<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003496</td>
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<td>Centre county:</td>
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<tr>
<td>Provider Nominee:</td>
<td>David Walsh</td>
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<tr>
<td>Lead inspector:</td>
<td>Ide Batan</td>
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<tr>
<td>Support inspector(s):</td>
<td>Kieran Murphy Philip Daughen</td>
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<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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<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, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

<table>
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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>
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<tr>
<td>Outcome 11. Healthcare Needs</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

This was an inspection of a centre which had been the subject of an Interim Order made by Kilkenny District Court on consent, on 26 June 2015, cancelling the registration of Our Lady's Unit, St. Patrick's Centre (Kilkenny) Limited, Kells Road, Co. Kilkenny, as a designated centre under Part 8 of the Health Act 2007, with effect from 19:00hrs on 26 June 2015 for a period of up to 28 days. In accordance with Section 64 of the Health Act 2007, the Health Services Executive (HSE) was directed to take charge of Our Lady's Unit from such time. The effect of the court order of June 2015 was to insert the HSE as registered provider of Our Lady's Unit at St Patrick's Centre in Kilkenny. The Interim Order was subsequently extended on consent of all the parties for a period of two months to 21 September 2015.

Following the issuing of the Interim Order the HSE had submitted an action plan to the Authority to address the deficiencies identified during the inspections of the centre on 22, 23 and 25 of June. There were 101 action plans in total from that inspection. The timeframes for the implementation of the action plans had not yet lapsed and the deficiencies identified were still outstanding. Some additional actions were noted on this inspection.

The purpose of the current inspection was to determine the situation within the centre and what, if any, progress has been made on remedial action with particular focus on any action taken to mitigate the risk with respect to governance, fire safety concerns, healthcare and staffing. This follow up inspection took place over three
days, with the first day of inspection focusing on the fire safety management systems.

The HSE secured an agreement from another local organisation to provide a group of senior management staff to enhance the management arrangements and structure and to assist Our Lady’s Centre in all aspects of management of the centre. However, on this inspection inspectors found it difficult to ascertain who was leading and managing the service as there had been three changes within the management structure since the interim court order was agreed. This is outlined in detail under the outcome governance and management.

This centre provided a home to 28 residents. The majority of the fire safety concerns identified on the previous inspections related to the main building although there were a number of fire safety concerns that related to all four buildings that made up the centre. Due to essential fire safety works in all the houses all residents had to be relocated since 26 June. During this inspection 10 residents were still being accommodated on a temporary basis in a nursing home. 18 residents were being accommodated in the centre. However, not all were sleeping in their original bedrooms as some residents were accommodated in other houses while the remedial works were being undertaken.

Inspectors found that while a significant quantity of fire safety remedial work had been completed, more was required in order for the buildings to be judged compliant with respect to fire precautions. Furthermore, inspectors identified that significant improvement was still required in relation to the fire safety management arrangements and fire procedures in place within the centre. The detail relating to this is contained within the body of the report.

Overall, inspectors were not assured that there was adequate oversight of safety arrangements, operational management and administration of the designated centre, by the HSE. The current governance and management systems did not support staff to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

The action plan of this report identifies the areas requiring to be addressed by the provider nominee and person in charge in order to ensure compliance with 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.
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 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
There were 13 actions from the previous inspection still outstanding and within their designated timeframes. These were not reviewed on this inspection.

This centre provided a home to 28 residents. The centre consisted of two distinct areas. The first area provided a home to 16 residents in three interconnected bungalows, called “sides”. The second area provided a home to 12 residents in three separate bungalows side by side. Due to essential fire safety works in all the houses all residents had to be relocated for a period of time since 26 June 2015.

During this inspection 10 residents were still being accommodated on a temporary basis in a nursing home. Inspectors visited the nursing home and while four residents had to share a bedroom, the other six residents had single bedrooms, most with en-suite shower, toilet and wash hand basin. One double bedroom had been converted to a dining area and there was a small living room for residents also. While staying in the nursing home the 10 residents were supported by two nurses and four healthcare assistants from their service during the day. There was one nurse and three healthcare assistants supporting residents during the night. In addition, one resident had 24 hour support from a personal assistant.

18 residents were being accommodated in the centre. However, not all were sleeping in their original bedrooms as the fire safety works were continuing on the dates of the inspection.

