

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Liskennett Centre
<b>Centre ID:</b>	OSV-0004263
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	St Joseph's Foundation
<b>Provider Nominee:</b>	Catherine O'Connell
<b>Lead inspector:</b>	Kieran Murphy
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	13
<b>Number of vacancies on the date of inspection:</b>	1

## 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 renewal 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:
31 July 2017 16:00	31 July 2017 19:00
01 August 2017 09:00	01 August 2017 17:00

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 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**

**Background to the inspection**

This was the third inspection of this centre by the Health Information and Quality Authority (HIQA). This inspection was undertaken to inform a decision in relation to an application by the provider to renew the registration of the centre; the provider also wished to increase the capacity of the centre to allow for the accommodation of 16 residents from its current capacity of 14.

On the previous inspection in March 2017, of the 18 outcomes inspected, eight were at the level of moderate non-compliance, one outcome substantially compliant and nine outcomes were compliant. This current inspection also followed up on the outstanding issues from the previous inspection.

**Description of the service**

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

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

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

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

#### How we gathered the evidence

Over the duration of the two day inspection, 13 of the residents met with the inspectors. Inspectors also met with staff and observed their interactions with the residents. In addition, inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

#### Overall judgment of our findings

There was some evidence of good practice and in particular the development of the Spraoi life-skills centre. Two of the 16 apartments were currently unoccupied and were being used as a life-skills centre where residents were supported to prepare meals and undertake day-to-day household activities and social outings in the community. The staff assigned to this unit appeared very committed to improving residents' quality of life.

It was noted on the last inspection that there was alleged normalisation in the centre of inappropriate and unapproved physical interventions in response to incidents. The St Joseph's Foundation had commissioned an investigation report into these incidents. The person in charge outlined that she had only received this report in the week prior to the inspection and had communicated the findings of this investigation report to staff. There were 25 recommendations from this investigation report and the person in charge had prepared an action plan to address the issues identified in the report.

Of the nine outcomes inspected, two were at the level of major non-compliance:

- it was not demonstrated that guidance issued by HIQA in relation to restrictive practices was implemented, and in particular the use of chemical restraint through the use of medicines. Records reviewed did not document that all other alternatives had been trialed and that possible underlying causes were considered and explored, for example, pain. The continual monitoring of the resident and effect of the medicine administered was not documented. In addition, there was no oversight or review of restrictions either by the multidisciplinary team or by a restrictive

interventions review committee to ensure that restrictions were proportional to the needs of residents.(Outcome 8: Safeguarding and Safety)

- the medicines management outcome was examined by a medicines management inspector who deemed this outcome at a level of major non-compliance due to unsafe medicines management practices resulting from a lack of effective oversight in this area. (Outcome 12: Medicines Management)

Further improvement was also required as:

- some practices did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space (Outcome 1: Residents' Rights Dignity and Consultation)

- in some cases, residents' personal plans were not being updated on an annual basis (Outcome 5: Social Care Needs)

- the risk assessment for each of the hazards was not always undertaken appropriately to ensure that the current risk rating was accurate. In particular, in some instances the risk rating was being reduced without additional controls being identified. The risk register, as provided to inspectors, did not accurately reflect the active hazards in the centre (Outcome 7: Risk Management)

- the management arrangements could not ensure effective governance, operational management and administration of the designated centre concerned. In addition, the clinical governance structure in place to ensure that all staff had regular and comprehensive supervision and performance appraisals was not effective (Outcome 14: Governance and Management)

- the number and skill-mix of staff required review to ensure that the needs of residents were being met (Outcome 17: Staffing)

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

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Some practices did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

There were documents seen in residents' files which recorded residents' sleep pattern during the night. While visiting some of the individual apartments of residents, it was noted by inspectors that some residents' bedroom doors had "viewing holes" in the door. The person in charge outlined that these "viewing holes" were so that staff could check whether the resident was awake or asleep during the night. While there were healthcare concerns for one resident to validate the use of these physical checks, for the other residents there was no safety, or other reasons, either documented or outlined during the inspection. This practice did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

There was a high level of security observed throughout the grounds and buildings that comprised the designated centre. Access to the grounds was only via external gates that had a key code access pad. Further access to the designated centre was via a second set of gates that also had keycode access pad. In the actual centre itself closed circuit television (CCTV) cameras were observed throughout the community apartments, including in circulation areas. There was CCTV camera in the communal living room of the community apartments but the person in charge said that this camera was not actively recording.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

Each resident's assessed needs were set out in an individualised personal plan. However, in some cases residents' personal plans were not being updated on an annual basis.

