs will be assessed and updated (Personal Outcome Measures) to ensure identified priorities are meaningful and actioned.

Due to the nature and complexity of the individual needs of residents (28) and the number of staff supporting them (62), it is planned to have 3 PIC's within this sector with responsibility for 10 residents and approx. 20 staff each. The unit will be divided into three separate designated centres 2 with 9 residents and one with 10 residents. The CNM2 will be assigned the 10 residents and the two CNM1s will be allocated 9 residents each. Each will apply to be the PIC for their new redesignated unit. Each then will be given responsibility for the residents they are assigned. Currently the CNM2 is responsible for all 28 residents and this way each PIC will have named individuals whose care plans and socialisation needs will be the responsibility of the as

Following assessment, highlighted needs will be referred for review to the relevant health professionals where necessity is identified. To date referrals have been made to the MDT on a priority basis. A discussion with an agreed plan of action with local Heads of Discipline regarding increased access to the Multi Disciplinary Team members will be held by 20th June 2016.

PIC will monitor compliance by reviewing customised daily checklists. These reports will be submitted to the Quality Officer and DOS to ensure compliance on a fortnightly basis.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

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

Support plans in many instances were still not dated or accompanied by a signature. Therefore it was not possible to identify who drafted the plan, who reviewed them or if the plans were still current.

**4. 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:**

All support plans will be reviewed by the Person in Charge (PIC) and signed off accordingly.

Following review of the lack of signatures the actual paperwork was found to be confusing and the support plans will be changed to ensure that it is easier for staff to sign off on the plans.

A review date will be identified and recorded on all Person Centred Plans. (PCP)

The PIC will retain a schedule of all PCP review dates which can be monitored and updated at supervision sessions with staff members.

**Proposed Timescale: 30/06/2016**

**Theme: Effective Services**

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

The lack of person centred goals set for residents and the limited and poor standard of goals established did not assure the inspector that resident's social care needs were being individually and adequately assessed, implemented or reviewed to a standard that met their needs.

**5. Action Required:**

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

PIC recognises that in the past goal setting and evidence of same in the personal plan has been vague and as a result, staff / keyworkers have been directed to support each service to facilitate individual personal outcome meetings by 29/06/16.

- Each person will have a desktop review of their PCP conducted by the Keyworker, PIC and Quality Officer by June 29th 2016.

- These new goals will be reviewed by the PIC/DOS and Quality officer to ensure they are to a standard to meet resident's needs on an ongoing basis but not less than three months.

- This review will inform Daily Activity Planners for each resident.

- Staff will record compliance with individual Daily Activity Planners on customised Daily Checklists.

- PIC will conduct weekly reviews of all Daily Checklists to track compliance.

- Further Quarterly PCP reviews will be informed by the outcomes derived from 1-4 above.



- These will continue on a quarterly basis, or more often if the needs of the resident changes. PIC will attend these meetings or have a designated senior person attend in her absence. Goals set and attainment of same will be monitored on a weekly basis by PIC/deputy.
- Staff performance against agreed objectives/goals will be monitored by the Staff Supervision process.
- The centre is currently developing a new Keyworker Policy and training for staff to enable them to function successfully as a keyworker is scheduled to commence in July.
- Following a recruitment drive 8 new staff are being appointed permanently and this will allow for consistent staff rosters to work with the residents towards achieving their goals.

**Proposed Timescale:** 30/06/2016

### **Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Residents' bedrooms were small and did not provide sufficient space for assistive equipment or personal belongings in some instances.

#### **6. 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:**

The entirety of St Patrick's Centre including this centre is not to be fit for purpose for our residents. This is acknowledged and St Patricks is chosen as one of the 11 national accelerated sites for de-congregation. Accordingly, all residents will relocate to alternative appropriate residential accommodation under this programme. The HSE is proactively supporting the Management team of St Patrick's Centre to work collaboratively with a multiplicity of interested and contributing stakeholders to advance this agenda as expediently as possible. The next multiple stakeholder meeting (to which HIQA representation has been invited) is scheduled for the afternoon of Monday May 30th 2016.

There are concerted efforts underway to reduce the expected timeframe for de-congregation from 5 years to 24 months. This involves negotiations with a voluntary housing agency.

A bid is being formalised for transitional funding through Genio/HSE to assist St Patricks including this centre to apply for training on person centred planning. This transitional funding bid will link this centre to other sites where residents have moved to allow for staff visits to see how other services provide true person centred care.

1.7m has been allocated to the centre for the purpose of Decongregation in 2016. Currently there are 4 houses at "Sale Agreed" stage with two further houses under offer.