A transition plan had been agreed with each resident during the moves from the original
buildings to alternative accommodation. Resident communication meetings had taken place to explain the process with the help of LÁMH communication (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland) picture communication. Inspectors reviewed the healthcare information for one resident who had displayed self injurious behaviour like pinching themselves and hitting themselves after they had moved from their home. However, inspectors saw evidence that the resident had been reviewed by the appropriate healthcare professionals and, with the support of staff, the resident had become more settled in their new environment.

Inspectors saw that a new care plan template was being trialled for one resident. Inspectors reviewed a sample of the existing personal plans. Personal plans were disjointed and inspectors found plans difficult to navigate due to the amount of unnecessary or duplicated information held in each one. This was discussed at the post inspection feedback meeting.

**Judgment:**
Compliant

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**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
There were 7 actions from the previous inspection still outstanding. These were not reviewed on this inspection.

As on the previous inspections there was evidence in the healthcare records that residents’ health needs were being reviewed as required by the general practitioner. There was evidence of good access to specialist care in psychiatry with residents being seen by a consultant psychiatrist on site as required. This included supporting residents while they were living in the nursing home on a temporary basis. Healthcare records were contained in three separate records and it was unclear which was the most up to date record. For example in one file there was a nutritional care plan but this did not refer to reviews by a clinical nutritionist which was recorded in another file. The healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan to direct care. For example, in relation to a resident’s drinking requirements there was a “post-it” note in the healthcare file saying the resident was “nil by mouth”. It was unclear if the resident’s healthcare plan had
been updated to reflect the instructions on the “post-it” note. While there was evidence that residents were supported to attend appointments and had been referred to hospitals and consultant specialists if required, the recording and follow up care planning required improvement. For example, following one resident’s recent hospitalisation it had been documented by the hospital that the resident had two healthcare acquired infections. However, there were no care plans in place in relation to these infections.

The centre had engaged an external clinical team to promote positive psychological interventions for residents. As part of this process each resident had engaged with the external clinical team to see what positive interventions the resident required. While these initial assessments had been completed they were not yet available as part of the stress support plans for residents. The external clinical team had also reviewed the care requirements of the centre and found the need for:

- Communication profiles for each resident required completion
- Sensory needs and profiles for each resident
- Care planning improvement
- Incident reporting system required improvement
- Understanding by staff in relation to restrictive practices.

These were all issues that inspectors had found on previous inspections of this centre. In relation to care planning, a new template to record issues relevant to each resident had been agreed for use. At the time of inspection it had been introduced for one resident.

The centre had also engaged another external clinical team to support residents who had communication difficulties and may need alternative ways to communicate. This team included Speech and Language Therapists to assist with assessment and recommendations on swallowing and modified diets. The team also included occupational therapists to advise on how a resident can live as independently as possible and improve their quality of life with a range of work and leisure activities. Staff were to receive training on communication and quality of life issues over the coming weeks. The person in charge described how weekly multi-disciplinary team meetings were now taking place. These meetings were attended by the psychiatrist, play therapist, behaviour therapist and nursing staff to discuss supports required for each resident.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily
Findings:
A significant number of the actions identified on previous inspections were found to either been partially or fully addressed by way of the remedial fire safety building work being carried out on an on-going basis at the centre. However, the inspector found that there were actions still outstanding, both in relation to the building and in relation to the fire safety management arrangements in place within the centre.

The inspection commenced in the main building. This building was found to be occupied by 16 residents who had been relocated there on a temporary basis from the other bungalows that make up the centre in the main. The inspector found that a significant quantity of fire safety remedial work had been completed within this building since the previous inspection.

A fire alarm system had been installed within the building. The system provided coverage throughout the building with repeater panels in appropriate locations. The inspector also found that emergency lighting was provided throughout. Fire fighting equipment was also provided throughout.

Fire doors and fire resistant construction had been installed in the building. However, while the building had been divided in to fire resistant sub compartments with same, the inspector found the provision of fire resistant construction to be incomplete. The provision of fire resistant construction was still not adequate as the bedroom doors, office and ancillary room doors had not been upgraded to fire doors as required. The inspector also identified an instance where the provision of fire resistant construction was incomplete and was not capable of effectively containing fire. In this instance, the incomplete installation of fire doors would allow smoke and heat to pass a door that was upgraded to a fire door thus breaching the fire resistant construction and making the fire door currently installed functionless.

The inspector noted that in many cases, the new fire doors were not provided with doorstops where required in order to prevent damage to the door that would occur if the door was pushed beyond its range of motion.

