<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011392</td>
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<tr>
<td>Centre county:</td>
<td>Kilkenny</td>
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<tr>
<td>Email address:</td>
<td></td>
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<tr>
<td>Registered provider:</td>
<td>St Patricks Centre (Kilkenny) Ltd</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>John Murphy</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Elizabeth Bowe</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ide Batan</td>
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<tr>
<td>Support inspector(s):</td>
<td>Caroline Connelly; Kieran Murphy (Day One)</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>14</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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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 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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>10 February 2014 10:30</td>
<td>10 February 2014 17:00</td>
</tr>
<tr>
<td>14 February 2014 09:45</td>
<td>14 February 2014 17:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
<th>Outcome 07: Health and Safety and Risk Management</th>
<th>Outcome 08: Safeguarding and Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

This was a monitoring inspection of a house that is part of the main campus of St Patrick’s. The inspection was announced and took place over two days. As part of the inspection inspectors met with residents, the person in charge, the provider, director of services, assistant directors of services and other staff members. Inspectors observed practices and reviewed documentation.

The Authority was also in receipt of unsolicited information which was explored during the inspection. Inspectors observed practices and reviewed documentation in relation to the unsolicited information such as care plans, medical records, policies and procedures.

Inspectors were satisfied, following observation, discussion with the management team and review of documentation, that the information received by the Authority was not supported by evidence.

Inspectors met with the nominated registered provider and director of services and discussed the management and clinical governance arrangements and the role of the person in charge at unit level. Inspectors reviewed centre-specific policies and procedures in relation to the centre such as medication management and risk management.
In summary, the person in charge was involved in the day-to-day running of the centre and was found to be easily accessible to residents, relatives and staff. There was evidence of individual residents’ needs being met and the staff supported residents to maintain their independence where possible. Inspectors observed that community and family involvement was encouraged.

The inspectors observed evidence of good practice during this visit and were satisfied that residents received an adequate standard of care with appropriate access to a general practitioner (GP) and allied health professional services as required. A range of social activities was available, inside and outside the centre.

The findings of the inspection are set out under seven outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The inspectors found that the service did not meet all of the requirements of the Regulations 2013, contraventions included
   • medication management practices
   • health and safety issues and risk management
   • staff training and development
   • some staff files were not adequate
   • resident and family consultation in development of personal plans.
**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

**Judgement:**
Non Compliant - Minor

**Findings:**
Residents had timely access to GP services and appropriate treatment and therapies. Specialist services and allied healthcare services such as physiotherapy, occupational therapy, speech and language therapy, chiropody and optical services were organised as required by the staff.

Residents could also access a play therapist/psychotherapist, nutritionist and a behaviour support specialist. The centre also paid privately for a psychologist to assess residents and there was access to a psychiatrist.

Residents’ health and social care needs were assessed using a support intensity scale. Care needs were set out in personal care plans that were revised following review. Inspectors saw that personal plans were revised on a yearly basis. There were minutes available of personal outcome measures meetings which were held every six monthly and yearly.

The purpose of the meetings was to clarify if the resident had attained their personal outcomes or goals. Residents and their families attended these meetings as observed by inspectors. In the sample of care plans reviewed there were some inconsistencies in relation to residents’ involvement in the development of their personal plans. It was also unclear if family members were involved in this process.

The centre operated a system whereby key workers took primary responsibility for assisting the individual to maintain their full potential in relation to the activities of daily living.
Residents had opportunities to participate in activities and records, separate from residents’ personal plans, identified organised activities for each individual resident. The records identified organised activities, such as outings to local places of interests and to restaurants. The person in charge informed inspectors that other activities were decided on a daily basis, dependent on weather conditions and residents’ preferences.

There was a swimming pool on site and inspectors saw residents using this facility. Relatives were also encouraged to have swimming sessions with their family members. Each house had its own bus and inspectors saw many residents going out on shopping trips, going home or on outings of their choice.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Findings:
Inspectors observed that fire evacuation notices were located in the house. There was a fire policy which was dated January 2014. There was evidence available that fire drills took place with residents and staff. Each resident had their own personal evacuation plan.

However, inspectors saw that mandatory fire training as required by the Regulations was not up to date - some staff had not been trained since 2002. Inspectors also observed that there was a digilock on a link door in the house which was unsafe practice and a risk of potential injury. For example, in the event of a fire, residents or staff members might be unable to access adequate means of escape. Staff demonstrated an appropriate understanding and knowledge of what to do in the event of a fire.