There will be no new admissions to the centre and as service users relocate to the community more space will become available for residents on campus.

A housing profile of each resident in the centre has commenced which will identify their preferences including the type of house, its location, the people (if any) they would/could share with, the type and size of rooms they and their needs require, the type of assistive equipment they may need etc

At least 2 of the centre's residents have been identified as likely to move in this calendar year.

**Proposed Timescale: 30/06/2016**

**Theme: Effective Services**

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

A number of bedrooms and other rooms in the centre were poorly maintained in appearance. The standard of cleanliness in some areas of the centre was also poor.

**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:**

Service users will be supported to decorate and personalise individual bedrooms on an ongoing basis to include choice of colour for paint for their bedrooms and inclusion of personal items in line with the residents interests and preferences.

St Patrick's Centre is one of the national accelerated sites for de-congregation. Accordingly, all residents will relocate to alternative appropriate residential accommodation under this programme. The HSE is proactively supporting the Management team of St Patrick's Centre to work collaboratively with a multiplicity of interested and contributing stakeholders to advance this agenda as expediently as possible. The next multiple stakeholder meeting (to which HIQA representation has been invited) is scheduled for the afternoon of Monday May 30th 2016.

The issue of cleanliness has been raised with Household and all staff 24.5.16  
The Household schedule was reviewed and audited on 24/05/16.  
Shortcomings in Household standards have been discussed and actioned 24.5.16.  
Cleanliness will be included on team meeting agenda 30/5/16 and on all subsequent staff meetings.

Daily Cleaning Task Checklists with sign off on completion will be implemented.  
PIC /Deputy will monitor and audit the environment for standards of cleanliness,

Cleaning Checklists and sign off on same using hygiene audit template.  
Expected Standards of cleanliness and hygiene will be included on all team meeting agendas and training needs will be identified following audits for household staff.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

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

There was a lack of appropriate assistive equipment.

**8. Action Required:**

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

1. A hoist recommended by the OT has been ordered (Delivery is expected by Friday 17th June 2016).
2. Any further assistive equipment which may be recommended by professionals will be purchased.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

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

The residential unit did not have a separate kitchen area with suitable and sufficient cooking facilities and kitchen equipment.

**9. 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:**

The provision of a separate and suitable kitchen area will be costed. However if it is cost prohibitive (due to the building and fire safety work required) and it could negatively impact the speed in which we can close the premises and move to the community. However as part of the review of each residents care plan each residents preferences will be considered in devising their personal activation plan including making breads, ice creams, waffles which are all possible without a suitable kitchen.

The entirety of St Patrick's Centre is one of the national accelerated sites for de-congregation. Accordingly, all residents will relocate to alternative appropriate residential accommodation under this programme. The HSE is proactively supporting

the Management team of St Patrick's Centre to work collaboratively with a multiplicity of interested and contributing stakeholders to advance this agenda as expediently as possible. The next multiple stakeholder meeting (to which HIQA representation has been invited) is scheduled for the afternoon of Monday May 30th 2016.

There are concerted efforts underway to reduce the expected timeframe for de-congregation from 5 years to 24 months.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

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

One bedroom consisted of padded walls and floors. The bedroom was without a bed or wardrobe or any other space where the resident could maintain personal effects. The resident's clothes were kept in a large cupboard on the corridor adjacent to their bedroom.

**10. 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:**

A full Multi Disciplinary Team risk assessment will be conducted to determine how best we can meet the needs of the resident providing safe care in a suitable bedroom for their specific needs.

If the bedroom is reconfigured a continuous risk assessment will be conducted to ensure the safety of the resident. This will be achieved by reviewing on a weekly basis the stated need for the padding (Self Injurious Behaviour & Epilepsy) to determine if any new arrangement provides a safe environment for the resident concerned.

**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:**

While systems in place for the overview of incidents and accidents had improved the inspector was not assured that the information collated would be accurate as some incident forms reviewed indicated risks to residents had not been accurately or appropriately recorded.

Corrective actions in response to accidents and incidents did not always address the risk in a comprehensive way.