The inspector found that the building was provided with an adequate number of escape routes. However, the inspector noted that the installation of directional escape signage was incomplete. The inspector found that while many escape route doors had been provided with appropriate door fastenings through the installation of electromagnetic locks with appropriate over rides, a number of escape route doors were not upgraded in this manner and continued to be operated with key locks.

From discussion with staff, the inspector was informed that the remainder of the fire safety remedial works were due to be completed as part of the next phase of works.

Of the three bungalows that make up the rest of the designated centre, two were closed at the time of inspection with building work on-going within. These were due for completion and re occupation on the 2nd September. From discussion with the builders, the inspector deduced that the works to be completed would bring the bungalows
concerned up to a similar standard as the main building described above and the reminder of the works would then be completed as part of a future phase. The third bungalow contained two residents with one to one staffing present at all times. This bungalow was still in the same condition as on previous inspections. There was no adequate fire alarm and no adequate fire resistant construction. This bungalow was due to be vacated by the 2nd September in order for the remedial work to commence.

In relation to the fire procedures in place, a new fire procedure was displayed within the main building but it was generic in nature and took no account of site specific arrangements or evacuation priorities.

The inspector also identified multiple areas of fire safety management that required improvement.

Upon review of personal evacuation plans for residents, the inspector identified a resident requiring evacuation by evacuation sheet at night. After questioning staff, the inspector was informed that the resident concerned was not supposed to be evacuated by evacuation sheet as the sheet cut across the resident's neck while being used. This was not found to be recorded within the evacuation plan and furthermore, the evacuation sheet was still present on the residents bed.

The inspector identified a further two incidents where residents were to be evacuated by way of being carried on their duvets in the event of an evacuation at night. Staff were unable to provide the inspector with a suitable reason as to why an evacuation sheet was not provided or indeed confirm if the staff had been trained or practiced in the use of a duvet for the purposes of evacuation.

The inspector asked about the provision of a grab bag containing useful equipment in the event of an evacuation of the centre. These grab bags were part of the daily checks in place within the centre. However, the relevant grab bag could not be found by staff in all cases.

The inspector also observed that the final exits from the occupied bungalow were secured with key locks. The exit to the rear was observed as being locked on inspection. One of the two staff did not have the key on their person for the exits and a spare key had not been provided adjacent to the door for use in emergencies.

The inspector also issued two immediate actions to the provider nominee. These related to the following failings:

The provision of fire resistant construction around the area specified to the provider nominee was incomplete and was not capable of effectively containing fire.

The arrangements in place for evacuating residents was inadequate in that not all residents were provided with suitable evacuation aids capable of being safely and effectively used.

The provider nominee agreed to address the failings identified in the immediate actions by 1/9/2015. Inspectors also observed on the third day of inspection that in one of the
temporary locations where residents live that no fire drills had been carried out since the relocation.

In summary, due to a combination of the incomplete remedial fire safety building works along with continued shortcomings in the fire safety management arrangements at the centre as detailed above, the inspector judged the centre to be majorly non compliant under Outcome 7: Health and Safety and Risk Management.

**Judgment:**
Non Compliant - Major

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**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

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

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

**Findings:**

There were 6 actions from the previous inspection still outstanding. These were not reviewed on this inspection.

The inspectors found that there was a management structure in place however, improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs.

Inspectors were not assured that there was effective leadership to guide staff in the overall care delivery to ensure that care delivered was in accordance with contemporary evidence based practice.

The structure of the local management team put in place following the court order was fragmented and not definitive leading to deficiencies in the overall governance, operational management and administration of the designated centre as evidenced throughout the inspection. The current provider nominee was on leave at the time of inspection and inspectors were not assured that there were robust arrangements in place to stabilise the current organisation of Our Lady’s unit in terms of governance,
resource management and quality service provision.

Inspectors were informed by the HSE that a memorandum of understanding was completed between another local organisation to provide a definitive group of senior management staff to support and structure all aspects of operation and management including improving quality of care for residents. This was to be implemented the following day subject to agreement with the Authority.

Inspectors engaged at length with the person in charge. Staff with whom inspectors spoke to were committed to providing good, safe care and to improving the services that the centre provided. Inspectors saw that following on from the district court meeting that twice weekly action plan group meetings took place and a policy review group met on a weekly basis. Meetings were minuted with action plans recorded persons responsible for actions named and completion timeframes recorded. There were scheduled meetings with the provider nominee and person in charge. Inspectors saw that the following policies had been signed off and distributed to Our Lady’s:
- Finance Policy
- complaints policy
- safeguarding policy
- admission and transition policy
- risk assessment policy.

