

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd
<b>Centre ID:</b>	OSV-0003499
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St Patricks Centre (Kilkenny) Ltd
<b>Provider Nominee:</b>	John Murphy
<b>Lead inspector:</b>	Ide Batan
<b>Support inspector(s):</b>	Kieran Murphy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	33
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

**The inspection took place over the following dates and times**

From:	To:
09 October 2014 10:30	09 October 2014 17:30
10 October 2014 08:15	10 October 2014 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was the first inspection of this centre by the Health Information and Quality Authority (the Authority). The inspection was carried out in response to an application from the provider to register the centre. As part of the inspection, the inspectors met with the residents, relatives and staff members. Inspectors reviewed documentation such as the centre's statement of purpose, person centred care plans, medical records, arrangements with regard to meal preparation, activities, staff training records, staff files, policies and procedures, fire safety records and the residents' accommodation.

This inspection was announced and took place over two days. The ethos of the designated centre as outlined in the centre's statement of purpose and function is one of integrity, professional conduct, openness, person centred and quality focused.

The centre is governed by a voluntary board of directors which also has a number of subcommittees each with their own terms of reference to aid with the development of particular aspects of the service. Services are provided with the financial assistance of the Health Service Executive (HSE) and fundraising. The nominated provider is also the Chief Executive Officer (CEO). As part of this inspection the inspector reviewed questionnaire feedback submitted by relatives. A high proportion of the distributed questionnaires were returned. The vast majority of feedback provided was very positive and complementary of the service provided and dedication of the staff.

The designated centre comprises of three residential units and one apartment which accommodates 33 male and female residents in total. The centre supports people with a variety of disabilities and with different levels of abilities and needs.

Throughout the inspection there was evidence of individual residents' needs being met and the staff supported and encouraged residents to maintain their independence where possible. Community and family involvement was evident and encouraged with many residents regularly going out and a number went home for weekends or holidays. There was an extensive range of social activities available internal and external to the centre and residents were seen to positively engage in the social and community life which was reflected in their person-centred plans.

Overall, the inspector found that residents received a good quality service in relation to activation, recreation and community participation. There was evidence of a level of compliance, in some areas, of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and this was reflected in a number of positive outcomes for residents.

The nominated person on behalf of the provider and person in charge demonstrated knowledge 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 Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection

The findings of the inspection are set out under eighteen 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 was non compliant in areas of the Health Act 2007 Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Contraventions included complaints policy, fire safety management, health and safety and risk management, staff files were not adequate, infection control, premises and food and nutrition.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Overall it was found that residents' were consulted with and participated in decisions about their care and running of the centre. Ongoing efforts were made to promote the rights of residents and seek the opinions of residents in relation to their satisfaction with the quality of the service provided. Resident's privacy and dignity was protected and promoted in practice and inspectors saw that staff knew each of the residents well and understood their needs and preferences.

There was a complaints policy, however it did not outline, in sufficient detail, the process for managing complaints, it did not identify a designated complaints officer and it did not identify an appropriate appeals committee to address complaints when the complainant was dissatisfied with the complaints officer's findings, due to the non-implementation of the local complaints process.

The person in charge said there were no recent complaints logged at the time of inspection. There was no signage on clear display identifying for residents, relatives and visitors how to make a complaint, the responsible person for dealing with complaints or an appropriate appeals process. Some relatives told an inspector that they did not know that there was a complaints policy in place.

The provider had developed a number of policies to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. Bank statements are issued to residents and relatives on a monthly basis. Records were also kept of any additional expenditure for residents. The inspector reviewed a number of these and noted transactions were being signed by two staff members and checked by

the person in charge. These practices provided greater clarity and transparency on individuals' expenditure to the resident, their representative and to the person in charge

Residents could keep control of their own possessions. Inspectors saw that there was adequate space for clothes and personal possessions. The laundry facilities were appropriately set up to facilitate residents in doing their own laundry if they wished. However, in most instances staff did the laundry for residents. Residents were facilitated to exercise their religious rights. Mass took place on campus every Sunday and residents could also go out to mass if they wished. Mass also took place in the units every two months for residents who were unable to go out. The person in charge said any other religious denominations would be facilitated.

Inspectors saw that all residents had access to advocacy services. The nominated provider had written to all families in relation to the provision and access to advocacy services in the centre. The nominated provider told inspectors that a two hour workshop had been held in relation to the role and function of advocacy services.

There was a human rights committee in operation. Inspectors saw that referrals were maintained in relation to any restrictive practices or any practice which impinged on residents rights. Following a committee meeting the chairperson wrote to the resident their family, key worker and the person in charge outlining the outcome of the meeting.

There was also a complex case committee in relation to individual cases. Inspectors saw that the behavioural therapist, play therapist and director of services were involved in these meetings. Inspectors saw that resident, family and sibling forum meetings took place on a regular basis. Inspectors saw minutes of the last meeting which had taken place on 30 August 2014. Staff told inspectors that these meetings were more effective for some than others because of capacity and communication issues. The key working system was used to try and keep residents informed and consulted more individually.