The environment was homely, kept generally clean and maintained. However, practices in relation to infection control were deficient. Hand gels and hand hygiene posters were available. Observation of hand washing by the inspector indicated best practice was not adhered to as staff did not take opportunities to wash their hands or use hand gels. In summary a culture of best practice in hand hygiene was not embedded in the service.

A review of protective measures in regard to some hazards was required, as there was potential for accidental injury to some residents. For example:
• the radiators were extremely hot to touch
• a step into a toilet and activity room required attention as it was a trip hazard
• windows in one area of the unit were leaking.
There was a safety statement which was dated 2010 which does not meet the requirements of the Regulations. There was a risk management policy which was generic. It was not dated and as it focussed mainly on risk identification, it did not therefore meet the requirements of the Regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

A lone working policy was currently being developed for staff. However, inspectors saw where a resident required one-to-one support the staff member did not have a bleep or phone in his possession. The potential degree of risk to residents/staff was evident as the appropriate controls that were in place for keeping them safe were located elsewhere. These practices pose a potential risk of injury in the event of an emergency situation should the staff member require the assistance of other staff.

There was no documented emergency plan available as is required by the Regulations. Manual handling training was up to date for staff as observed by inspectors.

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

Judgement:
Non Compliant - Moderate

Findings:
Policies and procedures were in place for the prevention, detection and response to allegations of abuse or reports of abuse. Staff with whom inspectors spoke knew what constituted abuse had and demonstrated an adequate understanding of abuse with particular reference to those with enhanced communication difficulties. However, not all staff were trained in abuse detection and prevention as required by the Regulations. The person in charge informed inspectors that she had recently completed a train-the-trainer course in abuse prevention, detection and response to abuse and would now be rolling this training out to all staff.

There was a policy on challenging behaviour and inspectors saw that staff had received training in the management of challenging behaviour.

Inspectors noted that all staff demonstrated a good standard of appropriate communication and respect for all residents at all times during the inspection. The inspectors observed that there were caring and respectful relationships between the
residents and staff.

There was no evidence available with regard to risk assessing in line with best practice for any resident that required the use of restraint. The personal plans did not adequately detail the use of restraint, informed consent in relation to the use of restraint, or the supervision and observation of a resident while restraint was in use. There was no evidence that all possible risks of a resident injuring themselves from use of restraint had been considered and there was no evidence that other less restrictive options had been considered for these residents.

There was a policy in place regarding residents’ personal property and possessions. Inspectors spoke with the finance manager for the campus and saw that there were transparent systems in place to safeguard all residents’ monies. Statements regarding finances were issued to residents each month. Inspectors saw that residents had easy access to personal money and could spend it in accordance with their wishes.

A record of the handling of money was maintained for two residents. Two signatures were recorded in all instances and a receipt was provided for each transaction. However, this system for managing finances required review to ensure clear accountability and transparency. The inspector noted there was no running balance available and therefore it was difficult to ascertain if the balance was correct prior to the resident receiving any money for shopping or going out.

**Outcome 11. Healthcare Needs**

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

**Theme:**  
Health and Development

**Judgement:**  
Compliant

**Findings:**
Inspectors reviewed a number of policies in relation to the care and welfare of residents including policies on health assessment and care management. The level of support that individual residents required varied and was documented as part of the resident support plan. From reviewing residents’ support plans, inspectors saw that residents were provided with support in relation to areas of the activities of daily living including personal hygiene and dressing.

The healthcare needs of residents were met. Residents had good access to medical and allied healthcare. The centre had sufficient medical cover and staff confirmed that out-of-hour services were adequate and responsive. Review of residents’ medical notes showed that medical staff visited the centre regularly.
Appropriate referrals for dietetic reviews were made, the outcomes of which were recorded in the residents’ personal plans. Staff used the malnutrition universal screening tool (MUST), which was an established weight monitoring/assessment tool that formed part of the resident’s assessment on admission to the centre. Inspectors saw that residents’ weight were monitored regularly and appropriate equipment was available to weigh residents in line with best practice.

Menus were displayed in the centre which offered choice. Staff were knowledgeable about residents’ likes and dislikes. Inspectors saw that residents who required assistance with eating or drinking were supervised and offered assistance in an appropriate manner.