There were separate assessments of residents' healthcare needs and social care needs in the personal planning process. In relation to social care needs, there was evidence that residents were being supported to develop an individual lifestyle plan and families were invited to be involved in the development of the lifestyle plan. Short and long-term priority goals or outcomes were being developed for residents. For example, long-term goals for one resident included:

- to live a most independent life possible
- to experience more typical social interactions
- good health
- swimming weekly
- develop interests in things the resident liked. However, in some cases residents' personal plans were not being updated on an annual basis.

In relation to social and life activities for residents, there was some evidence of good practice and in particular the development of the Spraoi life-skills centre. Two of the 16 apartments were currently unoccupied and were being used as a life-skills centre where residents were supported to prepare meals and undertake day-to-day household activities and social outings in the community. The staff assigned to this unit appeared very committed to improving residents' quality of life.

Residents were facilitated to go on social outings and drives. One resident had access to a day service based in the main campus of St Joseph's Services. For the other 11 residents, it was observed by inspectors over the two days of the inspection, that many of the activities were based on the grounds of the designated centre including walks,

chores, and helping in the office. This was confirmed from a review of the "daily activity charts" that were maintained for residents. Many of the short-term goals that had been developed as part of the person-centred plans for residents involved undertaking activities within the campus of the designated centre or in the main St Joseph's Foundation campus.

In relation to healthcare needs, assessments and care plans were in place for identified healthcare needs. There was evidence of input from the relevant healthcare professionals in relation to residents' needs and in particular a meeting, as required, of the multidisciplinary team to discuss residents' needs.

**Judgment:**

Substantially 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:**

The risk assessment for each of hazards was not always undertaken appropriately to ensure that the current risk rating was accurate. In particular, in some instances the risk rating was being reduced without additional controls being identified. The risk register as provided to inspectors did not accurately reflect the active hazards in the centre.

There was a new computerised incident management system in place and inspectors reviewed all of the records of incidents that were on this system covering the period 14 June 2017 to 1 August 2017. There had been 42 reported incidents which included 11 incidents of errors in medicines management with most of the rest of the incidents relating to peer-to-peer incidents or peer-to-staff incidents.

The centre had a separate risk register in place which was designed to log all the hazards that the centre was actively managing. In the document shown to inspectors there were 15 issues on the risk register. These were:

- pinching others
- accessing knives
- leaving the building unsupervised
- locking away cleaning products
- physical assault
- slips, trips, falls
- behaviour in public places

- kitchen in office area
- car park safety
- access to the boiler room
- access to equestrian centre
- playground
- self harm
- upstairs windows in the farmhouse apartments
- falling on stairs.

The risk assessment for each of these hazards was not always undertaken appropriately to ensure that the current risk rating was accurate. In particular, in some instances the risk rating was being reduced without additional controls being identified.

The risk register as provided to inspectors did not accurately reflect the active hazards in the centre. For example, an investigation report had been completed in May 2017 into safeguarding allegations. However, the risk register did not include this issue.

In addition, it was also unclear if, or how, hazards on the risk register were being escalated to the management team of St Joseph's Foundation.

**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):**

**Findings:**

Restrictive procedures were not in line with evidence-based practice and in particular the use of chemical restraint.

It was noted on the last inspection that there was alleged normalisation in the centre of inappropriate and unapproved physical interventions in response to incidents. The St Joseph's Foundation had commissioned an investigation report into these incidents. The person in charge outlined that she had only received this report in the week prior to the inspection and she had communicated the findings of this investigation report to staff.

