

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd
Centre ID:	OSV-0003497
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Patricks Centre (Kilkenny) Ltd
Provider Nominee:	Liam Quinn
Lead inspector:	Kieran Murphy
Support inspector(s):	Louisa Power (day one); Ide Batan
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
16 September 2015 10:30	16 September 2015 17:00
22 September 2015 10:30	22 September 2015 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the third inspection of a centre which was part of St Patrick's Kilkenny Limited that had made an application to register as a designated centre with the Authority. St Patrick's Centre (Kilkenny) Limited provided a range of day and residential services to children and adults with an intellectual disability. During an inspection in May 2015 there was significant non compliance in relation to some fundamental and essential components of the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 including core aspects of quality and safety of care. Following that inspection the provider was given written notice that the Chief Inspector proposed to cancel the registration of this designated centre on the grounds specified in Section 51(2) (b) and 51 (2) (c)(i) of the Health Act 2007. In

accordance with Section 54 of the Health Act 2007 the Registered Provider made a written representation to the Chief Inspector concerning the proposal to cancel the registration of the designated centre. This inspection was carried out in response to that representation.

This centre provided a home to 25 residents with complex healthcare needs and a high level of support needs. The centre was based in a campus style environment with other designated centre's on site.

Of the 16 outcomes that were reviewed on this inspection six were at the level of major non-compliance:

Outcome 5: Person centred planning

As on the previous inspection it was found that the some assessments of the needs of residents did have evidence of input from allied health professionals. Personal plans did not sufficiently outline the individual needs and choices of each resident.

Outcome 8: Safeguarding and safety

Restrictive measures had not yet been addressed.

Outcome 10: General welfare and development

Residents were again observed spending periods of time not engaged in any meaningful activity. Inspectors noted that residents with limited mobility were positioned in front of the television and left alone in the dayroom without any interaction from staff.

Outcome 11: Healthcare

As on the last inspection healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan that was sufficient to direct care.

Outcome 12: Medication management

Medication administration records were left blank at a number of occasions when medicines were due to be administered in all records examined by the inspector.

Outcome 14: Governance:

Inspectors were informed that a memorandum of understanding had been signed in September 2015 between St Patrick's Kilkenny Limited, the Health Services Executive (HSE) and another service provider for people with disabilities. This agreement was to assist St Patrick's Centre (Kilkenny) Limited in all aspects of operation and management of the St Patrick's Facility, including improving the quality of care and the resourcing of the required management team to establish an appropriate governance structure at the St Patrick's Facility. However, as referenced throughout this report there were actions from the previous inspections that had not been addressed. In addition to the repeat findings from the inspection by the Authority in May 2015 mentioned above, non compliances were again found in relation to:

- Communication needs of residents
- the discontinuation date for some short term and long term medicines were not indicated

- the statement of purpose did not contain all information required
- staffing levels.

Outcome 18: Management of records

Inspectors saw that “post-it” notes were being used on the front cover of the medication records to indicate that residents had commenced short-term medication.

Since the last inspection there had been significant upgrading of the premises including the replacement of all windows in one bungalow, painting of the building both internally and externally and improving accessibility of the buildings. The premises were also clean with new schedules and cleaning practices in place. Since the last inspection the centre was now compliant in relation to:

- Residents were being consulted about how the centre was being managed and one restriction, which was a locked door on a corridor, had been removed completely
- contracts for services clearly outlined all fees and additional charges
- a procedure was now in place so that all deaths of residents will be notified to the Authority and the Coroner’s office
- additional resources had been provided for the delivery of care and support in accordance with the statement of purpose.

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

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

Findings:

At the last inspection it was identified that two restrictions that imposed on residents' lives had been referred to the human rights committee and were outstanding. On this inspection one restriction, which was a locked door on a corridor, had been removed completely. Staff said that the removal of the locked door had a positive impact on the resident's life. In relation to the second restriction the human rights committee made a decision on 16 September 2015 and approved a restriction which was in place to protect a resident's gastrostomy site.

