

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Vincent's Centre
Centre ID:	OSV-0005623
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jackie Daly
Lead inspector:	Kieran Murphy
Support inspector(s):	Cora McCarthy
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	21

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 28 June 2017 09:00 To: 28 June 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 11. Healthcare Needs
Outcome 14: Governance and Management

Summary of findings from this inspection

Background to the inspection:

Since 29 March 2017, the Health Service Executive (HSE), in accordance with Section 64(4) of the Health Act 2007 had taken charge of this centre and was to carry on its business as if the designated centre was registered, with the HSE as its registered provider.

During the last inspection of St Vincent's Centre by the Health Information and Quality Authority (HIQA) on 29 March 2017 and 20 April 2017 all four of the outcomes inspected were at the level of major non-compliance, including the governance, fire safety, safeguarding residents, social care needs and healthcare needs of residents. The current inspection took place over one day and was to see if the quality and safety of care provided to residents was of a sufficient standard following the HSE taking charge of the centre.

Description of the service:

The centre was a congregated setting which had the capacity to provide residential care services for 60 women residents. On the date of inspection there were 39 residents living in the centre. 26 residents were living in the main building with many of these residents been living in this centre for a significant period of time. 13 residents were living onsite also but in a separate building. Residents who lived in this part of the centre ranged in age from 22 to 80 and all had minimal to medium support needs, with one resident attending University College Cork and other

residents attending a day service for part of the day.

Since the previous inspection the service had clarified that two people who lived adjacent to the service and received some supports from the service (including responding to fire safety management issues) were deemed not to be living in the designated centre.

How we gathered our evidence:

Inspectors met and spoke with approximately 15 of the residents who currently lived in this centre. Inspectors also met with the person in charge of the centre, the director of services, the nurse practice development coordinator, the representative of the HSE and other staff. Inspectors observed staff practices and interactions with residents and reviewed residents' personal plans.

Overall judgment of our findings:

Significant and ongoing non compliances were identified in relation to the care and safety of the residents. Issues identified included:

- there were a number of institutional practices in the centre that impacted negatively on the quality of life of residents including, the naming of various areas in the centre as "Blocks", the dining experience at mealtimes and the practice of administering medication to residents at their meals (Outcome 1: Residents' Rights Dignity and Consultation)
- residents were very anxious in relation to the future of the centre and were being supported by independent advocates in relation to living in the community. However, the management in the centre had no further information as to whether residents were moving, where residents were moving to or when the move was to take place (Outcome 1: Residents' Rights Dignity and Consultation).
- the designated centre did not meet the assessed needs of all residents as the service itself had identified that one resident was inappropriately placed. (Outcome 5: Social Care Needs)
- consistent assessment of residents healthcare needs were not being undertaken (Outcome 5: Social Care Needs)
- an updated care plan was not in place to ensure that one resident's care, support and wellbeing needs would be adequately met on her return from hospital (Outcome 5: Social Care Needs)
- the arrangements in relation to fire safety management systems were not effective (Outcome 7: Risk Management)
- there was evidence of a lack of clarity around the reporting of allegations of abuse. In addition, the person in charge said that not all staff had up to date training on safeguarding residents (Outcome 8: Safeguarding and Safety)
- residents' healthcare needs were not always being met through timely access to healthcare services and appropriate treatment and therapies (Outcome 11: Healthcare)
- the management systems were ineffective to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored;

Positive findings included residents having improved access to outside space as the gardens had been landscaped and any debris had been cleared away. It was also found that increased staffing in one part of the centre meant that residents had more

opportunity to engage in social activities in the community. It was also noted that, where required, there was advanced care planning documentation in place that provided clear instructions to staff in the event of a resident's health suddenly deteriorating.

Such were the significant findings on this inspection, the provider representative was requested to attend a meeting in the HIQA office on the 30 June 2017 to discuss the significant failings from the inspection of the 28 June 2017. At this meeting, attended by the provider representative, the person in charge and the provider's director of services, HIQA set out the expectations of the provider on what needed to be undertaken to bring the centre into compliance and requested a robust action plan response to address these serious and repeated failings.