Some incidents that had been recorded on the electronic system could not be reviewed fully as there were issues with accessing all information that had been logged at the time

**11. Action Required:**

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

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

- 1 All staff will be trained in risk management documentation by the staff training officer and specifically in the completion of Accident/Incident forms.
  2. Review of Accident / Incident forms to be included in agenda item for all team meetings.
  3. The Registered Provider also includes review of all incidents each fortnight as part of their meeting with the Head of Operations and the Director of Services
  4. A New Accident / Incident recording system is being implemented in the centre at present to include the corrective action required, clear identification of the person responsible and the time line for action completion.
  5. The HSE Incident management policy and procedures has been discussed at governance meeting (dates) with the management team
  6. National Incident Management Training for the PIC, Director of Operations and Health and Safety is arranged for 15th June 2016
  7. Quality, safety and risk is an agenda item on the governance meeting held fortnightly by the Registered Provider
  8. The collaborative proposal and action plan submitted by the Centre outlines subcommittees such as Quality and Safety Executive Committee (meeting monthly) and as per MoU whereby the management team cover all areas in the Centre, issues and lessons learnt will be shared and actions will be put into place to improve standards.
  9. Data and trends from this meeting will also be presented to the Provider Nominee for the HSE at the regular governance meeting held on site at the Centre.
- From a governance position a proposal is currently in discussion re: the ability to the BoM of the Centre to take operational responsibility under licence and MoU for the Centre – with the HSE remaining as the Registered Provider. This will enable the management team to be better supported and utilise structures and mechanisms such as the new BoM subcommittees to improve the standards in the centre.

**Proposed Timescale:** 30/06/2016

**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

**12. 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:**

Hygiene and Infection Control Practices will be reviewed by the PIC/DOS & Health & Safety/Facilities Manager and will be an agenda item on the PIC staff meetings. Auditing of same will direct future training needs. Training on Hygiene will be arranged by 30/09/2016

Remaining staff in sector requiring infection control training will be prioritised (Next Training Scheduled 13/6/16)

**Proposed Timescale: 30/06/2016**

**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.

**13. 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:**

All category A Fire Safety Works have been completed.  
Category B works will be addressed incrementally as resources become available.

The entirety of St Patrick's Centre is one of the national accelerated sites for de-congregation. Accordingly, all residents will relocate to alternative appropriate residential accommodation under this programme. The HSE is proactively supporting the Management team of St Patrick's Centre to work collaboratively with a multiplicity of interested and contributing stakeholders to advance this agenda as expediently as possible. The next multiple stakeholder meeting (to which HIQA representation has been invited) is scheduled for the afternoon of Monday May 30th 2016.

- There are concerted efforts underway to reduce the expected timeframe for de-congregation from 5 years to 24 months.

**Proposed Timescale: 30/05/2016**

**Theme:** Effective Services

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

Part of the fire safety works for the centre had been to ensure appropriate fire evacuation systems were in place for residents. The inspector did not find this was the case for all residents. Staff could not locate the ski sheet documented in the residents personal evacuation plan.

**14. 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:**

All CEEPS and PEEPS have been reviewed 27.05.16 and updated and these plans will be subject to regular audit by both the Health & Safety Manager and PIC. The PEEP has been updated to reflect the agreed evacuation procedure (duvet) which is in place.

**Proposed Timescale:** 27/05/2016

**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:**

The inspector observed one instance where a resident experienced prolonged environmental restriction during the course of the inspection.

**15. 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:**

Review conducted by keyworker (MSc Behaviour Support (13/10/15) indicates possible reasons for seating preference (observed as environmental restriction).

Referral sent to Psychologist (25.05.16) for input regarding possible reasons for this seating arrangement.

Outcome from recent review (by keyworker and CNM2) indicates the need to personalise service users table to include sensory stimulation items.

Daily Schedule was reviewed with service user and updated (on 24/05/16) to include a choice of the residents preferred activities.

- A Full MDT assessment is scheduled for 20th June 2016 for this service user.
- The requirement for OT input has been prioritised, as has been repeatedly referred previously - 22.02.2016 and 25.02.2016.

- A risk assessment will be completed by the PIC/Keyworker around suggested restrictive practice/s.
- Any / all identified restrictive practices will be referred to MDT (Restrictive Practice Committee).
- A safeguarding plan will be completed on receipt of MDT recommendation/s.

As stated all Heads of Service for the MDT Team will be requested to increase the access to the MDT for residents within the centre.

**Proposed Timescale: 23/06/2016**

### **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:**

Review of accidents and incidents indicated there had been some instances of peer to peer abuse which had not been notified to the Chief Inspector.

**16. 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:**

A Daily Senior Staff Checklist will be devised by the DOS for completion by senior staff at the end of each day, to include Notifications.

Notification of all incidents will be forwarded to Chief inspector as required by HIQA within the time-frames required.

Process for completion of accident incident forms and other relevant documentation to be discussed at all team meetings and individual staff supervision meetings. Next Team meeting is scheduled for 2.6.16. Staff Supervision Schedule has been populated and is attached.