**Outcome 12. Medication Management**

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

**Theme:**  
Health and Development

**Judgement:**  
Non Compliant - Moderate

**Findings:**  
Practices in relation to medication management required improvement.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident that was receiving the medication to reduce the risk of medication error. The prescription sheets that were reviewed were clear and distinguished between PRN (as needed), short-term and regular medication. The signature of the GP was in place for each drug that was prescribed in the sample of drug charts that was examined. However, the maximum amount for PRN medication to be administered within a 24-hour period was not stated on all of the drug charts reviewed.

Some residents required their medications to be crushed and inspectors saw that staff had made a record on the drug chart. However, this had not been signed off by the GP. This is not in line with best practice as drugs which are crushed are used outside their licensed conditions and only a medical practitioner is authorised to prescribe drugs in this format.

Inspectors saw that a verbal/telephone order had been given by the GP. However, this had not been confirmed by another staff member nor had it been signed by the GP four days following the drug having been administered.

Inspectors saw that one month’s supply of medication was dispensed from the pharmacy for each resident. As the pharmacy was off site, staff were unable to access references and resources for confirming prescribed medication with identifiable drug information. Such references and resources should include a physical description of the
medication and/or colour photograph of the medication. This would have been essential in the event that a medication had needed to be dropped or had required replacement.

Inspectors also saw that it was impossible to note the expiry date of some drugs as they were dispensed outside the original packaging. In some instances there was more than one month’s supply available in the drug trolley. Staff told inspectors that night staff would check in the month’s supply of medication for residents when it arrived. However, there were no records available in relation to dispensed medications from pharmacy which does not meet best practice in overall medication management.

A register of controlled drugs was maintained. However, these were not being checked at the changeover of shifts as required by An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) guidance to nurses and midwives on medication management.

A medication management policy was available. However, it required review in order to meet legislative and best practice guidelines. Staff told inspectors that they had not received medication management training. There was no evidence that medication management audits were being completed by either staff or the pharmacist.

The inspector recommends that regular audit and updated training in medication management would establish review and processes for evaluating the use of medication policies and protocols as part of quality care provision and risk management programmes.

### 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.*

<table>
<thead>
<tr>
<th><strong>Theme:</strong></th>
<th>Leadership, Governance and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Judgement:</strong></td>
<td>Compliant</td>
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</table>

**Findings:**
Overall inspectors found that governance arrangements were satisfactory. St Patrick’s Centre was managed by a board of directors who meet on every two months. The board of directors has a number of sub Committees, each with their own terms of reference. The general manager was the chief executive officer. There was a director of services and there are four assistant director of service, all of whom reported to the general manager.
There was a full-time person in charge who was a registered nurse with the required experience and clinical knowledge for ensuring the effective care and welfare of residents in the centre. In the absence of the person in charge the clinical nurse manager on duty undertook her responsibilities.

The person in charge was actively engaged in the governance and operational management of the house and, based on interactions during the inspection, she had adequate knowledge of the Regulations and the Authority’s Standards.

Inspectors saw that a copy of the Standards was available and the Regulations were available to staff on the unit.

Staff who spoke with the inspector said that they had not received any formal support or performance management in relation to their performance of their duties or personal development which is a requirement of the Regulations.

**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

**Judgement:**
Non Compliant - Moderate

**Findings:**
The inspectors were satisfied that the numbers and skill mix of staff available during the inspection was appropriate to meet residents’ needs. There was a centre-specific policy on recruitment and selection of staff. The person in charge stated that a large proportion of her staff had been employed in the house for a significant period of time and there was a high level of continuity.

Based on observations of inspectors, staff members were knowledgeable of residents’ individual needs and provided assistance to them in a respectful, caring and timely manner. Based on a review of training records viewed by inspectors, not all staff had received up-to-date training to support them in the delivery of evidence-based care. Training deficiencies were identified in areas such as, but not limited to, management of restraint, infection control, nutrition and medication management.

Inspectors reviewed a sample of staff files and noted that most of the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities were
available. However, not all staff files reviewed contained details or documentary evidence of any relevant qualifications, photographic identification or An Garda Síochána vetting.

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

**Report Compiled by:**

Ide Batan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<td>Date of Inspection:</td>
<td>10 and 14 February 2014</td>
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<tr>
<td>Date of response:</td>
<td>14 March 2014</td>
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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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

Failing to ensure the personal plan is developed through a person-centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.