**Judgment:**  
Non Compliant - Minor

## **Outcome 02: Communication**

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

**Theme:**  
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**  
This was the centre's first inspection by the Authority.

**Findings:**  
In the sample of care plans reviewed there was evidence that residents were assisted and supported to communicate at all times. This support included some residents using

picture enhanced communication and other residents using the Lámh communication method which was a manual sign system for people with an intellectual disability and communication needs.

Consistency and continuity of staff was described by staff as the most essential element in being able to assist residents to communicate effectively. This was clearly evidenced by the inspector who witnessed staff pick up on subtle cues from residents' and could clearly understand each resident's method of communication. The person in charge told inspectors that every effort was made to ensure continuity in each unit in relation to staffing.

As outlined under Outcome 1 there was a complex care committee which had a particular role in facilitating residents to access all the supports they required. A number of residents had been referred for play therapy via this committee. The play therapist outlined that she worked in conjunction with an external behaviour therapist who was available to residents for one and a half days per month. As an example of how this therapy related to communication inspectors reviewed a resident's play therapeutic care plan which included a recording for one month of the resident's behaviour.

Key staff completed an analysis chart and found that the resident appeared to be communicating at a complex level rather than the behaviour being seen as a sensory issue. The play therapist devised a day plan programme with an emphasis on visual communication and consistent responses from staff in how they communicate with the resident. This play therapeutic care plan was to be reviewed after it had been implemented over a number of months. There was evidence that other residents' challenging behaviour had reduced following the support received from a play therapy care plan.

The person in charge had arranged regular unit meetings in the centre as another way of supporting residents to communicate their views. The inspector saw notes of some of these meetings.

**Judgment:**  
Compliant

**Outcome 03: Family and personal relationships and links with the community**  
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**  
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**  
This was the centre's first inspection by the Authority.

**Findings:**

Residents were supported to develop and maintain personal relationships and links with the wider community. Inspectors saw that families were welcome in the centre and were free to visit.

There was a family forum with residents and their families were invited to attend regular meetings. Issues discussed included quality of the service provided; future plans for the centre any other issues that families had. Residents were facilitated to meet family and friends in private. Most residents had their own bedroom however some were sharing rooms in one unit. The provider had reconfigured a section of the main canteen which enabled residents and their families to use as a private area if they so wished.

The inspector received a number of completed relative questionnaires from family members which were highly complementary of the service. However, in some questionnaires it was highlighted that efforts could be made to improve communications by phone to families. Some families lived quite a distance from the centre and could only visit every couple of weeks and therefore depended on staff to ring them in relation to their family members condition.

Care plans read by inspectors provided evidence of family input. In addition multi disciplinary support team meetings documented the involvement and inclusion of family members in decisions around behavioural support plans and healthcare needs. Inspectors saw that residents were encouraged to participate in social activities provided within the local community. Each residential unit had their own vehicle. Inspectors saw in some personal plans that some residents went home for periods of time during the week or at weekends.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**

Effective Services

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

This was the centre's first inspection by the Authority.

**Findings:**

The admissions process was managed by the admissions committee which included the director of services, psychiatrist and a representative from the Health Service Executive (HSE). There were policies and procedures in place to guide the admissions process which included residential and emergency admissions. However, inspectors observed

that the policy did not take account of the need to protect residents from abuse by their peers.

Questionnaires from relatives indicated to inspectors that all prospective residents and their representatives were afforded an opportunity to visit the centre on numerous occasions and speak to staff prior to admission.

There had been no recent admission to the centre and the majority of residents had lived in the centre for a while. The nominated provider told inspectors that in line with the congregated setting report that admissions to the centre have decreased. The residents paid a weekly contribution towards their residence and this varied depending on whether nursing care was required or not.

There were contracts of care in draft format in the random selection of files reviewed. These set out the services to be provided and detailed services that required additional charges. However, the contracts did not meet the requirements of the Regulations, as they had not been agreed in writing with the resident or their relative where the resident was not capable of giving consent.

There have been no recent discharges from this service.

**Judgment:**

Non Compliant - Moderate

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Each resident had a personal support plan completed. There was evidence that this document was completed with the maximum participation of the resident concerned and their significant others. The sample of personal support plans reviewed by inspectors were observed to be comprehensive and person-centred. There was evidence of interdisciplinary team involvement in residents' care and supports. The content of personal plans reviewed was clearly organised and reflected individual needs relating to

behavioural issues, supports required, health issues and processes in place to enable each resident to achieve their stated goals. The inspectors noted that there were agreed time-frames in relation to identified goals and objectives. Personal outcome plans were reviewed on a monthly basis with each resident.

Evidence of interdisciplinary team involvement in residents' care included speech and language therapy, occupational therapy, general practitioner (GP) dietetic, psychiatric services. There was also evidence of residents and relatives involvement in developing and reviewing their personal plan. There was evidence of a number of assessments including self care and skill assessments, individualised risk assessments and activity assessments.

