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## St Lukes and St Matthews, OSV-0003013, 20 September 2018

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# Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	St Lukes and St Matthews
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	20 September 2018
Centre ID:	OSV-0003013
Fieldwork ID:	MON-0024091

## About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St Luke's and St Mathews comprises of two units, located on a campus based setting in Co. Louth. The centre is registered for nine adults. The units are within walking distance of each other. One of the units supports four male adults. There is a self contained living area in this unit where one resident is supported during the day. The other unit currently supports three male adults. Staffing levels comprise of seven staff during the day and four staff at night. The skill mix comprises of nurses and health care assistants. A nurse is assigned to each unit during the day and one nurse is assigned between both units at night time. This nurse is allocated based on the particular needs of the residents. Residents do not attend any formalised day services. They are supported by staff to have meaningful day activities during the day. There are two buses available in the centre for residents to access community activities. Some residents also avail of complimentary therapy sessions in the centre. The person in charge is responsible for three other centres under this provider. They are supported in their role in this centre by a clinic nurse manager who is assigned 12 hours supernumerary hours to ensure effective oversight of the centre.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	7
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## How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

### **1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

### **2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
20 September 2018	10:45hrs to 17:00hrs	Anna Doyle	Lead

## Views of people who use the service

The inspector met all of the residents residing in the centre. Residents were unable to engage with the inspector so as to fully impress their views on the quality of care being provided in the centre. However, one resident showed the inspector their bedroom and took pride in showing them some of the items in their room.

Residents appeared relaxed and at ease in the company of staff and staff were seen to interact with residents in a caring and warm manner. It was observed that staff knew and respected the communication style and preferences of the residents. For example, staff informed the inspector about residents who would not welcome engagement from people they did not know.

Residents were observed being supported by staff to engage in activities during the day. For example, when the inspector started the inspection some residents were already out on a walk and there was a plan for others to go out on a bus trip that morning.

## Capacity and capability

This inspection was carried out in response to the provider submitting information to HIQA, stating that this centre was no longer in a position to transition all residents from the centre by March 2019. This had been the providers intention at the time of the last inspection.

At previous inspections of this centre it has been identified that the premises were institutional in the layout and design and considered not fit for purpose. On foot of this the provider has made some changes to the centre and reduced the capacity of the centre to nine residents.

The inspector found that while some areas of the centre were well presented and homely, significant improvements were required in a number of areas to ensure that the premises were homely clean and well maintained. In addition, the units in the centre had a number of vacant rooms and the units were large given the number of residents being supported there.

Post this inspection a meeting was held with the regional director and senior managers to discuss the transition of residents from this centre and the remedial works required to the premises to ensure that they met the requirements of the regulations.

Assurances were provided at this meeting that the provider was still committed to closing this centre however the initial time frame of March 2019 was now not achievable. A transition plan was outlined which would see three new community homes purchased in 2019 to accommodate some of the residents from this centre,

with additional homes to be purchased in 2020 and 2021. This would mean that this centre would be closed by 2021.

In addition, assurances were given that issues related to the current premises would be completed on a phased basis with acknowledgment that any areas that required significant remedial works may not be reasonable given that the centre will close in 2021.

The inspector also found that the care and support being provided to one resident was in breach of a number of regulations which related to restrictive practices, positive behaviour support, risk management processes and timely access to allied health care professionals to support this resident.

In response to these findings the provider was issued with an urgent action plan the day after the inspection in order to respond to these findings within a specified time frame. This was submitted by the provider.

There were clearly defined management structures in place in the centre that outlined clear lines of accountability. However, the inspector was not assured given the findings of this inspection, that the oversight of restrictive practices and risk management in the centre required review.

There were sufficient staff in place in the centre to meet the needs of the residents. All staff had been provided with mandatory training and some additional training to meet the residents needs. Some refresher training was also scheduled to take place in the coming weeks.

The inspector also found that improvements were required to the admission of residents to the centre to ensure that it was conducted in a timely manner and considered the needs and wishes of the other residents residing there. For example, on the morning of the inspection staff were not aware of any new admissions to the centre even though the inspector had been informed that three residents were transitioning to the centre prior to this inspection. A senior manager informed the inspector that this arrangement had changed again and only one resident would be admitted. This resident was due to transition in the coming weeks.

#### Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. They were supported in their role by a clinic nurse manager to ensure oversight of the centre.

Judgment: Compliant

#### Regulation 15: Staffing

There were sufficient staff in place in the centre to meet the needs of the residents.
Judgment: Compliant
<b>Regulation 16: Training and staff development</b>
All staff had been provided with mandatory training and some additional training to meet the residents needs. Some refresher training was also scheduled to take place in the coming weeks.
Judgment: Compliant
<b>Regulation 23: Governance and management</b>
The oversight of restrictive practices and risk management processes in this centre required review.
Judgment: Not compliant
<b>Regulation 24: Admissions and contract for the provision of services</b>
Improvements were required to the admission of residents to the centre to ensure that it was conducted in a timely manner and considered the needs and wishes of the other residents residing in the centre.
Judgment: Substantially compliant
<b>Quality and safety</b>
Over all the inspector found that while the residents in the centre appeared well cared for, the care and support being provided to one resident was in breach of a number of regulations which related to restrictive practices, positive behaviour support, risk management processes and timely access to allied health care professionals to support this resident.
When reviewing an audit the inspector became aware of a restrictive practice used for one resident in the centre. On review of the records maintained and in discussion

with staff, the inspector was not satisfied about the rationale for its use, whether the resident had consented to this, whether it was the least restrictive measure and whether the records in place were guiding best practice in relation to this.