In addition, the provider was informed that a review of the weekly report submitted by the person in charge, at the request of HIQA, highlighted further issues including, for example:

- residents with medium to high risk of falls had no plan of care to guide staff
- residents who may engage in self injurious behaviour had no plan in place to guide staff on this matter
- conflicting and confusing information was in a resident's plan regarding continence.
- a resident with a diagnosis of dementia did not have a care plan in relation to this matter.
- one resident was waiting on a review by a dietician since January 2017 and another resident was waiting on the delivery of a specialised chair since November 2016.

At this meeting, the provider was put on notice as to the consequences of the continued non-compliance and that HIQA would use its statutory powers as required to ensure residents' health and welfare was protected in this centre.

These findings were presented to the person in charge throughout, and at the end of the inspection. 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):

No actions were required from the previous inspection.

Findings:

There were a number of institutional practices in the centre that impacted on the quality of life of residents including, the naming of various areas in the centre as "Blocks", the dining experience at mealtimes and the practice of administering medication to residents at their meals. In addition, despite the fact that residents were being supported by an independent advocate in relation to transitioning to community based living, the management in the centre had no further information as to whether residents were moving, where residents were moving to or when the move was to take place.

26 residents were living in the main building with many of these residents having lived in the centre for a significant period of time. 13 residents were living onsite also but in a separate building. Residents who lived in this part of the centre ranged in age from 22 to 80 and all had minimal support needs, with one resident attending University College Cork and other residents attending a day service for at least part of the day.

Inspectors were told that "a profile" of all residents had been completed by an external HSE consultant to identify if residents could live in alternative arrangements. Residents who spoke to inspectors were very anxious in relation to the future of the centre. Inspectors were told by the person in charge that independent advocates were to support the residents in relation to living in the community. However, the management in the centre had no further information as to whether residents were moving, where residents were moving to or when the move was to take place.

Additional staff support for the 13 residents who were living "semi-independently" had been provided with a change to staff rosters and one staff was now available every day

from 08:00 to 20:00. Residents who lived semi-independently said to inspectors that they felt they had more things to do during the day now with staff being more available.

The gardens and grounds outside the buildings had been landscaped and were now available for residents to use throughout the day.

For the 26 residents living in the main building there was an "activities room" for residents to access during the day. From the weekly roster for the date of inspection it was noted that one staff member was responsible for "activities" from 09:00 to 17:00 from Monday to Friday, with a social care worker rostered from 09:00 to 14:00 from Monday to Thursday. However, from the activities observed by inspectors and from a review of resident personal plans there was inadequate evidence that the programme of activities was tailored to meet the assessed needs of the residents.

Staff said that the service was acquiring a new bus so that transport would be more accessible to facilitate residents to engage in more activities in the community. It was noted that there was a specific bus driver on the roster from Monday to Friday. Inspectors were told that support staff were trained to drive the bus and drove residents to activities on the weekend.

Inspectors also noted a number of institutional practices in the centre that impacted on the quality of life of residents. For example, there was the use of non-person centred language to describe various resident living areas with signs for "Blocks" on display throughout the premises. In relation to the dining experience for residents, all meals were prepared in a large kitchen and served in the dining room through a "bain marie" service unit. All meals were eaten in a common dining room that was a large open space. The size and layout of the dining room made it difficult for residents to enjoy their meal in a comfortable space. The chairs, tables and general decor required updating. It was observed by inspectors at lunchtime that the "medication round" was administered from the medication trolley while residents were eating their meals.

Judgment:

Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

The designated centre did not meet the assessed needs of all residents as the service itself had identified that one resident was inappropriately placed. However, there was no definitive plan in place to resolve this issue. In addition, it was found that consistent assessment of residents' healthcare needs were not being undertaken and an updated care plan was not in place to ensure that one resident's care, support and wellbeing needs would be adequately met on her return from hospital.