Inspectors were informed by staff that there were a number of options available for all residents in relation to social activities. Inspectors saw that residents with profound disability attended the multisensory day services which were located off site. Many of the residents enjoyed art, music, walks around the campus and going out into the community. There was a swimming pool on site which had a dedicated occupational therapist to work with residents in the pool. Residents were supported to access and take part in social events and activities of their choices, apart from the activities provided in the centre the rest are community based, are age appropriate and reflect the goals chosen as part of their person-centred plan.

In relation to temporary absence from the service there were planned supports in place where a resident had to be admitted to hospital. There was a pre-prepared information pack completed with sufficient detail for the hospital to obtain a clear picture of the resident's needs. If required, staff stayed with the resident for the duration of hospitalisation.

Inspectors were satisfied that the care planning process used gave direction and coordination to care delivered to residents who had multiple complex care needs. For example up to date records of referrals to consultant specialities were maintained for all residents. In particular there was evidence of follow up communication with hospitals in relation to planned procedures and out-patient appointments.

**Judgment:**

Compliant

**Outcome 06: Safe and suitable premises**

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**

Effective Services

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

This was the centre's first inspection by the Authority.

**Findings:**

Accommodation was provided in two residential units and three apartments located as part of a campus setting.

The first unit had 14 residents, all with high dependency needs. In general this unit was sparsely decorated with parts of the floor covering, tiles, furniture and fittings having been removed by some residents. It contained a reception area with a main office, staff sitting room and two bathrooms. This foyer led, via a 'digilock' door, to a large open living room which had number of couches, a television and a music system. This area also contained three storage rooms with clean clothes and linen. The living room had three corridors leading from it; two of these corridors had active keypad locks on their doors.

Corridor one had five bedrooms, all of which contained a bed and wardrobe for clothes and personal possessions. A number of wardrobes were locked as the person in charge indicated that other residents could take clothes or other items. This corridor had a shower room which the person in charge outlined was due for renovation. Further along the corridor was a bathroom with an assisted bath and two toilets. The side of the assisted bath had been removed by one of the residents and this area was due for an upgrade also. The bathroom also contained a utility room which had an open sluicing area, a washing machine and a tumble dryer. The corridor also contained a nurses station, next door to which was a large sitting room. This room was entered via a 'digilock' door and had couches, armchairs and a television. There was an unused area accessible via the sitting room. A kitchen/dining room area was the next room.

Corridor two was accessed via a coded door and provided accommodation for four residents with one spare bedroom. Each bedroom had a digilock door. This corridor had the same layout as corridor one, containing a renovated shower area, a bathroom, nurses station, sitting room and a kitchen/dining room. Corridor three was accessed via a coded door. There were five bedrooms each of which had a 'digilock' door. There was one empty bedroom in this corridor which the person in charge indicated was to be developed into a sensory room. There was a shower room which was being renovated during the inspection. The bathroom contained a bath, two toilets, a utility room and the fire exit door did not have a key available. Similar to corridor one there was also a nurse's station, a sitting room and a kitchen/dining room. A room containing a swing was accessible via the sitting room. This was used as a quiet area for residents who exhibited challenging behaviour.

The second unit provided accommodation for 16 residents with complex care needs and a number of residents required adaptive seating. This unit was laid out over two corridors, with eight bedrooms in one corridor and six in the second. There were two double bedrooms with a curtain between beds to afford privacy for residents. Each corridor had a sitting room, a bathroom and a kitchen. Apartment one provided accommodation for one resident. It was well decorated throughout and had a bedroom with storage, a living room, kitchen and bath/shower room.

Apartments two and three were part of the same building which shared a central entrance lobby. There were toilet facilities in this entrance area which were used by staff. Apartment two was accessed via an unused sitting room which contained old items of furniture. There was a living room, bath/shower room, a bedroom which the resident had decorated himself and a quiet room. The person in charge outlined that there was a plan for a sensory room in this apartment and one of the windows was boarded up on the outside to darken this room. The entrance to apartment three had a lock and chain on the wall outside and the person in charge outlined that there was no reason why this was in situ. The apartment contained a large well decorated living room and a kitchen. On the day of inspection the resident did not wish the inspectors to view the rest of the living accommodation.

Inspectors saw that in unit one and two areas were visibly unclean. There was an open sluice area between apartments two and three which was also visibly unclean. The door frames throughout one unit were chipped and damaged mainly due to the size of the adaptive seating and poor accessibility in the design of the building. The flooring was ripped throughout the second unit and constituted a trip hazard in a number of areas. Inspectors saw that some adaptive equipment needed to be repaired or replaced.

Residents had access to outdoor garden areas which were well maintained.

**Judgment:**

Non Compliant - Moderate

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

While there was certification available to confirm the servicing and testing of the fire alarm system in October 2014, the centre was unable to produce confirmation from a properly and suitably qualified person that all statutory requirements relating to fire safety and building control had been complied with or that all the requirements of the statutory fire authority had been complied with. There was not any overall fire safety policy or fire safety strategy to ensure that effective fire safety management systems were in place. A consulting engineer's report from July 2014 seen by inspectors found that none of the residential buildings were divided into separate fire resisting compartments with the result that in the event of a fire it could spread throughout the building. The consulting engineer's report also found that corridors throughout the residential buildings were not fire protected and that there was a deficiency in the number of fire doors through the premises.