It was found on the last inspection that residents were not being consulted and were not participating in the organisation of the centre. Residents were now attending all team meetings and were also attending individual meetings about their lives with their key workers.

In relation to residents' finances there had been a change at unit level and each resident now had access to their own money. The director of finance confirmed that the service had been unable to open bank accounts for the residents given their lack of capacity to consent to same. This issue has been referred to an independent advocate on behalf of the residents

The director of finance also confirmed to inspectors that any issues regarding financial decision making are being referred to an independent advocate as required. The staff in individual units will be responsible for referring cases to the independent advocate. An easy to read policy on residents' personal property and finances had also been developed.

Since the last inspection the complaints process had been updated:

- the complaints procedure for residents was now provided in an accessible and age-appropriate format and included an appeals process
- measures were in place to identify improvement in response to a complaint
- complaints log now recorded the outcome of the complaint or if the complainant was satisfied with the outcome of the complaint
- there was now a second nominated person to respond and maintain complaint records as required under regulation

Judgment:

Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

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

Findings:

As was found on the previous inspection improvement was still required in relation to residents' communication needs.

The majority of residents were unable to communicate verbally. Inspectors reviewed a sample of communication needs assessments and communication profiles and found that the assessments did not always contain adequate information to ensure that individual communication requirements were highlighted. The sample of assessments seen did not always indicate if a resident was able to communicate verbally or could hold a conversation. While some residents were seen using i-Pads with adaptive technology to help them communicate, the communication assessments did not always indicate if assistive technology, aids and appliances had been considered to promote residents' full capabilities in relation to communication.

Assessments did not examine the supports required to maximise residents' abilities to communicate. There was no corresponding care plan to coordinate and guide staff to enable residents to communicate. Staff confirmed to the inspector that there was no care plan used to direct care in relation to communication needs of residents. Inspectors were not assured that unfamiliar staff would be able to communicate in a meaningful way with residents due to the lack of assessment and planning processes currently in use.

Judgment:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

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

Findings:

The person in charge confirmed that the contracts for services had been updated since the last inspection. Inspectors reviewed a selection of contracts and saw that the contracts for services clearly outlined all fees and additional charges.

Transportation costs were clearly described and a transparent system was in place to ensure that the fees charged reflected the services used by the resident. The contract stated that residents would not be required to pay for any food items as part of a prescribed diet. The director of finance confirmed to inspectors that I can confirm that all transport charges refunds due to residents have been processed and all refunds were made in July 2015.

The person in charge stated that the updated version of the contract had been sent to all residents' representatives but some signed copies were yet to be returned to the centre.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Inspectors reviewed a sample of assessments and personal plans. As on the previous inspection it was found that the some assessments did have evidence of input from allied health professionals. Personal plans did not sufficiently outline the individual needs and choices of each resident. For example, inspectors observed limited detail in relation to links with the community and friends/relationships sections. Information contained within personal plans did not reflect other care plans. For example the communication profiles of residents were not always updated.

Personal plans did not outline measures to improve the quality of life and outcomes for residents. For example day services/activation recording included drives, bathing, personal hygiene and free moment. Inspectors were not assured that these activities constituted meaningful activity or engagement. Inspectors saw that in a care plan there has been one outing recorded for the resident up to the date of inspection in September 2015.

The process for setting personal goal for residents was linked to activities of daily living and healthcare needs rather than things that would improve the lives of residents.

The inspectors were not assured that staff had sufficient knowledge on how to complete a personal plan and subsequent care plans. Inspectors were not assured that the reviews carried out assessed the effectiveness of the personal plans. Personal plans were reviewed on an annual basis and residents' families/representatives were consulted and involved in the review process.

At the last inspection it was identified that one resident specifically required more suitable alternative accommodation. While this person was still living in the centre there was evidence of a transition plan in place for this resident to live elsewhere.

However, as on the previous inspection there was evidence that personal care plans were not being updated to reflect changes in the needs and circumstances of residents. For example in the healthcare files of one resident, inspectors saw a request from the service to another service provider requesting alternative residential and day services for the resident. There was no reference to this request either in a resident's care plan or as an update to the goals for this person.