As all of the residents within the centre are vulnerable a safeguarding care plan will be completed for each resident by end August 2016

**Proposed Timescale: 31/08/2016**



## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

A 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.

Epilepsy care plans indicated emergency rescue medication was to be used. However, they did not outline what steps staff were to take should the resident not respond to the treatment, for example when to call emergency services.

### **17. 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:**

The Clinical Nurse Managers and Staff Nurses on all service users after which care plans will be updated to reflect recommendations.

All Emergency rescue care plans, (epilepsy and buccal midazolam), will be reviewed by nursing staff and GP (as appropriate).

Emergency Rescue Plans will include documented actions to be taken and timeframes to be observed should a resident not respond to emergency rescue treatment.

Updated Emergency Rescue Plans will be included in the Individuals overall Person Centred Plan and staff will be made aware, on an ongoing basis, as and when changes occur.

**Proposed Timescale:** 30/06/2016

**Theme:** Health and Development

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

A resident had been recommended a pressure relieving cushion which was to be used when they were seated to prevent pressure ulcer breakdown. The inspector did not see the cushion in use during the inspection and observed the resident seating in one position for an extensive period of time without moving.

Not all staff working in the centre had received training in the administration of rescue medication to control seizures. At the time of inspection only a nurse could administer the medication. This meant there could be a delay in a resident receiving emergency medication if the nurse on duty was not in the unit the resident lived in when they experienced a seizure. This posed a healthcare risk to residents.

### **18. Action Required:**

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

Trial of Pressure relief cushion was not tolerated by service user (documented in service users notes).

Pressure pad has been ordered to trial until further input from OT.

OT has received referral in relation to full OT assessment on a number of occasions.

Awaiting assessment appointment date. OT will return from A/L (31/5/16) and DOS will follow up on her return.

Seven (7) non nursing staff have been trained in Buccal administration to date which will provide improved cover across the week and support care.

A Further 40 staff members require training and dates are to be arranged over the next four months 30/09/2016 (14 staff scheduled to complete this training 8th & 9th June).

These staff will also be trained in Oxygen administration (to date 6 staff have received this training).

Two (2) Nurses roistered be on duty at all times until staff are trained and competent.

**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:**

The inspector was not satisfied residents were always reviewed in line with policies and procedures regarding residents' healthcare whereby an individual referral is made to the relevant allied health professional.

**19. Action Required:**

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

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

Each service user will be involved in a comprehensive social care needs assessment supported by family members, keyworkers and appropriate staff team members (Transition Toolkit).

Following assessment, highlighted needs will be referred for review to the relevant health professionals where necessity is identified.

Person In Charge will monitor compliance by reviewing customised daily checklists.

Nursing needs assessed/updated using the A1 Health Check and the Annual Medical Audits will be reviewed and updated for each service user to ensure all residents are getting their required medical input. Accordingly, the outcome of these reviews will inform the revised PCP.

A local GP routinely visits the Centre every Thursday and is available in the Local Medical Centre to see service users by appointment if necessary.

A GP referral book kept in house for weekly appointments.

A schedule of Annual Health Checks will be agreed with the GP Surgery for the coming year and recorded for inspection by the PIC, DOS and Registered Provider

**Proposed Timescale:** 30/06/2016

**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. Residents did not participate in the preparation of meals in the centre.

**20. 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:**

While it is accepted that the environment does not facilitate spontaneous involvement of residents with food preparation a concerted effort will be made to facilitate this as an achievable activity of daily life.

Involvement in food preparation will be built into Person Centred Plans and times will be allocated in daily Activity Planners to support residents to participate in the preparation of light meals and snacks in the centre.

**Proposed Timescale:** 30/06/2016

**Theme:** Health and Development

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

Mealtimes observed during the inspection were not always supportive to residents' needs.

**21. Action Required:**

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

PIC will ensure that;

- No other unnecessary activity is conducted at mealtimes – hoovering, cleaning (conflicting odours, loud noises), etc

- Dining area is appropriately welcoming so as to be conducive to enjoying the mealtime experience
- All staff will be focused on assisting residents with eating or drinking in line with their personal needs at meal times
- Dietary content and presentation is discussed with Dietician.
- Individual Dietician referrals are made where indicated.
- Individuals dietary preferences are respected and facilitated.
- Advice and guidance will be sought from the SALT as appropriate.

**Proposed Timescale:** 30/06/2016

## **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:**

Some documentation errors were on administration charts. From a sample of five administration charts reviewed all had errors where the date the medication was administered had not been entered.