Inspectors saw that the process of clinical audit had commenced and was ongoing. Inspectors saw that an infection control nurse had been engaged to review and assess the requirements in relation to prevention and control of healthcare associated infections. The recommendations of the review were being implemented at the time of inspection.

Inspectors saw that all medication plans for residents had been reviewed with pharmaceutical and medical input and were subject to ongoing audit. Inspectors reviewed a sample of medication charts and found that they adhered to legislation. Inspectors also observed that when an adverse incident occurred that it was investigated appropriately by the relevant disciplines and learning was discussed amongst the team.

The Statement of Purpose did not outline that the HSE was the current service provider. The Authority had not received the amended version of the Statement of purpose and function as agreed on the action plan.

However, as on the previous inspection the actions in relation to the annual review of the quality and safety of care remain outstanding.

Judgment:
Non Compliant - Major
Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:
There were 9 actions from the previous inspection still outstanding. These were not reviewed on this inspection.

Inspectors saw that staffing levels had been increased since the last inspection. The person in charge said that the current staffing levels and skill mix were adequate. However, due to the fact that residents were dispersed in three different locations currently it was difficult to maintain continuity of care always.

The inspectors spoke at length with the human resource manager who confirmed that there was an active recruitment campaign on going. The human resource manager informed inspectors of the new induction process. There was an allocations officer dedicated to ensuring adequate staffing and skill mix was available to meet residents' needs. Inspectors saw that all available nursing staff were being sourced within the service and neighbouring services to ensure that appropriate and optimum levels of staff are maintained at all times. Rosters viewed by the inspectors also confirmed this.

Overall since the previous inspection there was 72 personal assistant hours deployed to five residents. There was nursing staff deployed to each other location both day and night. 22 additional healthcare assistant hours had been put in place during the weekends to support residents to undertake social activities.

Inspectors observed that a training audit had been completed to identify training needs for staff. Inspectors saw that the following training had been completed since the previous inspection:
- Positive behaviour support
- Restrictive practices
- Medication management
- Fire safety
- Management of allegations of abuse
- CPI/Mapa training.

Inspectors were informed that other appropriate trainers were being sourced to provide training in other areas pertinent to residents needs such as end of life, positive
psychological interventions, communication, peripheral venous catheters and dementia. There was an annual calendar of planned training including refresher training for all staff.

Staff files were not reviewed on this inspection and there were no volunteers working in the centre. Inspectors saw that staff support and supervision was being completed. However, support, supervision and professional development requires further development to promote an ethos of partnership in which individuals and those who work with them cooperate, communicate openly, give and receive feedback without blame or fear of recrimination.

**Judgment:**
Non Compliant - Major

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**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
Provider’s response to inspection report

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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, 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 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans were not being kept up to date.

1. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

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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:
• Care Plans currently being updated for all identified healthcare needs. All future healthcare needs will have care plans completed as required.

• Individual communication assessments are now completed on 26 residents. Remaining two assessments to be undertaken 17 October 2015. Care Plans will be updated accordingly.
• Two Training sessions on PECS Passports and Total Communication have been delivered by CATTS to staff.
• Third scheduled training on alternative communications systems 20 October 2015.
• Training on new care planning delivered to staff.
• New care planning format in place for all 28 residents.

Proposed Timescale: 13/11/2015

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
“Post-it” notes rather than care plans were being used to direct care.

2. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

Please state the actions you have taken or are planning to take:
• “Post-it” notes no longer is use.

Proposed Timescale: 09/10/2015

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 lack of doorstops to limit the range of motion of the fire doors installed prevents the doors from being maintained in an adequately serviceable condition.

3. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
• Door stops have been installed where required (Completed)
• Maintenance contracts will be taken out on new fire systems, equipment and services.
• means of escape is checked by unit managers and recorded in the fire safety register.

**Proposed Timescale:** 30/11/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The means of escape are not adequate in the following respects:

• All escape routes are not adequately protected with fire resistant construction.  
• Doors on escape routes are not easily opening in the direction of escape in all cases.

**4. 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:  
• All escape routes will be protected with fire resistant construction as part of the Phase 2 Works.  
• All doors now upgraded with appropriate door fastenings through the installation of electromagnetic locks with appropriate overrides. (Completed).  
• Doors on escape routes have now been addressed incorporating new escape emergency doors. (Completed)  
• All staff now issued with fobs. (Completed)  
• All designated fire escape doors are compliant and are easily opened “without the use of a key”. All new doors will be fitted to open in the direction of escape (Phase 2).  
• Adequate means of escape is now provided. A fully certified L1 Emergency Lighting system has been installed throughout all buildings.