There was a resident in hospital at the time of inspection. There were planned supports in place where a resident had to be admitted to hospital. There was a pre-prepared information pack completed with sufficient detail for the hospital to obtain a clear picture of the resident's needs. The person in charge told inspectors that if required, staff stayed with the resident for the duration of hospitalisation.

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):

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

Findings:

On the last inspection there were significant issues relating to the premises including:

1. Centre had not been well maintained
2. Paintwork was peeling from the wooden windows and doors externally
3. Paintwork was damaged on walls and wardrobes inside the bungalows
4. Cobwebs clearly visible
5. Waste bins for household waste and waste bins for used incontinence pads did not have any covers
6. Paving stones leading to the entrance of one unit were in a state of disrepair
7. a sharp slope going into the activities room in the first bungalow which was a potential trip hazard and also did not promote accessibility with reference to the residents living here
8. Lack of suitable storage

All of these issues had been addressed on this inspection, including the replacement of all windows in one of the bungalows. The replacement of windows had been the subject of a complaint by a resident's family in 2014. Prior to the last inspection feedback from the family of residents to inspectors was that the premises were in need of an upgrade.

Judgment:

Compliant

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:

As on the last inspection while there was a process in place for hazard identification and assessment of risk throughout the designated centre, it was not understood by staff. Not all identified hazards had been assessed in accordance with an outline of whether it was a low risk, medium risk or high risk. Inspectors saw that risk assessments relating to service users had not been updated as required. There were also two forms to undertake risk assessments and it was unclear which form staff were to use.

In relation to infection control all issues identified on the previous inspection had been remedied including:

- The provision of a new chair in a shower room as the old chair had torn seat coverings
- the introduction of a new system of cleaning with disposable mop heads
- towels were now stored in each resident's own room, rather than in a communal storage press
- when not in use the nutrition giving sets were stored appropriately. Staff had received training on infection control in line with the standards for preventing and controlling healthcare associated infections.

Inspectors saw records of a hygiene audit which had been undertaken by the assistant director of service in August 2015. This audit showed compliance with hygiene standards.

In relation to the issues identified in relation to fire safety at the previous inspection in May 2015 most of the deficiencies had been remedied including:

- procedures to be followed in the event of fire were displayed prominently
- an exit door now had a thumb lock in place
- the emergency lighting systems installed in both bungalows were serviced in May 2015
- storage including coat racks on corridors had been removed
- both bungalows were now fitted with an automatic fire detection and alarm system
- there were clear procedures to be followed in the event of a fire
- personal emergency evacuation plans had been reviewed
- all staff had received fire training
- there were records available of fire drills including a simulated night time drill.

However, there were a number of outstanding fire safety issues and one of the bungalows had been the subject of an inspection by the Fire Authority of Kilkenny County Council and had received correspondence pursuant to Section 18 of the Fire Services Act 1981. The person in charge was to submit a report to the Fire Authority to address the deficiencies identified.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

At the last inspection it was found that restrictive measures were being put in place that were not in accordance with evidence based practice including the obtaining of consent for the use of restrictions. While these measures had not yet been fully addressed, inspectors spoke with a behaviour support specialist who had been recently appointed to the service. She had proposed a pathway to refer restrictions that limited a resident's life with the introduction of a behaviour consultancy clinic. This clinic will manage and deliver behaviour support to the residents of St. Patricks in an effective way in accordance with best practice. It will be the responsibility of support team in the centre to raise the use of any restrictive practices for review at the behaviour consultancy clinic. This group, which comprised the behaviour support specialist, director of service, clinical nurse manager and key worker will go through what is in place (for example if the restriction was an environmental restraint, chemical restraint or physical restraint) and discuss why the restrictive procedure was in place. The group will then discuss if the use of the restrictive procedure posed a greater risk that the removal of same. This will be based on evidence e.g. incident recordings to show the presence of dangerous behaviours. It will then be discussed the necessary actions for the removal/management of the restrictive practice (e.g. additional staffing, risk assessment etc). The actions will be named with staff responsible of the action and a follow up/review date.