There were 25 recommendations from this investigation report and the person in charge had prepared an action plan to address the issues identified in the report.

It is a requirement of the regulations that all serious adverse incidents, including safeguarding issues are reported to HIQA. Ten such incidents had been submitted to the Chief Inspector since the previous inspection. Documentation in relation to these incidents was reviewed during the inspection. However, the training records as provided to inspectors indicated that mandatory safeguarding training for five staff members had expired and there was no confirmation that refresher training had been completed.

The policy for use of restrictive practices was made available to inspectors and had been in place since 2014. The policy outlined that the organisation aspired to a restriction-free environment and that the least restrictive procedure was to be used for as short a time as possible. A local restrictive practice committee had been convened for this designated centre. This committee comprised the person in charge, the behaviour support therapist and the adult services manager.

Inspectors noted that some residents were prescribed 'as required' medicines to be used to relieve agitation. Records indicated that these medicines were administered as prescribed. Based on documentation reviewed and observations made, the inspectors formed the view that these medicines constituted chemical restraint; further clarification was required in line with guidance issued by HIQA in relation to the identification of what constituted chemical restraint in the centre.

It was not demonstrated that guidance issued by HIQA in relation to restrictive practices was implemented. Records reviewed did not document that all other alternatives had been trialled and possible underlying causes were considered and explored, for example pain. The continual monitoring of the resident and effect of the medicine administered was not documented.

The completed restrictive practices review log was not in the designated centre during the inspection. A reduced log containing two identified restrictions was made available to inspectors; and the restrictions were the locking of a door to one resident's apartment and the locked press in the main kitchen adjacent to the community apartments. However, improvement was required to ensure a rationale for all restrictions was documented clearly. In addition, there was no oversight or review of restrictions either by the multidisciplinary team or by a restrictive interventions review committee to ensure that restrictions were proportional to the needs of residents.

Inspectors reviewed a number of support plans. For some residents, the most up-to-date support plan was maintained electronically and an older support plan was stored in the resident's personal plan file. There was conflicting information in these plans. For example, the older support plan outlined that 'as required' psychotropic medicines were to be administered at level one of the reactive strategy while the newer support plan outlined that these medicines should be considered at level two of the reactive strategy.

Training records made available to inspectors indicated that training was mandatory for staff on how to safely disengage from situations that present a hazard to themselves or the person receiving care. However, the matrix indicated that six staff members were

scheduled to attend training in August 2017 with no previous training indicated. Refresher training was required for four staff with a scheduled date listed for one staff member. No initial or scheduled training was listed for three staff.

**Judgment:**  
Non Compliant - Major

### **Outcome 09: Notification of Incidents**

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

**Theme:**  
Safe Services

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
It is a requirement that all serious adverse incidents are reported to HIQA within three working days of the incident. Since the last inspection a record of all incidents occurring had been maintained and all notifications had been sent to HIQA as required. Due to an administrative error, one notification had not been sent on time. However, the representative for St Joseph's Foundation outlined that a new process was now in place to ensure that all notifications would be submitted as required.

**Judgment:**  
Compliant

### **Outcome 11. Healthcare Needs**

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

**Theme:**  
Health and Development

**Outstanding requirement(s) from previous inspection(s):**  
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**  
Overall, residents' healthcare needs were supported by staff. However, residents were not always able to access a dietitian in a timely manner.

The inspector reviewed a sample of residents' healthcare files and found evidence of

regular reviews by the resident's general practitioner (GP). There was evidence of review of residents' healthcare needs by consultant specialists as required. It was noted by inspectors that in some instances involvement of the consultant specialists was not always evident in the healthcare plans. Residents had access to a consultant specialist in psychiatry and as required.

Residents were referred for support as required to allied health professionals including speech and language therapy, physiotherapy and occupational therapy. There was clear and up-to-date guidance available to staff following any such review.