**Proposed Timescale:** 31/12/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Adequate arrangements are not in place for containing fire as the provision of fire resistant construction and fire doors is incomplete in multiple locations throughout the centre including bedrooms and fire hazard rooms.

Adequate arrangements are not in place for detecting fires as one of the bungalows was not equipped with an adequate fire detection and alarm system.

**5. Action Required:**  
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.
Please state the actions you have taken or are planning to take:
• All doors now upgraded with appropriate door fastenings through the installation of electromagnetic locks with appropriate overrides. (Completed).
• Fire detection and alarm systems are now installed in all locations. (Completed).
• The provision of fire resistant construction and fire doors throughout the centre including bedrooms and fire hazard rooms are part of Phase 2 Works.
• Bedroom doors, office and ancillary room doors are to be upgraded to fire doors as part of Phase 2 Works.
• All buildings have been divided into fire compartments and new fire doors are installed on these lines. Fire door to bedrooms will be installed in phase 2.
• A fully compliant certified L1 fire alarm system is now installed in all OLU 3 units
• A suitable fire detection and alarm system is installed to detect any fire.
• All buildings have been compartmentalised to contain fire
• Portable fire fighting equipment is installed in accordance with regulations to assist in extinguishing any fire. Fire safety training is also provided.

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements in place for evacuating the centre were inadequate in the following respects:
• The fire procedure displayed was generic in nature and took no account of centre specific considerations such as the determination of the fire location and the prioritisation of the evacuation of areas immediately adjacent to the fire.
• The plans, procedures and aids provided for the evacuation of individual residents were identified as inadequate in some cases.

6. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
New Fire Policy now in place incorporating site specific arrangements for evacuation. (Completed).
• All PEEPs & CEEPs now in place. (Completed).
• Fire Drills undertaken regularly.
• OLU staff 100% compliant on fire safety training.

Proposed Timescale: 09/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The procedure to be followed in the event of fire was not adequately displayed in that the installation of directional escape signage to direct occupants along escape routes in the event of an evacuation of the centre was incomplete.

7. Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
- Directional Escape Signage now in place.
- Emergency Lighting and signage now in place.
- Suitable evacuation aids have been provided and risk assessed.
- Duvet and ski sheet evacuation training has been undertaken with staff.
- Grab bags now in place in each building.

Proposed Timescale: 09/10/2015

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:
While there was an annual review it was not effective.

8. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
- A new annual review format will be introduced which will set out the responsibilities of those undertaking the review, the actions that may arise out of the review, who is responsible for ensuring those actions and recommendations are implemented and the timescale agreed to complete those actions and recommendations.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear if the annual review of quality of care had been shared with residents and their families.

9. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
- The Annual Review of Quality & Safety of Care & Support for the designated centre will be compiled following consultation with residents and their representatives and shared accordingly.

Proposed Timescale: 31/12/2015
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that there were robust arrangements in place to stabilise the current organisation of Our Lady’s unit in terms of governance, resource management and quality service provision.

10. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
- New operational management structure in place that includes new operational and assistant management positions and additional roles in quality assurance, staff training, clinical management and extra MDT positions.

Proposed Timescale: 09/10/2015

Outcome 17: Workforce
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that there is continuity of care to meet residents' needs at all times.

11. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
- Ongoing recruitment is reducing the volume of agency and relief staff across the
centre. It is expected that OLU will have its full complement of nursing and HCA staff within the next few weeks.

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not accessed other appropriate training pertinent to residents needs such as dementia, end of life care and cardiopulmonary resuscitation.

12. **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:**
There is an extensive schedule of training ongoing across the centre. At present the number of staff that have completed both mandatory and other training programmes are as follows;

- Fire Safety (Level 1) - 100% Compliant
- safeguarding-Prevention of abuse - 86% Compliant
- manual handling/Patient Moving - 93% Compliant
- CPI/Mappa - 89% Compliant
- personal Care Planning - 76% Compliant
- personal Outcomes - 76% Compliant
- Health Act 2007/Regulations 2013 - 76% Compliant
- Basic Life Support - 7 Staff
- CATTS Communication Skills - 4 Staff
- Dementia training - 7 Staff
- Epilepsy Awareness - 4 Staff
- Positive Behaviour for Managers - 2 Managers

New End of Life Care Plan being rolled out after which training will commence.

| Proposed Timescale: 30/11/2015 |