Action Required:

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
- Review of Personal plan for each resident with their family where appropriate June 2014
- Review and update Cared4 policy on personal planning April 2014
- Training of key workers on above adapted policy April 2014
- Letter to residents and families about accessibility to information 30 March 2014
- Key worker role in communication of information
- Review and amend Cared4 policy on assessment and planning 30 April 2014

Proposed Timescale: 30/06/2014

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:
Failing to ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following:
(a) hazard identification and assessment of risks throughout the designated centre;
(c) the measures and actions in place to control the following specified risks:
(i) the unexpected absence of any resident
(ii) accidental injury to residents, visitors or staff
(iii) aggression and violence
(iv) self-harm.
(d) arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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:
- Risk Management training for all persons in Charge Completed 20 March 2014
- Launch of Risk management system within service and populated with identified risks
- Identify controls in line with risks 20 March 2014
- Capacity to print out incident and risk reports for learning, planning and reporting by manager and staff of centre 30 April 2014

Proposed Timescale: 30/04/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that there is ongoing review of risk and that there is an emergency plan in place.
Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
• Work has commenced on the development of an emergency plan for St Patrick’s Centre and it is expected that this plan will be completed for adoption before 30 April 2014 responsible Health and Safety Coordinator

Proposed Timescale: 30/04/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that the residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
• Infection control committee to meet monthly chaired by ADOS Margaret Butler
• Audit commissioned into compliance with policy
• Hand-washing guidelines to be developed, displayed and highlighted to staff 30 March 2014
• Workshops completed for all staff in relation to infection control for non acute settings 31 March 2014

Proposed Timescale: 31/03/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that staff receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points, and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control
techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
- Please state the actions you have taken or are planning to take:
- All Staff will have completed fire training before 15 April 2014
- All staff will participate in monthly fire drills
- Personal evacuation plans for each resident will be reviewed (annual)

### Proposed Timescale: 15/04/2014

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure by means of fire safety management and fire drills at suitable intervals that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
- All staff will participate in monthly fire drills
- Personal evacuation plans for each resident will be reviewed (annual)

### Proposed Timescale: 14/03/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

**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:
- Restrictive practices training workshop to be delivered to entire staff team
  o 50% completed 30 March 2014
  o 100% complete 30 April 2014
- Policy documents distributed to staff
**Proposed Timescale:** 30/04/2014

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**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:**
- All persons in Charge in St Patrick’s Centre have received Train the Trainer in designated person training in 2013 (Wolfe Consultancy)
- Trust in Care training for all staff completed 31 March 2014
- Staff workshops on detection prevention and reporting of abuse completed 30 May 2014

**Proposed Timescale:** 30/05/2014

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**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:**
Failing to ensure that there are suitable and appropriate practices relating to the ordering, storing, receipt, prescribing, disposal and administration of medicines.

**Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
- All nursing staff to have medication management training on line course completed before 31 March 2014
- Bi Monthly meetings to be scheduled with person in charge and pharmacy team with compliance report to issue commencing April 2014
- Medication policy under review with pharmacy, person in charge, doctor, psychiatrist
- Review completed for adoption by Centre before 20 April 2014.
- Controlled Drugs (DDA) practice has been reviewed and practices changed in compliance with NMBI guidelines, enacted immediately.

**Proposed Timescale:** 20/04/2014
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:
Failing to ensure that effective arrangements are in place 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.

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:
• Training provided for all managers and persons in charge and ass managers grade within St Patrick’s Centre on core skills competencies in people management processes in a care setting. Completed March 2014  
• Completed negotiation with unions of the service on the roll out of quarterly supervision for all staff 15 April 2014  
• Supervision documentation will be available for inspection from May 31 2014  
• Training needs analysis report process will commence in tandem with support and supervision process. The person in charge will include in monthly reports the training needs or emerging training needs of the centre April 2014  
• Persons in Charge in St Patrick’s Centre will participate on accredited supervisory training (FETAC VI) in the coming year.

Proposed Timescale: 31/05/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2 of the Regulations.

Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
• All Garda Vetting forms submitted and returned from vetting March 2014  
• On completion of a human resource audit of all human resource personnel files within the service a letter will issue to all staff in the centre in relation to outstanding
information 22 March 2014
• All information will be returned and on file before 30 April 2014
• The human resource department will prepare a compliance report for person in charge
5 May 2014

**Proposed Timescale:** 05/05/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**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:**
• Mandatory training report will be prepared and available to person in charge. 15 April 2014
• Training needs and competency report to be developed in association with staff support and supervision process. Key information will be included in person in charge management monthly reports April 2014.

**Proposed Timescale:** 30/04/2014