However, residents were not always able to access a dietitian in a timely manner. Inspectors were told that due to the unavailability of a dietitian within the service, one resident's family were paying privately for a dietetic appointment. In another resident's healthcare file staff recorded on 9 March 2017 that a dietitian had been contacted to obtain an appointment for the resident. It was further noted that the same resident had been further seen by their doctor in June 2017 who noted that the resident had apparently lost weight. Inspectors were told by the person in charge that the letter from the dietician appointment had been obtained on the second day of the inspection.

It was observed by inspectors that staff cooked the meals in each of the apartments with assistance from residents if they wished. The meals were well presented.

**Judgment:**  
Substantially Compliant

## **Outcome 12. Medication Management**

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

**Theme:**  
Health and Development

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

No actions were required from the previous inspection.

### **Findings:**

The medicines management outcome was examined by a medicines management inspector who deemed this outcome at a level of major non-compliance due to unsafe medicines management practices resulting from a lack of effective oversight in this area.

A review of medicines-related incidents had been undertaken on 30 May 2017. The review identified that poor practice was evident and had led to medication-related incidents. A detailed action plan was developed following the review. A meeting took place on 21 July 2017 to discuss medication-related incidents and the action plan was formalised. The actions outlined to prevent recurrence included moving medicines storage to residents' apartments, regular review of documentation and the use of a 'do

not disturb' tabard by staff when administering medicines. Medicines storage was moved to the apartments during the inspection. However, inspectors noted staff wearing the 'do not disturb' tabard when not administering medicines which reduced the efficacy of this control.

Medication-related incidents reports since 30 May 2017 were reviewed and it was noted that a minimum of nine incidents or near miss events had occurred. Four of these reports described incidents which were similar to incidents that had been included in the review in May 2017. This included the omission of the same medicine, medicines not in monitored dose system on the correct day and two incidents where medicines were found on the floor. The reports indicated that a multi-factorial review had not been undertaken in response to each incident and the corrective actions outlined focused on the operators rather than a systems-based approach. A lack of strong oversight in relation to medicines management had led to a pattern of medicines-related incidents and near misses, the delay in implementation of corrective actions following the review and the ineffective implementation of corrective actions. This placed residents at undue risk of serious harm due to medicines not being administered as prescribed.

Medicines for residents were supplied by a local community pharmacy. The pharmacist had completed a medicines usage review with staff in April 2017. The purpose of this review was to identify suboptimal use of medicines by residents. The pharmacist made a number of interventions including clarifying frequent re-ordering of medicines for some residents and counselling staff on the most appropriate administration of certain medicines. The recommendations made by the pharmacist were seen to be implemented. There was a medicines management policy which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines.

Medicines were stored securely throughout. Medicines requiring refrigeration or additional controls were not in use at the time of the inspection.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy corresponded with the medication prescription records. The majority of medicines were supplied in monitored dose systems and the systems were used to administer medicines. The monitored dose systems were labelled with medicines contained within the system and the resident's details. However, it was confirmed that identifiable information was not available to identify a specific medicine amongst the other medicines within the system. The person outlined that this had been identified as a requirement and would be implemented at the next dispensing cycle. In addition, cautionary and advisory labels instructions which warn or remind staff of certain actions were not present or available to staff. Therefore, there was a risk that medicines would not be administered as prescribed.

A sample of medication prescription and administration records was reviewed. Medication prescription records were current and contained the information required by legislation. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications.

Staff outlined the manner in which medications which were out-of-date or dispensed to

a resident but were no longer needed; stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

**Judgment:**  
Non Compliant - Major

**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:**

Due to the findings on this inspection, it was not demonstrated that the current arrangement of one person in charge over two centres, both accommodating residents with complex needs could ensure the effective governance, oversight, operational management and administration of both designated centres. In addition, there was no strong clinical governance structure in place to ensure that all staff had regular and comprehensive supervision and performance appraisals.