Inspectors observed that a smoke alarm in the kitchen of the second bungalow was noted to have a battery missing. There was a key locking system on all final exit doors. However, one of the keys in the first bungalow was noted to be missing. The inspectors reviewed the fire register and found that records were not maintained of checking the means of escape, checking of emergency lighting or checking of the fire alarm system. As outlined in Outcome 8 inspectors had concerns that residents could become isolated in the event of fire due to the use of 'digilock' doors as an environmental restraint.

There was a risk management policy which outlined the arrangements in place for hazard identification and incident reporting. Inspectors reviewed the reported incidents for 2014 which included falls, incidents of challenging behaviour and medication management. There was a formal review of incidents which took place monthly and included recommendations to prevent recurrence of an incident. There was evidence of the main hazards for each residents being risk assessed and recorded in the healthcare records. However, the risk management policy did not comply with legislation as it did not include measures to control specified risks including unexpected absence of a resident, accidental injury, aggression and self harm,

Inspectors observed a number of issues which required risk assessment including:

There was a bottle of bleach/toilet cleaner in the bathroom of the first bungalow which was not stored away  
there were latex gloves in this area also which were not stored securely  
there were paper towels for residents to dry their hands in bathrooms but these were not stored in wall mounted units and the person in charge identified that some residents could swallow these items  
a blind cord was observed to be hanging free in the kitchen in the first unit  
a radiator in the hallway was noted not to be covered and it was hot to touch  
a cord for blinds was noted to be swinging free in the kitchen of the second unit.

This room also had two chains (for a swing that was no longer used) hanging from a ceiling. Apartment two had an unused sitting room which contained old items of obsolete furniture.

There were two conflicting emergency policies in place the first of which did not have an issue date. However, the health and safety statement introduced in April 2014 outlined the emergency arrangements in relation to:

Evacuation

temporary accommodation of residents in the event of evacuation

flooding

gas leak

fire.

Each individual resident had an evacuation plan in place which recorded whether the resident required assistance, their mobility status and medication requirements during the emergency. All staff had received fire training and there was evidence of monthly fire drills taking place. There was a policy in relation to control and prevention of infection. However the practices in relation to infection control required improvement as

in some places the centre was visibly unclean. In particular inspectors observed that:

On the first day of inspection clean linen was being stored next to the sluice in the first unit. There were no alginate bags available for soiled items in the first unit. On the second day of inspection soiled clothes were observed on the ground next to the washing machine. There did not appear to be any cleaning schedules in place and care staff were observed to have responsibility for cleaning bathroom/toilet areas. While staff spoken with were aware of infection control principles, examples of limited infection control practices observed included a mop with the cleaning head in a bucket of water and staff outlined that this mop was used to clean the bathroom area.

The maintenance log showed regular maintenance conducted and suitable repairs recorded. Service contracts observed by inspectors were maintained and up to date. Manual handling records for staff were up to date.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Inspectors found that there were measures in place to protect residents from being harmed or suffering abuse and residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges.

There was a policy on, and procedures in place for, the prevention, detection and response to abuse which staff were trained on. Staff who spoke with the inspector were able to clearly articulate what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

Staff confirmed that the person in charge and the provider were very approachable and they would have no hesitation in reporting any incident if it so occurred. The person in charge was a train the trainer in prevention, detection and reporting of abuse. Records showed that the majority of staff had received training in 2014 and training for

remaining staff that had been on leave was due to take place.

There was a policy relating to delivery of personal/intimate care 2014 which outlined the measures that would be taken to provide personal intimate care in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity and found this was comprehensive and implemented in the centre.

Inspectors noted a positive, respectful and homely atmosphere that mainly emanated from the easy dialog between residents in their interactions with staff. The inspectors were satisfied that the provider and person in charge had taken adequate steps and safe-guarding practices to protect the residents.

There was a restrictive practice committee which reviewed and provided oversight on the use of restrictive measures for residents. There was a policy on restrictive practices. Where restrictive strategies were deemed necessary, emphasis was placed on staff exhausting positive behavioural supports in the first instance and a rationale for the restraint was recorded. Inspectors noted that a number of residents had bedrails in place and that lap belts on a variety of different mobility chairs were used for a number of residents when required.

Where restrictive practices were required, a clear system of tracking was in place and this included the date, time, duration and level of restraint used. This information was then used to review the restrictive plans in place to monitor its use and to prevent its abuse and/or overuse and to ensure their safety. Environmental restrictions were in place in some areas of the centre such as restricted access to many areas including communal rooms. In this area documentation required improvement to ensure a rationale for restricted access was documented and these restrictions should also be the subject of review to ensure they were proportional to the needs of the residents.

There was a policy on challenging behaviour and inspectors saw that staff had received training on dealing with positive approaches to behaviours that challenge. The person in charge had also completed Further Education Training Awards Council (FETAC) Level 8 training in the challenges of challenging behaviour. A behavioural therapist worked onsite one and a half days per month and also provided support to staff. From a selection of personal plans viewed by the inspectors they noted that behavioural interventions records gave clear directions to staff on how best to prevent or appropriately respond to behaviour that challenges.