At the last inspection it was found that staff had not received training in responding to behaviours that challenge to ensure that residents were supported appropriately to manage their behaviour. The behaviour support specialist had started a training programme for all staff to ensure that residents were supported to manage their behaviours. This programme covered the basic principles of behaviour, measuring behaviour, skill development for residents, behaviour support plans and reactive strategies/restrictive procedures. There was also an advanced training programme planned for staff.

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

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: During the previous inspection it was found that the death of a resident met the criteria of an unexpected death and should have been notified to the Authority within three working days. The person in charge outlined that a procedure was now in place so that all deaths of residents will be notified to the Authority and the Coroner's office.</p>
<p>Judgment: Compliant</p>

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
As on the previous inspection residents were again observed spending periods of time not engaged in any meaningful activity. Inspectors noted that residents with limited mobility were positioned in front of the television and left alone in the dayroom without any interaction from staff.

Many residents did not attend a day service external to the centre. Activities within the centre were limited and focussed on activities of daily living such as personal care. There was little variety of activities seen in the 'day service recording' sheets for residents. The activities available to residents included watching DVDs, listening to music and sitting on specialised leisure chairs. A reflexologist and a hairdresser attended the centre to provide services for residents. Residents were supported to walk around the grounds but not on a daily basis. Some residents attended the weekly music sessions on the campus but the person in charge stated that the number of residents who could attend was dependent on staff levels on the day.

Opportunities for activities external to the centre were limited. Record sheets for community inclusion detailed that some residents had participated in a maximum 8 social outings in an 8 week period. It was clear that the social outings, though limited, were meaningful and residents enjoyed going for a walk at local parks, trips to the

seaside, attending the spa in the local hotel, shopping for personal items.

There was evidence of a disparity in the provision of activities for residents. Where a resident had access to a personal assistant (PA), the resident had greater access to the community. For example, where a PA service was available for a resident, the resident accessed the community 2-3 weeks including regular trips to the local church for Mass, visits to local theatre and shopping with the PA.

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:

As on the last inspection healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan that was sufficient to direct care. For example, one resident had an epilepsy care plan. However, it did not reference a review by a consultant specialist in April 2015 and the reduction of dose in a medication to control epilepsy.

One resident had an methicillin resistant staphylococcus aureus (MRSA) infection in a gastroscopy site. While there was a care plan in place for this infection it did not adequately direct care as it did not identify the site or record the most recent results of bacteriology swabs from the site.

There was evidence that residents were seen as required by their general practitioner (GP). While there was evidence that residents were supported to attend appointments and had been referred to hospitals and consultant specialists if required, the recording and follow up care planning in the centre required improvement. In one example a resident had an investigation in 2013 with a recommendation for a follow up investigation in 2015. There was no care plan available to indicate whether this identified healthcare issue was an ongoing problem or if it had been resolved. There was also no indication as to whether the follow up investigation had taken place.

At the last inspection it was found that due to the complex healthcare needs of residents the level of multidisciplinary support available was not sufficient. Since then a clinical nurse specialist in dementia had been appointed; a behaviour support specialist had been appointed; there were extra hours from a psychologist, consultant psychiatrist and extra contracted general practitioner (GP) hours.

Since the last inspection two residents had received a definitive diagnosis of dementia. It had been confirmed that one resident, who was being treated as having dementia, did not have a definitive diagnosis. The clinical nurse specialist in dementia had prepared an action plan for the development of dementia services in the centre and a care pathway for the two residents had been developed. These action plans were being developed under the direction of a consultant psychiatrist. The clinical nurse specialist in dementia had also provided training for staff in the care of residents with dementia.

Inspectors saw that the process of planning for end of life care had commenced. There was an advance end of life care pathway in an early stage of development being rolled out. Staff told the inspector that the multidisciplinary team were involved in the process and inspectors saw evidence of this in minutes of meetings. The local clergy had also been invited to attend these weekly meetings to contribute to end of life needs. Inspectors saw that the GP spent additional time in the centre planning and discussing end of life care needs with families. The end of life care policy was available in a draft format. The person in charge told inspectors that the centre is currently developing a proposed role for a clinical nurse specialist in end of life care.