It had been identified on the previous inspection that one of the residents was inappropriately placed in the centre. It was planned that this resident would be discharged from the centre and would live in house based in the community. Inspectors were told that an application had been submitted to the HSE for an alternative placement. However, this application had not been approved and there was no definitive plan in place at the time of inspection. On this inspection there was evidence both from clinical professionals and through the service incident reporting system that this inappropriate placement was having a negative impact both on this resident and the other residents who were living there.

It is a requirement that all serious injuries are reported to the Chief Inspector within three working days of the incident. Since the previous inspection HIQA had been notified of an incident where a resident had fallen and had been subsequently admitted to hospital. The centre did not have up-to-date relevant information or knowledge about the hospitalisation or the date of discharge. In addition, the centre did not have an updated care plan in place to ensure that the resident's care, support and wellbeing needs would be adequately met on her return from hospital.

Inspectors reviewed a sample of residents' healthcare plans. It was noted that there was inconsistent information in various parts of residents' healthcare files. For example:

- following appointments with doctors or other healthcare professionals, staff were making notes of these appointments. In one example staff had recorded that one resident required further review by a consultant specialist. However, the doctor's note of that appointment visit by the resident, which was available in another healthcare file, had specifically stated that the resident did not require further review.
- in relation to an assessed healthcare need, one part of a resident's healthcare file provided contradictory information to another part of the same healthcare file.

Since the previous inspection the service had clarified that two people who lived adjacent to the service and received some supports from the service (including responding to fire safety management issues) were deemed not to be living in the designated centre. However, a level of support was provided by the provider to the persons which necessitated that staff leave the designated centre to attend to respond to, for example, a house or fire alarms.

Judgment:

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:

A single aspect of this outcome was reviewed on this inspection, namely fire safety. As on the previous inspection it was found that the arrangements in relation to fire safety management systems were not effective.

It is a requirement of the regulations that all serious adverse incidents, including if a safety fire issue took place, are reported to HIQA. It was reported that a false alarm had occurred in the centre on 18 June 2017. There was documentation available to show that this incident had been appropriately managed by the centre. It was noted that a previous fire incident had taken place in April 2017 in the smoking room. Following a review of that incident by the fire service, issues identified had been addressed including the provision of telephone coverage throughout the building in the event of an emergency. The smoking room had been relocated to a sheltered courtyard outside the building. There was a fire extinguisher and fire blanket available in this location. Furthermore, inspectors did note, that due to the location of the new smoking shelter, a smell of cigarette smoke throughout the lower ground floor of the building.

However, overall, the effectiveness of the fire safety management systems in place was not demonstrated. For example, inspectors saw a record of an incident that occurred on 13 June 2017 in a house that was not part of the centre but for which the centre was responsible for fire safety management. An incident had occurred where people living in the house had thought the house alarm was going off. However, when staff were called to investigate, staff found that the fire alarm was going off as an electrical appliance had overheated.

In addition, in relation to fire evacuation drills the records indicated that an evacuation drill had not taken place in the main building since February 2017. This was confirmed by the person in charge who also confirmed that not all staff had up to date fire training. This was of particular significance, cognisant of the number of agency staff working in the centre; management confirmed that some agency staff had not worked in the centre before.

At the previous inspection it was noted that fire stopping arrangements appeared inadequate, in particular in relation to the effectiveness of fire doors to prevent the spread of smoke in the event of a fire. The service had submitted to HIQA two fire

safety surveys that they had commissioned one in March 2017 and the second in April 2017. The findings in both reports were at variance to each other in a number of respects, for example;

- the adequacy of the construction separating compartments throughout the main building and separating it from adjoining areas is not clear
- the recommendations with regard to fire doors throughout are contradictory. It is therefore not evident that fire doors in the centre are capable of restricting the spread of fire and smoke and provide an adequate means of escape to residents and staff.

Both reports were consistent in their findings with regard to inadequate fire stopping of service penetrations and the required replacement of un-insulated glazing within the compartment walls. The nominated representative of the HSE said to inspectors that a tender process was underway for the completion of the fire safety works. However, further details were not available of what had been submitted as part of the tender works or the timelines for completion of these works.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Appropriate safeguarding measures were not in place.