A medication management error had been documented as a resident engaging in behaviours that challenge.

### **22. 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:**

New Medication Error or Near Miss Report & Action Form to track medication errors and promote a culture of learning from all medication incidents has been introduced in the centre.

**Proposed Timescale:** 16/05/2016

## **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:**

While the centre was managed by a suitably qualified and experienced person in charge, the inspector found limited evidence that actions from the previous inspection, which were the responsibility of the person in charge, had been addressed in a comprehensive way

**23. Action Required:**

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

Provider Nominee met with management team and PIC on 12th April 2016 and 17th May 2016 and specifically addressed concerns raised by the Inspector from this visit in regard to PIC, management and support structures.

Provider Nominee found the PIC to be suitably qualified and experienced but requires support to meet the challenges in providing the standards required to support residents. These challenges range from environment factors through to providing care via a team with a high percentage of agency staff.

We agreed on a number of initiatives that will support the PIC to effect the required changes and are outlined below;

Director of Services supporting the PIC & staff of the centre on site daily since 16/05/16.(20 hours per week)

Weekly Managers Meetings attended by the Director of services (DON), Assistant Director of Services (ADOS) and all Persons In Charge (PIC).

Fortnightly meetings between PIC and DOS.

Monthly meetings between provider nominee and PIC & DOS.

Supervision Policy reviewed & updated and regular staff supervision has recommenced.

New Quality Officer commenced on 19/05/16. While this appointment has an Organisation wide brief, the initial focus is to support this centre in achievement of compliance with regulations relating to documentation/audits etc.

Advancement of proposals to delegate internal managerial responsibility of the centre is currently underway with staff and unions. Due to the nature and complexity of the individual needs of residents and the number of staff supporting them (62), it is proposed to have 3 PIC's within this sector with responsibility for approx. 9 or 10 residents and approx. 20 staff each. It is proposed that the centre will be divided into 3 designated centres each with its own PIC.

The centre has a number of agency staff that are currently being converted to centre staff which will lead to a more stable workforce and offer greater support to residents and the PIC.

**Proposed Timescale: 30/06/2016**

**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.

**24. 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:**

New Quality Officer & Practice Development Manager have commenced with a background in disability services and they will support the Person in Charge (PIC) as well as the management team, to work with the staff to embed good practice and make necessary changes to their practices. With these changes and additional support, we expect to see an improvement in the quality of life and quality of care provided to the residents of the centre.

An internal (Annual) Audit re the Quality & Safety of Care to be conducted by the Director of Services.

Monthly PIC Audit to be designed and commenced.

Quality Officer Audits to commence.

Quarterly Health and Safety Audits to be conducted by Health and Safety Manager to commence.

The first meeting of the new Board of Management Quality & Safety Sub-committee took place on 04/05/16 at which terms of reference (attached) were agreed. The second meeting is scheduled for 01/06/16 after which there will be clearer direction as to the management systems to be implemented to ensure the quality and safety of care in the centre.

**Proposed Timescale: 30/06/2016**

**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 which was indicated to have taken place in 12 April 2016, in accordance with Regulation 23. However, quality audit had not taken place.

**25. 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:**

The Provider Nominee did an unannounced inspection on 12th April 2016. This visit was coupled with a governance meeting and so did not issue a report.

In future there will be a separate report done following unannounced visits by the provider nominee. The unannounced inspections will use an audit tool on all actions required for follow up to commence by 14th June 2016.

The quality audit tool will be sent back to the PIC with recommendations based on the visits.

**Proposed Timescale:** 30/06/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Not all staff had training in administration of rescue medication to treat seizures caused by epilepsy.

**26. 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:**

Seven (7) non nursing staff have been trained in Buccal administration to date. 14 scheduled to complete training on 8th & 9th June.

Further training dates for staff (40) will be arranged over the next four months to ensure that residents activities and care plans are not limited due to their diagnosis of epilepsy 30/09/2016

These staff will also be trained in Oxygen administration. 6 staff have been trained to date.

Two (2) Nurses roistered be on duty at all times until staff are trained and competent.

**Proposed Timescale: 30/09/2016**

**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.

**27. 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:**

An updated Supervision Policy was introduced on 23/5/16.

Revised Supervision Forms will be used to compliment Policy at 1 above.

Supervision meetings to be conducted at least quarterly are being facilitated by Clinical Nurse Manager 1 and Person in charge throughout the sector.

The Supervision Schedule for the coming quarter was submitted to HIQA as part of this action plan response.

**Proposed Timescale: 30/06/2016**