The person in charge was a registered nurse in intellectual disability and had completed a six day management qualification in "ensuring professional practice and accountability". She had been appointed as person in charge of this centre in May 2017 and had worked for St Joseph's Foundation for over 10 years. However, she was also the person in charge for another designated centre. However, due to the complexity of the healthcare needs of residents, inspectors were not satisfied that these arrangements could ensure the effective governance, operational management and administration of both designated centres.

At an operational level the person in charge was supported by a specialist therapist in behaviour support who was on-site for three days per week.

There were four social care leaders who provided day-to-day management of the supports being provided to residents, with one social care leader on duty on each shift. The social care leaders directly supervised the care being provided to residents.

However, during the course of the inspection the social care leader had overall responsibility for medicines management for the two days. It was observed by inspectors that this meant there was limited opportunity for the social care leader to adequately support and supervise staff. In addition, there was no strong clinical governance structure in place to ensure that all staff had regular and comprehensive supervision and performance appraisals.

An annual review of the quality and safety of care provided by the centre had been completed for 2016. A number of issues identified on this inspection had also been identified in the annual review including:

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

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

**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:**

The number and skill-mix of staff required review to ensure that the needs of residents were being met.

Staff appeared very committed to improving the quality of life of residents and was observed to interact appropriately and respectfully with residents during the two days of the inspection.

Families who spoke with inspectors said that in general they were happy with the care being provided. However, it was stated by families to inspectors that there was "a

problem with consistency of staff members". The person in charge also said to inspectors that it was difficult to keep staff.

There were four social care leaders who provided day-to-day management of the supports being provided to residents, with one social care leader on duty on each shift. It was noted by inspectors from speaking to staff and review of the staff rota that a significant number of staff were new to the service and inexperienced in providing care to people with high support needs including autism. There was 40 other staff, healthcare assistants, most of whom were qualified at Level V of the National Framework of Qualifications (NFQ). The social care leaders directly supervised the care being provided to residents.

All of the residents had high support needs and were supported individually by a high staff complement, mostly on a one-to-one basis. Inspectors observed one resident in distress over the two days of the inspection. This resident was being supported by an inexperienced staff member who was observed in the office on morning of the second day of inspection seeking advice from other staff.

The training records (matrix) provided to inspectors indicated that there were gaps in manual handling training. Three staff were scheduled to complete training shortly. Refresher training was required for nine staff. One staff member was not listed as having completed training and did not have a scheduled date listed. The training matrix indicated that 35 staff had yet to complete specific training in autism support.

The training matrix indicated that two staff had completed refresher mandatory fire training. The person in charge outlined that some staff completed an initial online training programme in fire safety and would complete a classroom practical session soon after. However, the training matrix indicated that two staff members had completed online training six months before the inspection and had not completed the classroom practical session. In addition, the matrix indicated that two further staff were completing online training but no confirmation that this training had been completed.

The training matrix indicated that infection prevention and control training was considered mandatory for the organisation. The training matrix indicated that nine staff required initial training and two staff required refresher training.

The person in charge outlined that social care workers administered medicines following training. The inspector spoke with staff who demonstrated knowledge in this area and were aware of the responsibilities as per the centre's policy. However, the training matrix provided during the inspection indicated that one social care worker had not received training in the area of medicines management to ensure safe medicines management practices.

**Judgment:**  
Non Compliant - Moderate

## Closing the Visit

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

### **Acknowledgements**

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

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

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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by St Joseph's Foundation
<b>Centre ID:</b>	OSV-0004263
<b>Date of Inspection:</b>	31 July 2017
<b>Date of response:</b>	31 August 2017

### 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:**

There were a number of practices which did not ensure that each resident's privacy and dignity was respected in relation to their personal and living space.