As outlined under Outcome 1 there were robust and transparent arrangements in place for the management of resident finances.

**Judgment:**  
Non Compliant - Minor

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

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

**Theme:**  
Safe Services

**Outstanding requirement(s) from previous inspection(s):**  
This was the centre's first inspection by the Authority.

**Findings:**  
Practice in relation to notifications of incidents was satisfactory. The nominated provider and person in charge were both aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. The inspectors saw that there was a process for recording any incident that occurred in the centre and the procedure for maintaining and retaining suitable records as required under legislation. All incidents and accidents were recorded in a comprehensive computerised incident reporting system. To date all relevant incidents had not been notified to the Chief Inspector by the person in charge.

**Judgment:**  
Compliant

### **Outcome 10. General Welfare and Development**

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

**Theme:**  
Health and Development

**Outstanding requirement(s) from previous inspection(s):**  
This was the centre's first inspection by the Authority.

**Findings:**  
The inspectors were satisfied that resident's opportunities for new experiences, social participation, education and training were facilitated and supported. There was evidence of residents learning to use communication devices. There were assessments of each residents' goals relevant to their general welfare and development. Goals were developed in accordance with his/her preferences and to maximise his/her independence.

All of the residents had access to a day activation centre, which could be accessed in accordance with their personal plan. Services provided to residents included music therapy, art, massage, swimming, reflexology, sensory, and walks. Some residents had also been assisted to access community activities by staff from the activation centre, by family and by volunteer staff. Considering the age profile and level of disability of residents these activities were reflective of residents dependency needs rather than

focusing upon educational, training or employment opportunities.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

This was the centre's first inspection by the Authority.

**Findings:**

Residents' health care needs were met through timely access to GP services and appropriate treatment and therapies. Individual health needs were appropriately assessed and were met to a satisfactory standard by the care provided. Residents' files evidenced regular GP reviews and a record was maintained of all referrals/appointments to allied health professionals.

The resulting outcome following appointments with allied health professionals such as speech and language therapist, occupational therapists, dieticians, and psychiatrist were all recorded in the residents' notes. The inspector found that input and recommendations made by these professionals was implemented in practice. Access to diagnostic services was through the local hospital or outpatient department. Residents also had access to dental services, ophthalmology and audiology as evidenced in residents' care plans.

Residents' weights were recorded monthly or more often and it was evident that the documentation of a weight loss/gain prompted an intervention once a concern was identified. Of a sample of care plans reviewed by inspectors all contained records of relevant monitoring with regard to nutrition and weight. The inspector saw that nutritional assessments were reviewed by staff.

The inspector saw that where residents had any specialist needs related to swallowing, gaining or losing weight or variable eating patterns that care plans reflected the arrangements in place to meet their nutritional requirements.

Meals for residents were prepared in the main kitchen on campus. In most of the units at a minimum of once per week residents and staff prepared the meal for that day depending on residents' choice. However, in one unit this was not possible as there were no cooking facilities available. Staff told an inspector in this unit that they would order a take away instead.

Residents that required their food to be purée was puréed separately and put on the plate separately to maintain the flavour and the colour of the individual foods. However, there was no choice available for residents on specific modified consistency diets. Inspectors noted that there were a number of residents who required assistance with eating and staff provided such assistance in an appropriate manner. Inspectors observed that the lunch time service was not presented or served to residents in a manner which was attractive or appealing in nature in terms of texture, flavour and appearance which does not enhance or maintain appetite or nutrition for residents. Inspectors saw that there was no choice available to residents in relation to their main meals. Inspectors observed this on both days of inspection.

The inspector spoke with the catering manager who stated that if a resident did not like what was on the menu, an alternative was always available. There were no formal communication procedures available in the main kitchen in relation to special dietary needs. A weekly menu was sent to the units. However, inspectors did not observe that the daily menu was displayed. Inspectors were not satisfied that residents received a varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

This was the centre's first inspection by the Authority.

**Findings:**

Overall inspectors found that residents were protected by safe medication management policies and practices. All residents were supported in the administration of their medication by qualified nursing staff. The receipt of medication was being recorded and medication was being stored in a locked trolley in the staff office. The prescribing and administration of all medication was in compliance with the Regulations and in line with best practice guidelines. A pharmacist was available on site to provide guidance as required and also to audit medication.

There were appropriate procedures in place for the handling and disposal of unused and out of date medicines and formal records were maintained for all returns to the pharmacy. At the time of the inspection, staff spoken with confirmed that no resident had been assessed as having the capacity to safely manage their own medication or was liaising directly with the pharmacist but the inspector saw that each resident was

provided with information on their medication regime in a format that was appropriate to their abilities and needs. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear and distinguished between PRN (as required), short-term and regular medication.

There were robust systems in place for reviewing and monitoring safe medication management practices. The GP was available to the centre on a weekly basis and prescriptions demonstrated medication review in line with the resident's changing needs; Nursing staff monitored the usage of each PRN medication medications as seen by the inspector reflected this robust oversight, as usage was infrequent and episodic.