As on the previous inspection there was evidence of a lack of clarity around the reporting of allegations of abuse. In the incident reporting records seen by inspectors there had been an incident which should have been managed according to the centre's protocol on the allegations of abuse. However, a review of the incident in line with the protocol had not taken place. In addition, the person in charge said that not all staff had up to date training on safeguarding residents.

It is a requirement of the regulations that all serious adverse incidents, including safeguarding issues are reported to HIQA. Five such incidents had been submitted to

the Chief Inspector since the previous inspection. Documentation in relation to these incidents was reviewed during the inspection. All incidents had been managed as per the service protocol.

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:

Residents' healthcare needs were not always being met through timely access to healthcare services and appropriate treatment and therapies.

There was evidence in the healthcare records that the general practitioner (GP) was reviewing residents' health needs as required. There was evidence that residents were supported to attend appointments in acute general hospitals and had been referred to consultant specialists if required. There was also evidence of good access to specialist care in psychiatry.

It was noted that, where required, there was advanced care planning documentation in place that provided clear instructions to staff in the event of a resident's health suddenly deteriorating.

As noted on the previous inspection, the person in charge confirmed that there was a heavy reliance on agency staff. However, inspectors noted again on this inspection, information was inadequate to guide staff and in particular agency staff.

There were issues relating to access to relevant allied health professionals. For example, one resident required a communication assessment by a speech and language therapist. However, it was recorded in the healthcare record that the services of the speech and language therapist were "difficult to source at present due to workload". There was evidence that the person in charge had contacted an occupational therapist and had received advice on how best to support a resident with dementia. However, these recommendations had not been implemented.

In other healthcare files it was noted that appropriate professional input had been obtained in relation to swallow difficulties from a speech and language therapist, and

the use of appropriate equipment from an occupational therapist. Residents had also been seen by a physiotherapist, although the records of this review were filed loosely on a notebook page in the healthcare file. This could not guarantee the confidentiality of residents' personal information. It was noted that a "post-it" note regarding a healthcare issue was now selotaped into the resident's healthcare file. This unsafe practice had been highlighted in previous inspections.

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:

The management systems were ineffective to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored and on a daily basis. Systems in place did not support and promote the delivery of quality and safe care.

The significant findings on this inspection indicated that there were not effective management systems in place to oversee and monitor the safe care of residents and on a daily basis. During the inspection, clear and continued deficiencies were identified in areas including:

- institutional practices
- fire safety management
- inadequate implementation and updating of residents' personal plans and goals
- inadequate auditing of the quality of care by the provider and inadequate supervision in the centre
- staff training; not all staff had attended relevant or mandatory training; no clarification with regard to the training agency staff had attended.

Inspectors found evidence to support that the quality of care of some residents, and in particular residents with complex co-existing conditions with nursing and clinical care needs, was not adequately monitored on an ongoing basis. There was insufficient

clinical oversight to ensure that the recommendations from specialist allied professionals were included in residents' personal care plans.

The person in charge, on secondment from the HSE, commenced in the centre on 5 December 2016. The person in charge outlined that she was supported by a management group that included senior members of the disability services of the HSE. This group also included members from maintenance, finance and communications in the HSE. Inspectors were told by the person in charge that this management group met weekly.

From 29 March 2017, the registration of the centre was cancelled under the Health Act 2007. Following this cancellation of the centre's registration as a designated centre, the Health Service Executive (HSE), in accordance with Section 64(4) of the Health Act 2007 took charge of the centre and was to carry on its business as if the designated centre was registered, with the HSE as its registered provider.

A director of services had started on 25 May 2017 to oversee operational management. She told inspectors that her priorities since starting in this role included improving documentation and the safety of the service. Inspectors also spoke with the coordinator of practice development who had commenced in April 2017. This role involved review of nursing key performance indicators, undertaking audits of care and education of staff on clinical policies, procedures and guidelines.