#### **1. Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

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:**

- The use of CCTV was risk assessed by the Provider Nominee, Person in Charge, Head of Residential Services, Clinical Nurse Manager 3 and the Chief Executive Officer. Based on this risk assessment, all the CCTV cameras presently in use on a 24 hour basis in the internal corridors excepting the camera facing the front door which is in place for security reasons have been put on a timer to activate between the hours of 8.00pm to 8.00am when staffing is reduced thereby removing the restriction during day hours. This has commenced from 16/8/2017.
- Risk assessments have been completed by the MDT members on the requirement for hourly night checks and based on this assessment it was agreed to reduce the night checks immediately to three hourly checks with a review again in six weeks to assess possibly further reducing the checks.
- The viewing panels on each bedroom door have now been covered completely with an option of opening a small area of this panel for supervision purposes once every three hours during the night time so as not to disturb sleep. A protocol has been written up for use of same.

**Proposed Timescale:** 31/08/2017

**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:**

In some cases residents' personal plans were not being updated on an annual basis.

**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:**

- All residents' personal plans have been reviewed by the Multi-Disciplinary Team. Family consultation for plans for two residents had to be rescheduled to facilitate input from family members and will be fully completed by 01/09/2017.
- A scheduled review process had been identified for the coming year for all annual reviews.

**Proposed Timescale:** 01/09/2017

**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:**

The process for risk assessment for some specific hazards was not always completed to accurately reflect the current risk rating.

**3. 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:**

- A full review of the Risk Folder has been conducted by a Multi-Disciplinary Team comprising of Senior Psychologist, Social Worker, Occupational Therapist, Senior Behaviour Analyst, Health & Safety Officer, Person In Charge and the keyworker (where possible) and was completed on the 15/08/2017. Current risk ratings were completed by identifying additional controls as appropriate;
- Risks relating to Health & Safety have been reviewed and new risks assessments completed by the Health & Safety Officer, Area Manager & Person in Charge;
- A review of the Risk Management process is presently being conducted and training on risk has been scheduled for 18/10/2017 for all Persons in Charge with particular reference to completion & review of risk assessments and escalation process.

Proposed Timescale: Completed

Completed

18/10/2017

**Proposed Timescale: 18/10/2017**

**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:**

Further clarification was required in line with guidance issued by HIQA in relation to the identification of what constituted chemical restraint in the centre.

It was not demonstrated that guidance issued by HIQA was followed in relation to the use of potential chemical restraint.

**4. 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:**

- All residents who are prescribed psychotropic medication are being reviewed by the Consultant Psychiatrist taking account of the guidance issued by HIQA in relation to chemical restraint – to be completed 31/08/2017;
- In all instances where PRN medication is required a detailed account of the reason for same and the alternative measures taken prior to the administration of medication to be documented in the daily notes and in the PRN reporting template;
- A Senior Behaviour Analyst has commenced an analysis of behaviours for seven individuals to support the formulation of behaviour support plans which will identify all alternative measures to be taken prior to the consideration of the use of any restrictive intervention- to be completed by 30/09/2017;
- A review of the remaining seven support plans will be conducted by the Senior Behaviour Analyst which will reflect all alternative measures to be taken prior to the consideration of the use of any restrictive intervention- to be completed by 30/09/2017;
- A Pharmacist has been engaged to deliver training on policy and medication management and will be completed for all staff administering medication by 30/09/2017;
- A competency based refresher day has been scheduled where all staff who administer medication will attend and will include practical training – to be completed by 30/09/2017;
- The recruitment of a nurse post will allow for two staff to administer medications on a daily basis to reduce the risk of medication errors.

**Proposed Timescale:** 31/10/2017

**Theme:** Safe Services

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

Gaps were noted for training in the management of behaviour that is challenging including de-escalation and intervention techniques.

**5. Action Required:**

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

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

- The training matrix provided to and viewed during the inspection did not accurately reflect the training records of the centre. Of a total of 42 staff employed in the centre:
- 29 staff have received training in Understanding Autism. 1 staff member had attended training prior to commencement of employment. Remaining 12 staff are scheduled to receive training by 31/09/2017;
- 38 staff have received training in Fire Safety. Remaining 4 staff are scheduled for training on 06/09/2017;
- 38 staff have received training in de-escalation and intervention techniques (MAPA). Remaining 4 staff are scheduled to receive training on 08/09/2017;

**Proposed Timescale:** 30/09/2017

**Theme:** Safe Services

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

Behaviour support plans contained conflicting information.

