<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003499</td>
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<td>Centre county:</td>
<td>Kilkenny</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>St Patricks Centre (Kilkenny) Ltd</td>
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<tr>
<td>Provider Nominee:</td>
<td></td>
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<tr>
<td>Lead inspector:</td>
<td>Kieran Murphy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Ide Batan(day two and day three); Philip Daughen (day one)</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>32</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</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 inform a registration decision. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times
From: To:
15 July 2015 09:30 15 July 2015 15:30
05 August 2015 10:30 05 August 2015 17:00
06 August 2015 08:30 06 August 2015 16:00

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

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<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 03: Family and personal relationships and links with the community</td>
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<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection
This was an inspection of a centre which was part of St Patrick’s Centre Kilkenny Limited and was a follow up to an inspection that had taken place in October 2014 when an application had been made by St Patrick’s Kilkenny to register the centre with the Authority. This follow up inspection took place over three days, with the first day of inspection focusing on the fire safety management systems as this had been identified as an area of major non-compliance on the inspection in October 2014.

St Patrick’s Kilkenny provided a range of day and residential services to children and adults with an intellectual disability. This centre was based in a campus style environment with other designated centres on site and provided a home to 32 residents:
- 13 residents, all with high support needs and some residents required significant
support to manage their behaviour lived in one unit (building 1)
• 3 residents with challenging behaviours each lived in their own separate apartment adjacent to the other units (building 2)
• 16 residents, all with complex care needs and a number of residents required adaptive seating, lived in a second unit (building 3)

Four immediate action plans were issued which set out what the provider had to do as a matter of urgency to ensure the safety of residents. On the first day of inspection it was found that the provider was failing to ensure that effective fire safety management systems were in place and three immediate action plans were given to the provider in relation to separate fire safety issues. On the second day of inspection, which was two weeks after the works were to have been completed, it was found that the provider had not implemented all the responses to these failings as a coded lock door was still in place on a resident’s bedroom door in building 2.

A fourth immediate action plan was issued as inspectors formed the opinion that the registered provider was not protecting residents from all forms of abuse. In particular inspectors found that:
• Care staff sourced via a recruitment agency did not have any experience in the area of intellectual disability
• Care staff sourced via a recruitment agency were not given an appropriate induction
• An allegation of physical and verbal abuse against a staff member was not investigated according to St Patrick’s guidelines for investigation and management of allegations of abuse (2015).
• The lead designated person for investigation of allegations of abuse in St Patrick’s service stated to inspectors that the final investigation report as provided to inspectors was not complete.
• The lead designated person for investigation of allegations of abuse in St Patrick’s service stated to inspectors that there were inconsistencies in the details of what was reported to her initially as the designated lead person and in the outcome of the final investigation report as completed by another manager at the request of the provider nominee.

Overall 14 outcomes were inspected and it was found that nine were at the level of major non-compliance with the Health Act 2007 Regulations and National Standards.

While there was a management structure it did not provide for effective governance, operational management and administration of this centre. As outlined in more detail throughout this report there were significant deficits in the quality of service provided to residents.

Inspectors found the premises to be unclean and poorly maintained with spiders and cobwebs visible in some areas and flooring held together with duct tape in some areas. Paint was peeling from the ceilings in many areas and in particular in building 3.

The Action Plan at the end of the report identifies other areas where improvements are needed to meet the requirements 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. Areas for improvement included:

- Residents rights
- complaints management
- visits
- contracts of care
- care planning
- notification of serious events
- resources
- staffing.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found the use of coded doors prevented residents from moving freely throughout their living space. It was also found that residents were not supported in relation to financial decisions. There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre. Inspectors were not satisfied that there was an effective complaints process in place.

As had been identified on the previous inspection in October 2014 and is discussed in more detail later in this report in Outcome 7, there were a number of rooms in building 1, mostly bedrooms, which were entered via a ‘digilock’ door. By the end of the second day of the inspection all of these ‘digilock’ doors had been removed. However, a number of corridors in building 1 were also accessed via a coded door. Inspectors were told that these coded doors opened automatically in the event of a fire. However they still prevented residents from moving freely throughout their living space.

There was evidence that residents were not being protected in relation to the management of their own money. There were records to show that in 2015 a resident had purchased, at their own expense, bedroom furniture. This was not in keeping with St Patrick’s policy on residents’ private property which outlined that it was “St Patrick’s service responsibility to fund from its own resources the cost of necessary furniture, fittings and equipment”. There were not any records available of discussion with or advice given to the resident in relation to these purchases. There was no record of any input from an independent advocate in relation to these purchases. There was no record of any rationale from the service provider as to the reason why these purchases were
made by the resident.

Inspectors saw records relating to two residents who were on specialised prescribed diets. The residents had to pay for any extra snacks or drinks that he/she required in relation to this specialised diet. This issue has been discussed with the provider on previous inspections in St. Patricks.

Bank accounts were not held in the name of the residents to whom the money belonged. The residents’ money was instead held in a central account which was managed by the centre. Inspectors saw that monthly bank statements were being issued to residents and their families.