Again as noted on the previous inspection; notwithstanding matters being discussed at a senior and strategic level in relation to the transitioning of the service to another provider, the person in charge outlined that the HSE proposed to transfer the management and operation of the centre to another provider of services. However, no progress had been made on this matter.

HIQA had been notified of alleged financial irregularities, potentially involving resident finances. A final report was due to be issued and inspectors requested a copy of this report to be sent to HIQA once available.

Such were the significant findings on this inspection, the provider representative was requested to attend a meeting in the office of the Chief Inspector on the 30 June 2017 to discuss the significant failings from the inspection of the 28 June 2017.

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 Health Service Executive
Centre ID:	OSV-0005623
Date of Inspection:	28 June 2017
Date of response:	31 July 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:

- Residents who spoke to inspectors were very anxious in relation to the future of the centre. However, the management in the centre had no further information as to whether residents were moving, where residents were moving to or when the move was to take place.
- There were a number of institutional practices in the centre that impacted on the

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

quality of life of residents

- The size and layout of the dining room made it difficult for residents to enjoy their meal in a comfortable space.
- There was inadequate evidence that the programme of activities was tailored to meet the assessed needs of the residents.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Transition Working Group established since 29th March 2017, a sub-group has been formed to work on a plan around residents that can transfer to community living with supports.

A/Provider Nominee

Group established since 5th July 2017 – working is on-going

Independent Advocates engaged to work with the residents around preparing them for transitioning.

A/Director of Nursing

complete

Schedule of Meetings with Advocates - 5th July Santa Barbara, 10th July for the main building and 6th September for adjoining house.

A/Director of Nursing

complete

Monthly meetings are taking place with residents on the future planning of the centre. First meeting held on 11th July and next planned for 15th August.

A/Director of Nursing and A/Director of Services

On-going

Psychotherapist attends the centre 8 hours per week – a plan will be prepared for the therapist to work with the sub-group for transitioning services and working with the Independent Advocates.

A/Director of Nursing and A/Director of Services

31.08.17

A profile of the residents in the centre using the National Disability Assessment Tool has been completed

A/Provider Nominee

Complete

A communication plan to be prepared around transition plan in order to ensure that residents, families, staff and all stakeholders are communicated with effectively

A/Provider Nominee

30.09.17

In 2014, a recommendation from Cork City Fire Department outlined that signage indicating the Block should be displayed throughout the centre in order to facilitate the passage of fire officers through the building in case of fire. – Therefore we cannot remove the Block from the signage.

Complete

There are a number of residents who require medications with their meals, however a new process of administering medication by staff has been introduced. This includes no medication trolleys entering the dining areas.

A/Director of Nursing

Completed 10th July 2017

The activity programme for the centre will be reviewed on a monthly basis by the A/Director of Nursing, CNM1s and Activity Coordinator.

A/Director of Nursing and A/Director of Services

On-going

Fit for life Programme introduced for the residents in March 2017, includes weekly individual sessions with physiotherapist and weekly individual and group exercise programmes.

A/Director of Nursing and A/Director of Services

On-going

Annual Holiday Plan in place for residents

A/Director of Nursing and A/Director of Services

On-going

Proposed Timescale: 30/09/2017

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:

The designated centre did not meet the assessed needs of all residents.

2. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

HSE is actively seeking an alternative accommodation for 2 residents whose assessed needs cannot be met by the centre.

A/Provider Nominee, A/Director of Nursing and A/Director of Services

On-going

In the interim, additional supports have been put in place for both clients to meet the assessed needs of both residents. Care plans are in place to document the needs of both residents.

A/Director of Nursing and A/Director of Services
Complete

A meeting with therapists, GP and centre management takes place every six weeks, cases are prioritised based on clinical assessment.

A/Director of Services
On-going

Documentation Management Workshop for the healthcare staff is being developed.

A/Director of Services and CNM3 with ID experience
30.09.17

Comprehensive care plans are being developed for each resident within St. Vincent's Centre, in order to ensure all documentation is correct.

A/Director of Services and CNM3 with ID experience
30.09.17

Proposed Timescale: 30/09/2017

Theme: Effective Services

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

Consistent assessment of residents healthcare needs were not being undertaken.