**6. Action Required:**

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

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

- Updated behaviour support plans have been inputted to the computerised filing system and a copy retained in the individuals file.

**Proposed Timescale:** 31/08/2017

**Theme:** Safe Services

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

Restrictive procedures were not being applied in accordance with national policy or evidence based practice.

**7. Action Required:**

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

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

- A review of the Policy on the Use of Restrictive Interventions has been completed and is in line with national policy and evidence based practice;
- A full review of all Restrictive Interventions conducted by a Multi-Disciplinary Team comprising of Senior Psychologist, Social Worker, Occupational Therapist, Behaviour Support Analyst, Health & Safety Officer, Person In Charge and the keyworker (where possible) and was completed on the 15/8/2017. This team discussed and completed an Assessment & Decision Making Form with associated risk assessments for all interventions relating to individual residents. Review dates for all restrictive interventions have been scheduled.

**Proposed Timescale:** 31/08/2017

**Theme:** Safe Services

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

The training matrix indicated that mandatory safeguarding training for five staff

members had expired and there was no confirmation that refresher training had been completed.

**8. Action Required:**

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

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

- The training matrix provided to and viewed during the inspection did not accurately reflect the training records of the centre. Of a total of 42 staff employed in the centre:
- 39 staff have received training in Safeguarding. Remaining 3 staff are scheduled for training on 11/09/2017.

**Proposed Timescale:** 11/09/2017

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents were not always able to access a dietitian in a timely manner.

**9. 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:**

- In consultation with residents where appropriate, & family members, private appointments will be arranged where indicated with a dietitian in a more timely manner;
- A staff member with a qualification in Health Promotion will meet with staff to advise on healthy eating options and dietary requirements for residents;
- Accessing a dietitian will be an agenda item on the September meeting with the Disability Services Manager.

**Proposed Timescale:** As required  
30/09/2017

**Proposed Timescale:** 30/09/2017

**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:**

The following did not support that medicines were administered as prescribed:

A lack of strong oversight in relation to medicines management had led pattern of medicines related incidents and near misses, the delay in implementation of corrective actions following the review and the ineffective implementation of corrective actions.

One social care worker had not completed medicines management training, as indicated on the training matrix.

Identifiable information to identify a specific medicine within the monitored dose system and cautionary and advisory labels were not available to staff.

**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:**

- A recruitment process has commenced to recruit nursing staff to work in the centre. This post along with the Social Care Worker post will allow for 2 staff to be on duty daily to be responsible for the administration of medication in nominated areas.
- A Pharmacist has been engaged to deliver training on policy and medication management and will be completed for all staff administering medication by 30/09/17;
- Competency based refresher days have been scheduled whereby all staff who administer medication will attend and will include practical training – to be completed by 30/09/17;
- The pharmacy have provided a visual of all medications with the MARS system with the delivery of prescribed medications dispensed by the pharmacy week commencing 21st August;
- A folder of information sheets on all medications has been printed and is available in the main office for any staff member. A reference sheet to this folder is on display in each apartment;
- Medication errors will be reviewed on a monthly basis by the Person in Charge and will be a standing agenda item at supervision meetings & staff meetings;
- Major medication incidents will be reviewed by the Person in Charge within 24 hours and an immediate review meeting conducted with the relevant staff member. A discussion on appropriate action will be discussed with the Clinical Nurse Manager 3 and /or Head of Residential Services.

Proposed Timescale: 31/10/2017;  
30/09/2017;  
30/09/2017;  
Completed;  
Completed;

Monthly;  
As required.

**Proposed Timescale:** 31/10/2017

#### **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:**

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

**11. Action Required:**

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

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

- A recruitment process has commenced for a Person in Charge whereby the Person in Charge of this centre will have responsibility for this centre only. Following a successful candidate being identified the required documentation & training will be completed. In the interim, an Area Manager is supporting the Person in Charge in managing both centres;
- An Area Manager (PPIM) Clinical Nurse Manager 3 grade, will provide support to the Person in Charge and a weekly Support & Review Meeting will take place commencing week beginning 20th August.