Drug errors were recorded and reported using the organisation accidents and incident reporting mechanism. A monthly 'MPARS' audit was carried out by the person in charge to assess the effectiveness of the MPARS system which is the system for prescribing and administering of medication. There was a resident that required scheduled controlled drugs at the time of the inspection. The inspector found that management, storage and checking of stock scheduled controlled drugs was in accordance with professional guidance in medication management. A monthly stock take of all medication dispensed from pharmacy was completed by the night nursing staff also.

**Judgment:**  
Compliant

### **Outcome 13: Statement of Purpose**

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

**Theme:**  
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**  
This was the centre's first inspection by the Authority.

**Findings:**  
The statement of purpose consisted of a statement of the aims of the centre and a statement as to the facilities and services which were to be provided for residents. The statement of purpose contained all of the information required by Schedule 1 of the Regulations. The inspectors found that the statement of purpose was implemented in practice.

**Judgment:**  
Compliant

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The nominated provider, the director of services and the person in charge were actively engaged in the governance and operational management of the centre, and based on interactions with them during the inspection, they had an adequate knowledge 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. Inspectors saw that there was a copy of the National Standards and the Regulations were available to staff in each unit along with other relevant documentation.

The provider had undertaken a number of audits and reviews of the quality and safety of the service. There were regular reviews of risk management arrangements and incidents and accidents. The inspectors read a report of an unannounced inspection of the centre carried out on behalf of the provider which is a requirement of the Regulations. This report highlighted progress in relation to the last inspection carried out by the Authority, as well as identifying areas for improvement independently.

There was a clearly defined management structure which identified the lines of authority and accountability in the centre. Staff who spoke with the inspector were able to demonstrate a good awareness of the management and told inspectors that those involved in the management of the centre were responsive and approachable. The inspectors noted that residents were familiar with the person in charge and approached her with issues and to chat during the inspection. Residents, relatives and staff identified the person in charge as the one with authority and responsibility for the service. Staff who spoke to the inspector were clear about whom to report to within the organisational line and of the management structures in the centre.

Staff who spoke with the inspector said they had regular team meetings and received good support from the person in charge. The person in charge told inspectors that she had commenced the process of performance reviews.

There was a quality policy committee. A review of policies had also been carried out and a number of policies have now been updated or replaced including the policy of providing intimate care, safeguarding of vulnerable adults, intimate care, communication

and education. There was a quality and governance committee also which convened on a monthly basis. Inspectors reviewed minutes of the last meeting.

The existing management structure included supports for the person in charge to assist her to deliver a good quality service. These supports included a director of services, three assistant directors of services, night manager, clinical nurse managers and medical specialists. The nominee provider is on site daily and was knowledgeable about the service. The person in charge also met with the nominee provider and others participating in management on a weekly basis, and these meetings were recorded.

The inspectors found that the person in charge and the person deputising in her absence were appropriately qualified and had continued their professional development with ongoing training including appropriate management training. Both person in charge and her deputy engaged at length with inspectors during the inspection and were found to be suitably experienced, qualified and knowledgeable to carry out their roles effectively.

**Judgment:**

Compliant

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

**Findings:**

The inspector found that adequate arrangements were in place through the appointment of a named person to deputise in the absence of the person in charge, the appointee was an experienced clinical nurse manager. The person in charge had not been absent for a prolonged period since commencement and there was no requirement to notify the Authority of any such absence. The provider was aware of the need to notify the Authority in the event of the person in charge being absent.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

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

**Theme:**

Use of Resources

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

This was the centre's first inspection by the Authority.

**Findings:**

The inspectors formed the opinion that the centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose. There is an annual budget for the centre which is reviewed regularly. The accounts and budgets are managed by the accounts department and are overseen by the registered provider who reports to the board of directors. The inspectors saw that there was sufficient assistive equipment to meet the needs of residents with servicing records up to date. The inspectors noted that there was accessible transport services provided for residents and that residents were regularly transported to different venues including social occasions as required.

Inspectors spoke with the person in charge and staff members who confirmed that activities and routines were not adversely affected or determined by the availability of resources. However at the onset of inspection the provider informed inspectors that an external review in relation to the adequacy and allocation of staffing resources was taking place on the day of inspection. Given the level of dependency needs of residents it had been identified by management that at certain periods of the day there was insufficient resources provided to meet the social needs of residents.

**Judgment:**

Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

This was the centre's first inspection by the Authority.

**Findings:**

There were sufficient staff with the right skills, qualifications and experience to meet the needs of residents on the days of inspection. Staffing levels reflected the statement of purpose and size and layout of the building. An actual and planned staff rota was maintained. There was a policy on recruitment and selection of staff and there was evidence of effective recruitment procedures and a comprehensive induction procedure.

The inspector reviewed a sample of staff files and noted that in general all 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, the inspector observed that some references were of a personal nature and were undated which is not in accordance with Regulation.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies. Mandatory training was provided as confirmed by staff and training records. Further education and training completed by staff included food hygiene, medication management, restrictive practices and supervisory management. A support and supervision system had been recently implemented and reviews were conducted on a quarterly basis.