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:

The MDT Team in St. Vincent's include:

Visiting Physiotherapist

Visiting Occupational Therapist

Visiting Dietician

Visiting Psychologist

Visiting Speech and Language Therapist

A meeting is scheduled with the MDT team, GP and centre management every 6 weeks to discuss priority cases.

A/Director of Nursing and A/Director of Services
On-going

All urgent referrals to the Dietician have been seen and a total of 5 referrals are due to be seen.

A/Director of Nursing
31.08.17

2 Referrals are outstanding for the Speech and Language Therapist
A/Director of Nursing
31.08.17

The Centre has access to a psychotherapist who attends twice weekly for group and individual sessions. Behaviour therapy support care plans are being formulated by the "An Cuan" service from Cope for 7 residents. Additional behavioural support therapy within the centre will be available from September.

A/Director of Nursing
30.09.17

The occupational therapist has seen 6 residents who required an OT assessment and her recommendations are being followed up.

A/Director of Nursing
30.9.17

Proposed Timescale: 30/09/2017

Theme: Effective Services

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

The centre did not have up to date relevant information about one resident's hospitalisation and did not have an updated care plan in place to ensure that the resident's care, support and wellbeing needs would be adequately met on her return from hospital.

4. Action Required:

Under Regulation 25 (2) you are required to: On the return of a resident from another designated centre, hospital or other place, take all reasonable actions to obtain all relevant information about the resident from the other designated centre, hospital or other place.

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

Standard Operating Procedure has been prepared around the communication process with another designated centre/hospital/service if a resident is transferred there.

A/Director of Nursing
Complete

Proposed Timescale: 31/07/2017

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 arrangements in relation to fire safety management systems were not effective, as demonstrated by inappropriate response to fire incidents, lack of fire evacuation drills and all staff not having up to date fire training.

5. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

FCC Fire Safety consultants have undertaken a risk assessment of the building. One red risk notified in relation to a fire alarm and immediate steps were taken to replace same.

Estates Dept HSE

Complete

Tender Process for other works identified in the risk assessment. A time line will be agreed around commencement of work. A/Provider Nominee and Estates Dept

On-going

Weekly Fire Drills have commenced

A/Director of Services

On-going

Daily Checklist on fire exits and equipment has been updated and is signed by the person carrying out the checks.

A/Director of Services

On-going

Fire Safety Awareness Training and Evacuation Training Scheduled for 8th, 25th and 28th August.

A/Director of Services and A/Director of Nursing

31.08.17

Fire Equipment Training is scheduled, for the 14th and 15th August.

A/Director of Services and A/Director of Nursing

31.08.17

The following policies have been developed:

- Policy on Fire Evacuation Strategy
- Policy on Fire Prevention & Smoking
- Policy on Fire Door Checks
- Policy on Fire Prevention Checklist
- Policy on Fire and Flammable Liquids
- Policy on Boiler House Practice
- Policy on Control of Combustibles
- Staff handout on Fire safety

A/Director of Services

Complete

A handout has been given to all staff members on Fire safety

A/Director of Services

Complete

On a Daily basis – new agency staff are provided with a tour of the centre, shown the fire exits and equipment. They are provided a fire safety procedures, colour coded list of residents' evacuation requirements, red (require complete assistance), yellow (require some assistance) and green (no assistance required). They are also shown each resident's PEEP which is located at the back of the resident's door. This checklist is signed by the agency staff member and the resident staff member giving the induction.

A/Director of Services and A/Director of Nursing

Complete

Proposed Timescale: 31/08/2017

Theme: Effective Services

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

The effectiveness of fire stopping arrangements to prevent the spread of fire was not demonstrated.

6. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

FCC Fire Safety consultants have undertaken a risk assessment of the building. One red risk notified in relation to a fire alarm and immediate steps were taken to replace same.