Proposed Timescale: 30/10/2017  
Completed & ongoing

**Proposed Timescale:** 30/10/2017

**Theme:** Leadership, Governance and Management

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

There was limited opportunity for the social care leader to adequately support and supervise staff. In addition, there was no strong clinical governance structure in place to ensure that all staff had regular and comprehensive supervision and performance appraisals.

**12. Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to

support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

- A recruitment process has commenced to recruit nursing staff to work in the centre. This post along with the Social Care Worker post will support the Person in Charge to supervise the activities, completion of documentation, administration of medication, reviews and the staff on an ongoing basis. The Person in Charge will conduct a weekly Support & Review Meeting with these staff;
- A schedule of staff supervision meetings is in place. All staff except those on leave have participated in a supervision meeting. Those outstanding are scheduled to be completed by 09/09/2017 on their return. A schedule of monthly supervision meetings has been developed and advised to staff;
- Performance Appraisal documentation is presently being finalised by the Human Resource Department which will be followed by training with Senior Managers and Persons in Charge. Roll out of this system will commence 01/01/2018.

Proposed Timescale: 31/10/2017;  
9/9/2017;  
01/01/2018.

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

**Theme:** Leadership, Governance and Management

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

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

**13. Action Required:**

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

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

- An unannounced visit to review the quality & safety of care & support in the centre has taken place as per regulation. The recommendations from this review have been actioned and all actions completed except for the recruitment of a nurse post to support the service.
- Recruitment for nurse post has commenced.

Proposed Timescale: Completed  
30/10/17

Proposed Timescale: 30/10/2017

### Outcome 17: Workforce

Theme: Responsive Workforce

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

The number and skill mix of staff required review to ensure that the needs of residents were being met.

#### 14. 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:**

- A recruitment process has commenced to recruit nursing staff to work in the centre. This post along with the Social Care Worker post will support the Person in Charge to supervise the activities, completion of documentation, administration of medication, reviews and the staff on an ongoing basis. The Person in Charge will conduct a weekly Support & Review Meeting with these staff;
- An Area Manager (PPIM) Clinical Nurse Manager 3 grade, will provide support to the Person in Charge and a weekly Support & Review Meeting will take place commencing week beginning 20th August;
- A Senior Behaviour Analyst supports the staff and management of the centre in the development and implementation of Behaviour Support Plans;
- A Multi-Disciplinary Team will conduct scheduled reviews with the Person in Charge and keyworker and a referral system is in place for issues occurring outside these reviews.

Proposed Timescale: 30/10/17  
Completed  
Completed  
As required

Proposed Timescale: 30/10/2017

Theme: Responsive Workforce

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

The training needs of staff required review to ensure that residents needs were being met.

**15. Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- The training matrix provided to and viewed during the inspection did not accurately reflect the training records of the centre. Of a total of 42 staff employed in the centre:
- 37 staff have received training in Manual Handling Training. 4 remaining staff are scheduled for training on 07/09/2017, 1 staff will be scheduled on return from leave;
- 38 staff have received training in Fire Safety. Remaining 4 staff are scheduled for training on 06/09/2017;
- 39 staff have received training in Safeguarding. Remaining 3 staff are scheduled for training on 11/09/2017;
- 38 staff have received training in MAPA. Remaining 4 staff are scheduled to receive training on 08/09/2017;
- A staff member who administers medication and appeared not to have received training in SAMS on the training matrix had completed same in July;
- 29 staff have received training in Understanding Autism. I staff member had attended training prior to commencement of employment. Remaining 12 staff are scheduled to receive training by 31/09/2017;
- 38 staff have completed online training in Hand Hygiene. Remaining 4 staff to complete same by 08/09/2017.

**Proposed Timescale:**

07/09/2017;  
06/09/2017;  
11/09/2017;  
08/09/2017;  
31/09/2017;  
08/09/2017.

**Proposed Timescale: 30/09/2017**