Inspectors also observed that residents’ privacy and dignity while receiving intimate and personal care could not be ensured. In the shower room of building 3 there was only one set of shower curtains when the person in charge acknowledged that there should have been two sets of curtains.

Since the last inspection the complaints policy was now on display and identified for residents, relatives and visitors how to make a complaint, the responsible person for dealing with complaints and appropriate appeals process. Inspectors reviewed the complaints log and found that while complaints were being logged and followed up by the person in charge, the outcome of the complaint wasn’t always being recorded.

At the last inspection it had been found that efforts were made to seek the opinions of residents in relation to their satisfaction with the service provided. However, the director of services confirmed that since 2014 there had not been family forum meetings with residents and their families discuss issues like quality of the service provided, future plans for the centre and any other issues that families had.

Inspectors saw that some restrictions that imposed on individual residents’ lives had been referred to the human rights committee, which was chaired by a senior manager of the service. The provider nominee outlined that the membership of the human rights committee had recently been reviewed and a new chairperson had been appointed.

Judgment:
Non Compliant - Major

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

**Findings:**
There was a policy on visiting and staff said to the inspectors that families were welcome and were free to visit. A log was maintained of all visitors. However, as on the last inspection there was not adequate communal space to receive visitors. This was particularly evident on the second day of inspection as the “digilock” on one door accessing the sitting room of building 1 had been removed.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Since the last inspection the admissions policy had been updated to take account of the need to protect residents from abuse by their peers.

In the sample of contracts of care viewed by inspectors each one had been signed on behalf of the resident by their relatives. However, the details regarding the services provided, the type of accommodation and the additional costs that may be incurred as part of their service were not fully outlined. For example there was a transport charge which St Patrick’s Service charged residents every time there was a trip or activity involving the use of St Patrick’s own buses. This transport charge was capped by St Patrick’s Service at €14 per week but was not reflected in the contract. Inspectors saw records to show that 12 residents had been refunded transport charges in excess of €500 per year from previous years. However, it couldn’t be confirmed if a refund was to be given to all residents from previous excessive charging for transport costs.

The contracts did not outline that residents on specific diets would have to pay extra for snacks associated with specific diets.

**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):

Findings:
Inspectors reviewed a sample of the personal plans and saw there were inconsistencies in the completion and review of the 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.

From the sample of personal plans that were reviewed by inspectors not all of them had been reviewed yearly or more often if required. A number of personal plans had not been updated in accordance with the resident's changing circumstances and there was also no clear evidence that the plans had been developed in consultation with residents.

Overall, inspectors found that the personal plans did not set out in a formal manner the services and supports required to enhance the quality of life of residents, to promote their independence and to realise their goals and aspirations. The plans did not adequately address:
- Education, lifelong learning and employment support services, where appropriate
- development, where appropriate, of a network of personal support
- transport services
- the resident's wishes in relation to where he/she want to live and with whom
- the resident's wishes or aspirations around friendships, belonging and inclusion in the community
- the involvement of family or advocate.

Judgment:
Non Compliant - Major

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
Theme:
Effective Services

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

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

As on the previous inspection in some places the centre was visibly unclean. In particular inspectors found:
- Cobwebs and spiders in one bathroom
- the two sluicing areas in building 3 did not appear to be clean
- the exit flow from an assisted shower trolley in building 3 was visibly unclean
- the bath in one bathroom in building 2 did not appear clean and the person in charge said that it needed replacement
- there were what appeared to be food stains on the ceiling of the dining area in building 3
- mop heads appeared dirty and staff could not verify when the mop heads had last been changed
- there were no cleaning schedules in place.

As on the previous inspection it was found that the centre had not been well maintained. In building 1 two of the shower rooms had been upgraded and were clean. However a bathroom area which was identified on the last inspection as having tiles and fittings removed by some residents was still in a poor state of repair. As had been identified in the last inspection here was a bathroom/laundry/sluice area in building 2 which was visibly unclean. The person in charge agreed that this area was not fit for use.

While in some areas new flooring had been put down there were still parts where the flooring was damaged. For example the flooring was held together with duct tape in a bathroom in building 3.

Inspectors found that there weren’t suitable arrangements in place for the safe disposal of general and clinical waste. For example used incontinence pads were being left in open bins in one bathroom in building 3. In a second bathroom in this building used incontinence pads were being put in bins in a closed wooden cabinet which was not in keeping with best practice for the control of infection. Staff were observed bringing these used bags of incontinence pads through the main living rooms to dispose of them outside.

Inspectors observed that the paintwork was peeling from the ceilings in a number of areas. The doors of some residents’ bedrooms were badly marked, most likely from the
use of wheelchairs and assistive seating.

Inspectors noted that radiators were on even though it was a warm day. The person in charge advised that the heating cannot be turned off as it was used to provide hot water.

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 implemented.

Findings:
Overall, the inspectors were not satisfied that the provider had taken all reasonable measures to ensure that fire safety was appropriately managed within the centre. These failings have put the residents at risk and furthermore resulted in three immediate actions being issued on the date of the inspection. In addition, inspectors were not satisfied that appropriate manual handling practices were being implemented.