The person in charge demonstrated willingness to the delivery of person-centred care and to work towards meeting regulatory requirements. The centre had volunteers. However, there was no evidence of written agreements that set out the roles and responsibilities of volunteers.

Staff employed in the centre, observed and spoken to during the course of the inspection demonstrated an intimate knowledge of the residents they support. Residents were supported by key working staff and the staff who were spoken to were familiar with the personal plans and goals set for their key clients.

**Judgment:**

Non Compliant - Minor

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

This was the centre's first inspection by the Authority.

**Findings:**

Overall records and documentation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

A directory of residents was maintained in the centre and this contained all of the items required by the Regulations. The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Inspectors saw that Schedule 3 resident records and Schedule 4 general records were maintained in a secure manner and were retrievable. The residents were provided with a Residents' Guide. The inspectors were provided with a copy of an insurance certificate which confirmed that there was up to date insurance cover in the centre.

The provider had completed a recent audit and review of all policies and procedures across the broader organisation and had just recently re-issued revised versions of a number of policies including safeguarding of vulnerable adults, the provision of intimate care and medication management.

All of the policies and procedures as required by Schedule 5 of the Regulations had been developed with the exception of the creation of, access to, retention of, maintenance of and destruction of records.

**Judgment:**

Non Compliant - Minor

## 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:***

Ide Batan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd
<b>Centre ID:</b>	OSV-0003499
<b>Date of Inspection:</b>	9 October 2014
<b>Date of response:</b>	6 November 2014

### 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:**

While there was a complaints policy in place it did not identify an appropriate appeals committee to address complaints when the complainant was dissatisfied.

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

**Action Required:**

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

The centre will review the complaint document and it processes to ensure more transparency in relation to complaint officers and appeals officer. Through linkage with other services we will have an easy read version adopted for use in the service.

**Proposed Timescale:** 20/12/2014

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

The contracts did not meet the requirements of the regulations, as they had not been agreed in writing with the resident or their relative where the resident was not capable of giving consent.

**Action Required:**

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

St Patricks Centre will adopt the current draft contracts and commence a process of offering them to residents and their families for signing. It is expected that all contracts will be on file in 6 months. This will coincide with planned family meetings and personal outcomes planning.

**Proposed Timescale:** 31/01/2015

**Theme:** Effective Services

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

Inspectors observed that the admissions policy did not take account of the need to protect residents from abuse by their peers.

**Action Required:**

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

Admission policy will be amended to include reference to to protect residents from abuse by their peers.

**Proposed Timescale:** 30/11/2014

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Inspectors saw that in unit one and two areas were visibly unclean. There was an open sluice area between apartments two and three which was also visibly unclean.

**Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

1. A deep clean will be commissioned for the following sectors  
sector a - section 1 , 2 & 3 including all common areas.  
sector b - Side 1 & 2 Including all common areas.
2. The cleaning rosters and cleaning audit sheets will be reviewed for increased awareness and practices
3. Training and orientation of household staff.
4. Working with residents across the centres to develop decoration in line with photo frames currently commencing in service highlighting the resident and their family linkages
5. In relation to sluice are to create a review of this area and close of this unused sluice area while enabling the resident to access laundry services
6. Unused items of furniture to be removed where possible.
7. Action to make area more welcoming and homely where possible
8. A wooden floor has been commissioned for all the hallways in the centre

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

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

Some areas within the centre were not maintained in a good state of repair. The door frames throughout one unit were chipped and damaged mainly due to the size of the adaptive seating and poor accessibility in the design of the building. The flooring was ripped throughout the second unit and constituted a trip hazard in a number of areas.

**Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

A maintenance plan for the on-going upkeep will be developed and will be included in budget planning for 2015

**Proposed Timescale:** 31/01/2015

**Theme:** Effective Services

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

Inspectors saw that some adaptive equipment needed to be repaired or replaced.

**Action Required:**

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

Armrests on chairs will be upholstered

**Proposed Timescale:** 30/11/2014

**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:**

The risk management policy did not include measures to control specified risks including unexpected absence of a resident.

**Action Required:**

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

The risk management policy will be reviewed to identify unexplained absence as a risk and to develop appropriate controls

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services

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

The risk management policy did not include the arrangements in place for accidental injury to residents, visitors or staff.

**Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

The risk management policy will be reviewed and amended to include the measures and actions in place to control accidental injury to residents, visitors or staff.

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services

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

The risk management policy did not include the arrangements in place to control violence and aggression.

**Action Required:**

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

Plan to review the risk management policy to ensure that the measures and actions in place to control aggression and violence are included.

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services

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

The risk management policy did not include the measures and actions in place to control self harm.

**Action Required:**

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

Plan to review the risk management policy to ensure that the measures and actions in place to control self harm are included.