There was evidence that residents were referred for treatment by allied health professionals including speech and language therapy in relation to swallowing difficulties. Some residents had been seen by a clinical nutritionist on a regular basis. However, as found with other reviews by healthcare professionals these recommendations did not always form part of a plan of care for the resident.

Since the last inspection the meals for residents had been reviewed by a dietitian in terms of appropriateness of nutritional value. In addition, the director of finance confirmed to inspectors that one resident had been reimbursed money and was no longer been charged for extra snacks and drinks that he required in relation to a specialised diet.

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

Findings:
A sample of medication administration records was examined. At the previous inspection, it was found that each individual prescription did not contain an authorisation

by the prescriber to crush the medicine prescribed and discontinuation dates for short term medicines were not always indicated. On this inspection it was found that, where a resident required a medicine to be crushed prior to administration, individual prescriptions contained an authorisation by the prescriber to crush the medicine prescribed. However, the discontinuation date for some short term and long term medicines were not indicated.

There were a significant number of gaps noted in the medication administration records. Medication administration records were left blank at a number of occasions when medicines were due to be administered in all records examined by the inspector. This included a total of 21 occasions where the record was left blank for a topical barrier cream leaving a resident at an increased risk of developing a pressure sore. There was also incidents where gaps were evident for antibiotics, medicines for the treatment of epilepsy and antifungal agents. Therefore, medicines were not administered as prescribed.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

Findings:
As was found on the previous inspection the statement of purpose did not contain all information required by Schedule 1 as it did not clearly outline the following:

- Specific care needs the designated centre is intended to meet
- criteria used for the admission to the designated centre
- arrangements for dealing with complaints
- arrangements for residents to access education, training and employment.

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:

At the last inspection it was found that actions from a previous inspection report undertaken by the Authority in February 2014 had not been addressed. During the course of this inspection the provider nominee was on leave. Inspectors were informed that a memorandum of understanding had been signed in September 2015 between St Patrick's Kilkenny Limited, the Health Services Executive (HSE) and another service provider for people with disabilities. This agreement was to assist St Patrick's Kilkenny Limited in all aspects of operation and management of the St Patrick's Facility, including improving the quality of care and the resourcing of the required management team to establish an appropriate governance structure at the St Patrick's Facility. However, as referenced throughout this report there were actions from the previous inspections that had not been addressed. Repeat findings from the inspection by the Authority in May 2015 were made in relation to:

- Communication needs of residents
- meaningful activities for residents
- management of healthcare information
- multi-disciplinary involvement in the review of personal plans
- personal care plans were not being updated to reflect changes in the needs and circumstances of residents
- restrictive practices
- healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan that was sufficient to direct care
- the discontinuation date for some short term and long term medicines were not indicated
- the statement of purpose did not contain all information required
- staffing levels.

At the last inspection it was also found that there was no effective communication between the provider nominee and the person in charge. On this inspection, Inspectors were provided with a schedule of meetings between the person in charge and the new operational manager.

Judgment:

Non Compliant - Major

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

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

Findings:

Since the last inspection additional resources had been provided to ensure the effective delivery of care and support in accordance with the statement of purpose.

As outlined in more detail in Outcome 6: safe and suitable premises, the centre was now maintained to a good standard inside and out with new windows, new kitchen units and a newly installed fire alarm system.

As outlined in more detail in Outcome 17: staffing, additional nursing and care staff had been sourced as required. In addition, there had been extra resources allocated to ensure residents had increased access to the multi-disciplinary team including a behaviour support specialist and increased GP hours.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

At the last inspection an immediate action plan was issued as it was found that the provider was failing to ensure that the staffing levels were adequate in relation to the number and assessed needs of residents with due regard to the size and layout of the centre. Inspectors had particular concerns about there being only one nurse on duty at night between midnight and 8 a.m. in one bungalow. This had been rectified following the inspection with an extra staff on duty in this bungalow at night.