Estates Dept HSE

Complete

Tender Process for other works identified in the risk assessment. A time line will be agreed around commencement of work A/Provider Nominee and Estates Dept

On-going

Weekly Fire Drills have commenced

A/Director of Services

On-going

Daily Checklist on fire exits and equipment has been updated and is signed by the person carrying out the checks.

A/Director of Services

On-going

Fire Safety Awareness Training and Evacuation Training Scheduled for 8th, 25th and

28th August.

A/Director of Services and A/Director of Nursing

31.08.17

Fire Equipment Training is scheduled for the 14th and 15th August.

A/Director of Services and A/Director of Nursing

31.08.17

The following policies have been developed:

- Policy on Fire Evacuation Strategy
- Policy on Fire Prevention & Smoking
- Policy on Fire Door Checks
- Policy on Fire Prevention Checklist
- Policy on Fire and Flammable Liquids
- Policy on Boiler House Practice
- Policy on Control of Combustibles
- Staff handout on Fire safety

A/Director of Services

Complete

A handout has been given to all staff members on Fire safety

A/Director of Services

Complete

On a Daily basis – new agency staff are provided with a tour of the centre, shown the fire exits and equipment. They are provided a fire safety procedures, colour coded list of residents' evacuation requirements, red (require complete assistance), yellow (require some assistance) and green (no assistance required). They are also shown each resident's PEEP which is located at the back of the resident's door. This checklist is signed by the agency staff member and the resident staff member giving the induction.

A/Director of Services and A/Director of Nursing

Complete

Proposed Timescale: 31/08/2017

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:

There was evidence of a lack of clarity around the reporting of allegations of abuse. In addition, the person in charge said that not all staff had up to date training on safeguarding residents.

7. Action Required:

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

abuse.

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

The National Safeguarding Policy is in place within the centre and managed by the A/Director of Nursing

A reporting procedure is in place within the centre.

A/Director of Nursing

Complete

Safeguarding Training plan is in place, additional dates confirmed to complete the outstanding 27% of staff that require training. These dates are 4th August and the 1st September 2017.

A/director of Nursing

30.09.17

Proposed Timescale: 30/09/2017

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' healthcare needs were not always being met through timely access to healthcare services and appropriate treatment and therapies.

8. 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:

The MDT Team in St. Vincent's include:

Visiting Physiotherapist

Visiting Occupational Therapist

Visiting Dietician

Visiting Psychotherapist

Visiting Speech and Language Therapist

A meeting is scheduled with the MDT team, GP and centre management every 6 weeks to discuss priority cases.

A/Director of Nursing and A/Director of Services

On-going

All urgent referrals to the Dietician have been seen and a total of 5 referrals are due to be seen.

A/Director of Nursing

31.08.17

2 Referrals are outstanding for the Speech and Language Therapist
A/Director of Nursing
31.08.17

The Centre has access to a psychotherapist who attends weekly for group and individual sessions. Behaviour therapy support care plans are being formulated by the "An Cuan" service from Cope for 7 residents. Additional behavioural support therapy within the centre will be available from September.

A/Director of Nursing
30.09.17

The occupational therapist has seen 6 residents who required an OT assessment and her recommendations are being followed up.

A/Director of Nursing
30.9.17

Proposed Timescale: 30/09/2017

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 systems were ineffective to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored. During the inspection clear deficiencies were identified in areas including institutional practices, inadequate care planning for residents; and fire safety management.

9. 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:

The Centre has the following management structure in place:

- Director of Services and a Director of Nursing.
- Clinical Nurse Manager 3 with special interest in Intellectual Disability Services provides support 2 days per week to the centre around Care Planning.
- Practice Development Coordinator to facilitate the roll out of new care plans, clinical policies and guidelines and to carry out audits of practice.
- Two Clinical Nurse Manager 1 who supervise the implementation of care plans, policies and procedures.

A section 23 audit has been completed by the Area Manager for Disability Services in Cork and Kerry along with a CNM3 and Provider Nominee from another ID Centre.

Transition Working Group has been established with supports of finance, HR, communication, maintenance and management.

Management on-call system in place.

Proposed Timescale: 31/07/2017