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services

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

Inspectors observed a number of issues which required risk assessment including:

There was a bottle of bleach/toilet cleaner in the bathroom of the first bungalow which was not stored away  
there were latex gloves in this area also which were not stored securely  
there were paper towels for residents to dry their hands in bathrooms but these were not stored in wall mounted units and the person in charge identified that some residents could swallow these items  
a blind cord was observed to be hanging free in the kitchen in the first unit  
a radiator in the hallway was noted not to be covered and it was hot to touch  
a cord for blinds was noted to be swinging free in the kitchen of the second unit.

**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:**

All issues named in this report have been responded to as a matter of urgency and are completed

Plan to review the health and safety risk register to update and insert controls in relation hazard identification where necessary.

Health and safety workshop with senior staff to in turn work with all staff on hazard identification training and audit.

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services

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

Practices in relation to infection control required improvement as in some places the centre was visibly unclean. Inspectors observed that clean linen was being stored next to the sluice in the first unit. There were no alginate bags available for soiled items in the first unit. On the second day of inspection soiled clothes were observed on the ground next to the washing machine. There did not appear to be any cleaning schedules in place and care staff were observed to have responsibility for cleaning

bathroom/toilet areas. Inspectors observed that a mop with the cleaning head in a bucket of used water was used to clean the bathroom area.

**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:**

Deep clean planned for Centre. We will review o infection control policies and practices within the centre.

Run workshop for all staff in centre. We will develop audits for compliance on Infection Control.

**Proposed Timescale:** 31/01/2015

**Theme:** Effective Services

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

There was not any overall fire safety policy or fire safety strategy to ensure that effective fire safety management systems were in place.

**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:**

1. St Patrick's Centre will commission for the audit a set of priority proposals for action plan and submit same to HSE for inclusion in budget planning 2015.

A review will be commissioned to ensure that immediate actions will commence where possible:

- a. Ensure all existing systems are working according to plan by November 2014
- b. Ensure all fire exits are clear and monitor same daily. This is completed
- c. Roll-out of Master key system for all exit doors in the centre by December 2014
- d. Review and implement necessary signage within the centres by November 2014

**Proposed Timescale:** 31/03/2015

**Theme:** Effective Services

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

Inspectors reviewed the fire register and found that records were not maintained of checking the means of escape, checking of emergency lighting or checking of the fire

alarm system. Inspectors had concerns that residents could become isolated in the event of fire due to the use of digilock doors as an environmental restraint.

**Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

Review the fire register and ensure that records are maintained and audited by person in charge.

review all means of escape within the centre for access

review that all emergency lighting are working

review that all existing fire alarms are functioning

review digi-lock door as used in one section for safety

develop a centre wide checklist to be held in Central office

daily Fire Safety Checks in Place and fire register updated daily.

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services

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

The inspectors reviewed the fire register and found that records were not maintained of checking the means of escape, checking of emergency lighting or checking of the fire alarm system.

**Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

To review and ensure that record are maintained to a very high standard that refer to the fire register with reference to

Means of escape

Emergency lighting

Fire Alarm systems.

**Proposed Timescale:** 30/11/2014

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

While risk assessments on the use of restrictive procedures were completed in one instance the inspectors observed that the use of an environmental restraint for a resident was not clearly assessed or recorded.

**Action Required:**

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

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

A full review will take place following guidance from the Human Rights Committee and other specialist multidisciplinary team contribution. Submission for inclusion of the least restrictive practice will be available to the person in charge

**Proposed Timescale:** 31/01/2015

## 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:**

There was no choice available for residents on specific modified consistency diets. There was no choice available to residents in relation to their main meals.

**Action Required:**

Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

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

A full review of food and food choice available to residents will be undertaken within the service noting the input of dietician, external food consultant, catering manager and person in charge. There will be a special focus on residents with specific modified consistency diets. This report will be available to Director of Service. A food audit process in relation variety and food choice will be developed for catering manager and specific training will be made available to catering staff.

**Proposed Timescale:** 31/01/2015

**Theme:** Health and Development

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

Inspectors observed that the lunch time service was not presented or served to residents in a manner which was attractive or appealing in nature in terms of texture, flavour and appearance which does not enhance or maintain appetite or nutrition for residents.

**Action Required:**

Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

A full review of practices in relation to food preparation and presentation to residents will be completed. The sector will review how to present meals in an attractive and appealing manner to residents.

**Proposed Timescale:** 28/02/2015

#### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The inspector observed that some references were of a personal nature and were undated which is not in accordance with Regulation.

**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:**

Staff files will be reviewed and amended to include professional references.

**Proposed Timescale:** 31/12/2014

**Theme:** Responsive Workforce

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

There was no evidence of written agreements that set out the roles and responsibilities of volunteers.

**Action Required:**

Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

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

A written policy document will be developed for inclusion of volunteers within our service.

**Proposed Timescale:** 31/12/2014

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

All of the policies and procedures as required by Schedule 5 of the Regulations had been developed with the exception of the creation of, access to, retention of, maintenance of and destruction of records.

**Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Draft policies on file (Schedule 5) will be formally adopted December 2014. A policy on records will be developed by November 30 2014. A policy on policies will also be developed.

**Proposed Timescale:** 31/01/2015