The details of this restriction are not included in this report, however on foot of these findings the inspector issued an immediate action to the provider, the day after the inspection.

In addition, the inspector found that the residents behaviour support plan contained conflicting information in respect of this restriction. The recommendations from an allied health professional had not been implemented and therapeutic interventions recommended for this resident had not been completed in a timely manner.

There were systems in place for the management of risk in the centre. However, a number of incidents had occurred in the centre which could have resulted in significant risk to a resident and these had not been comprehensively reviewed to ensure that control measures were implemented to mitigate this risk.

### Regulation 17: Premises

Significant improvements were required in a number of areas to ensure that the premises were homely, clean and well maintained. In addition, the units in the centre had a number of vacant rooms and the units were large given the number of residents being supported there.

Judgment: Not compliant

### Regulation 26: Risk management procedures

Some incidents were not been reviewed to ensure that risks to the resident were mitigated.

Judgment: Not compliant

### Regulation 7: Positive behavioural support

On residents positive behaviour support plan contained conflicting information and had not been reviewed since May 2017.

An urgent action plan was issued to the provider the day after the inspection to ensure that a restrictive practice in place for one resident was reviewed to ensure there was a clear rationale for its use, the resident or their representative had

consented to it, whether it was the least restrictive measure and that the records in place were guiding best practice in relation to this.

The recommendations from an allied health professional had not been implemented and therapeutic interventions recommended for this resident had not been completed in a timely manner.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant

# Compliance Plan for St Lukes and St Matthews OSV-0003013

Inspection ID: MON-0024091

Date of inspection: 20/09/2018

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ol style="list-style-type: none"> <li>1. In response to the urgent action issued on 21.09.2018; the Director of Care and Support reviewed all therapeutic interventions within the Designated Centre and identified that prescriptions were not in place from allied health professionals with regard to use of all helmets, body armor and hip protectors.</li> <li>2. Actions to rectify were completed 11.10.18 and the audit will be repeated in three months.</li> <li>3. The next scheduled North East Region's peer internal audit (to be completed by 31.12.18 across all centres) will include a sample audit of compliance with Regulation 7.5b.</li> </ol>	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:</p> <ol style="list-style-type: none"> <li>1. Residents were informed of new admission to their home by staff during a residents' meeting in September.</li> <li>2. The resident who was transitioning to St Matthews visited the house frequently to become accustomed to his new surroundings and meet residents with whom he would be living, before being admitted to the Centre on 24 October 2018.</li> </ol>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises: We recognise that the Centre is based within an institutional setting and that the current premises cannot (economically) be made fit for purpose.</p> <ol style="list-style-type: none"> <li>1. The Provider will complete a decoration, maintenance and minor works schedule (but</li> </ol>	

not significant remedial works) for the Centre, commensurate with its anticipated timeframe for closure, by 30 November 2018.

2. The Provider will work through the schedules, as funding permits, with a focus on creating and maintaining an improved living environment for residents, one that is more conducive to addressing their comfort, privacy, dignity, and respect.

Regulation 26: Risk management procedures

Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

11. The risk register is reviewed monthly

2. Restrictive practices are reviewed three monthly by local management and our Governance of Restrictive Interventions Committee (GRIC)

3. Positive Behaviour Support Plans are reviewed annually, or sooner if required, and the recommendations are discussed with the staff team and implemented as agreed in conjunction with the relevant member of the MDT or behavioural specialist.

4. The new Audit of Restrictive and Therapeutic Interventions will highlight any discrepancies regarding the interventions utilised; expiry dates are highlighted.

5. Peer auditing is conducted across the service and Restrictive Interventions will be added to the schedule.

Regulation 7: Positive behavioural support

Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The issues identified with one behavior support plan were addressed, subsequent to the urgent action plan, and resolved on 24.09.18

1. In line with SJOG's Positive Behaviour support policy, restrictive interventions are reviewed by the Governance of Restrictive Intervention Committee (GRIC), which comprises allied health professionals who oversees the restrictive practices in the service. All restrictions are reviewed three monthly.

2. The GRIC's terms of reference have been modified to 'specify the duration of each approved restriction, together with specified 'rest periods and/or conditions' between repeat applications of the same restriction; together with any other appropriate conditions'. Therapeutic interventions are prescribed by allied health professional and reviewed six monthly.

3. Peer audits will review both Restrictive (behavioural) and Therapeutic interventions going forward.

## Section 2:

### Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/11/2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/11/2018
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	01/03/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2018
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2018

Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/12/2018
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Red	28/09/2018
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Red	28/09/2018
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Red	28/09/2018
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Red	28/09/2018
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Red	28/09/2018