From a review of the rosters there had been an increase in staffing levels which included the appointment of an additional clinical nurse manager. One resident informed inspectors that they had been allocated a personal assistant for five hours per week which meant that the resident had greater community inclusion. While 22 additional staffing hours had been put in place at weekend, there was a disparity in the provision of activities for residents due to insufficient staff to support residents to access activities in the community.

At the last inspection it was found that some of the staff files did not have a job description. One of the references available on file was personal in nature and not related to professional experience. One of the references was not signed. Following an audit of staff files by the human resources manager all files now had job descriptions and appropriate references.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

As on the previous inspection the management of healthcare records required improvement.

In one of the healthcare files seen by inspectors all the daily communication or "progress notes" were filed loosely at the front of the file. In another resident's healthcare file there was a swallow care plan filed loosely and an eye clinic appointment again filed loosely. Inspectors saw that "post-it" notes were being used on the front cover of the medication records to indicate that residents had commenced short-term medication. These practices could not guarantee the confidentiality of resident healthcare information but also could potentially mean that residents were not getting the treatment that their healthcare needs required.

Healthcare information in relation to residents was kept in three different files for each resident. The files contained duplicate information in different formats and the information was not easily retrievable. For example inspectors in one resident's healthcare file there was results of certain scans had been completed in 2013 with a recommendation to follow up in 2015. Inspectors could not ascertain if these follow ups had occurred and staff could not find the information either. Therefore inspectors were not assured that the assessment and planning process could bring direction and coordination to care for residents with diverse medical needs.

It had been found on the previous inspection by the Authority that the risk management policy did not meet the requirements of regulations. This had been rectified.

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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd
Centre ID:	OSV-0003497
Date of Inspection:	16 September 2015
Date of response:	29 October 2015

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 02: Communication

Theme: Individualised Supports and Care

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

Communication needs assessments did not always contain adequate information to ensure that individual communication requirements were highlighted.

1. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all

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

times to communicate in accordance with the residents' needs and wishes.

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

- SALT in place working 37.5 hrs pw. Currently conducting assessments which will be completed by end of November.
- Training to staff on total communication and info re dysphagia has commenced.
- All assessments currently under review by SALT and communication plans will be updated in line with recommendations.
- Care plans will be updated to reflect individual communication needs.
- Induction for new staff will include briefing on each resident's communication needs and preferred methods of communicating.
- After training staff will be able to develop communication care plans.
- Future assessments will include assistive technology assessment

Proposed Timescale: 31/12/2015

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:

As on the previous inspection it was found that the some assessments did have evidence of input from allied health professionals.

2. 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:

- Health Care Audit currently underway after which residents will be referred to the appropriate health care professional if required.
- New format for personal plans which includes 3 monthly reviews of personal goals currently being rolled out.
- Staff training on personal planning ongoing.
- Activities audit underway after which new activities daily schedule will be completed for each resident.
- New Service user satisfaction survey format completed and to be rolled out in the coming weeks.

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Personal care plans were not being updated to reflect changes in the needs and circumstances of residents.

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:

- SALT conducting assessments and care plans will be updated accordingly.
- New MDT guidelines and meetings are in place. Reviews have commenced where residents may be referred for review every 2 weeks. Care plans will be updated accordingly.
- Psychologist attending weekly and care plans will be updated accordingly.
- A full review of each resident clinical and healthcare needs currently underway.

Proposed Timescale: 31/12/2015

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 there was a process in place for hazard identification and assessment of risk throughout the designated centre, it was not understood by staff.

4. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- 23 staff have been trained in Health & Safety & Risk Assessment to date and this training is on-going for remaining staff.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

One of the bungalows had been the subject of an inspection by the Fire Authority of Kilkenny County Council and had received a written warning pursuant to Section 18 of the Fire Services Act 1981. The person in charge was to submit a report to the Fire Authority to address the deficiencies identified.

5. 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:

- Upgrading of Fire Alarm System currently underway across the centre.
- Issues identified by the Fire Authority are now included in the schedule of works currently underway across the centre.

Proposed Timescale: 31/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive measures were being put in place which were not in accordance with evidence based practice

6. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

- If Risk assessments indicate a restrictive practice may be required, first it is reviewed by the Behaviour Support Specialist and the MDT.
- If MDT uphold decision it is referred to Human Rights Committee for discussion. Consent is sought from residents / and their representatives/ advocate.

Proposed Timescale: 29/10/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Opportunities for meaningful activities were limited for many residents.

7. Action Required:

Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

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

- New activities coordinator to be appointed in the next couple of weeks.
- Staffing levels have increased which will allow for more opportunities to engage in meaningful activities.
- Activities audit underway after which new daily schedules will be completed for each resident.
- Training for staff re Personal Planning underway.

Proposed Timescale: 30/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Residents had assessed healthcare needs but these needs were not always written in a plan that was sufficient to direct care.

8. 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:

- Audit to be undertaken to ensure that each residents has an up to date care plan to reflect their assessed healthcare needs.
- All residents assessed healthcare needs will be written in a plan, with sufficient detail to direct care.

Proposed Timescale: 30/11/2015

Outcome 12. Medication Management

Theme: Health and Development

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

There were a significant number of gaps noted in the medication administration records.

9. 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 protocol to ensure the safe administration of medications now in place.
- Weekly audits on MPARS records now conducted by PIC.
- Monthly meetings with nursing staff underway to review practice and promote learning.

Proposed Timescale: 29/10/2015

Theme: Health and Development

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

The discontinuation date for some short term and long term medicines were not indicated.

10. 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:

- Meeting with prescriber and pharmacist scheduled to resolve identified issues.
- New bio-dose system being considered.
- Staff have completed Safe Practice Workshop (INMO) and HSE Online medication management training programme.
- Nursing hours increased.
- Audit of medication errors underway to identify trends, promote learning and reduce future errors.

Proposed Timescale: 16/11/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The Statement of Purpose did not contain all information required by Schedule 1.

11. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and

Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

- SOP to be updated to include all info in schedule 1.

Proposed Timescale: 30/11/2015

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:

Items from a previous inspection report undertaken by the Authority in February 2014 had not been addressed.

12. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

- New Operational Management Team in place.
- New Quality Assurance Team and Process in place.
- Communication needs of residents currently being assessed by SALT. Training in Total Communication underway for all staff.
- A full audit of current activities underway after which new schedule of daily activities for all residents to be completed.
- Healthcare Information is now organised in a new and more accessible format.
- New MDT in place which is reviewing all personal plans after which all will be updated to reflect current and future health needs.
- All restrictive practices are now risk assessed and reviewed by the MDT and Human Rights Committee.
- The assessed healthcare needs of all residents are being reviewed and care plans will be updated to ensure they reflect assessed need.
- New protocol to ensure the safe administration of medications now in place.
- Weekly audits on MPARS records now conducted by PIC.
- Monthly meetings with nursing staff underway to review practice and promote learning.
- Statement of Purpose currently being updated.
- Staff levels including nursing hours have increased.

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffing levels had an impact on residents being able to undertake social activities.

13. Action Required:

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

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

- Nursing hours increased.
- Activity Audit and new timetable to reflect improvements to daily schedule. Protected time around residents undertaking social activities introduced.

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

These management of healthcare information could not guarantee the confidentiality of resident healthcare information but also could potentially mean that residents were not getting the treatment that their healthcare needs required.

14. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

- New Care Plan format in place and all residents' healthcare needs being assessed/reviewed to ensure care plans reflect this.
- Post-it notes no longer used in Health Care information records.

Proposed Timescale: 30/11/2015

Theme: Use of Information

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

The files contained duplicate information in different formats and the information was not easily retrievable.

15. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

- New Care Plan format in place and all residents' healthcare needs being assessed/reviewed to ensure care plans reflect this.
- Post-it notes no longer used in Health Care information records.

Proposed Timescale: 30/11/2015