On the previous inspection numerous failings were identified in relation to the fire precautions in place in the centre. These failings primarily related to fire safety management and maintenance records. On this inspection it was found that the provider had taken positive steps to improve the standard of record keeping and fire safety management within the centre in line with their action plan response to the previous inspection report. However, the inspectors identified further failings in relation to the fire precautions in place on this inspection, including numerous failings relating to the buildings themselves that make up the centre. Furthermore, the inspectors identified numerous fire safety related deficiencies relating to the building that can only be rectified through the undertaking of a programme of remedial work and cannot be addressed through improvement of the fire safety management regime. It is also the case that many of the failings identified during this inspection were previously identified in a consulting engineers report on fire safety commissioned by the provider dated July 2014.

The inspector issued three immediate actions to the provider nominee at the conclusion of the inspection. These related to the following failings:
- The key code locks on escape routes cannot be overridden in an emergency thus compromising the means of escape from the centre.
- the storage of combustible materials throughout unoccupied areas of building 2 does
not constitute adequate precautions against the risk of fire.  
• the means of escape from the residents' bedroom in two apartments of building 2 is inadequate as there is no protection of the bedroom corridor from the living area with fire resistant construction.

The provider had confirmed to the Authority within the agreed time frame that the immediate actions had been completed in order to address these failings. However, on the second day of inspection, which was two weeks after the works were to have been completed, it was found that the provider had not implemented all the responses to these failings as a coded lock door was still in place on a resident’s bedroom door in building 2.

Building 1
The inspection commenced in building 1. This building was observed as being a single storey structure divided in to three accommodation wings off a central circulation space. The building provided accommodation for up to 14 residents. The staff informed inspectors that the residents presented with high support needs and the majority of residents had little to no mobility impairments. Each resident was provided with a single bedroom. There were also communal living and kitchen areas provided for the use of the residents. The inspectors observed that this building was provided with an adequate number of escape routes.

The inspectors also noted the absence of any adequate fire resistant construction where necessary throughout the building. For example, services were not adequately fire stopped where they penetrated the ceiling in the building. In addition to this, the inspectors noted that the doors provided throughout the building were not adequately fire rated where necessary and would have limited effect in containing fire and protecting means of escape in the event of a fire in the building. For example, rooms of special fire risk such as kitchens and laundry rooms were not fitted with fire doors with the necessary fire/smoke seals and self closing devices. Bedroom doors and all other doors were noted as being of a similar standard. This building was noted as having been provided with first aid fire fighting equipment and emergency lighting system. However the fire alarm system provided was noted by the inspectors as being inadequate due to the lack of any adequate facility for the automatic detection of fire within the building.

Building 2
This building was also a single storey structure. This building had originally been provided as a communal residential accommodation building but had been repurposed in more recent times into three self contained apartments providing accommodation for one resident in each apartment. The staff informed the inspectors that the residents presented with high support needs and with significant behaviours that challenge and the residents had little to no mobility impairments. A sizable proportion of the building was unoccupied and these areas had been utilised for the storage of large quantities of combustible materials such as unused furniture and cardboard.

As with building 1, inspectors noted the absence of any adequate fire resistant construction where necessary throughout the building. For example, one of the rooms used for the storage of combustibles was separated from the living area of one of the apartments by a wall made up in part of plastic glazing and plywood sheeting.
The inspectors noted that none of the doors provided throughout the building were adequately fire rated where necessary and would have limited effect in containing fire and protecting means of escape in the event of a fire in the building. For example, the inspectors in particular noted the absence of a fire rated door in two locations necessary to protect the escape route from the bedrooms in two of the three apartments.

The inspectors noted that this building was provided with first aid fire fighting equipment and emergency lighting. The fire alarm system was inadequate in that there was no adequate facility for the automatic fire detection throughout the building with the exception of one of the three apartments. The inspectors also noted drapes and curtains hung across escape route doors in a manner that would obstruct the use of the door in the event of an emergency.

**Building 3**

Building 3 was a single storey structure providing residential accommodation for up to 15 residents with high support needs. A significant number of the residents had limited mobility and four of the residents were non ambulant and required staff assistance in order to carry out all activities of living. The sleeping accommodation was provided in a combination of single and double bedrooms. There were also communal living and kitchen areas provided for the residents.

The building was noted as having been provided with an adequate number of escape routes, although a number of them had steps at the final exit and were therefore unsuitable for use by the residents with limited mobility. A number of final exits were identified as being narrow and therefore unsuitable for residents with impaired mobility. This building had the same issues in relation to fire resistant construction as the other buildings in that there was an inadequate provision of fire resistant construction throughout the building and there was no adequate provision of fire doors where necessary to contain fire and protecting means of escape in the event of a fire in the building. The inspector observed that this building was provided with a fire alarm, emergency lighting and first aid fire fighting equipment.

In general, the inspectors identified that the fire alarm system provided throughout the majority of the centre was inadequate. The only automatic fire detection found by inspectors throughout the majority of the centre was by way of domestic battery operated smoke alarms. The main fire alarm system could only be activated through the use of a manual call point in these parts of the centre. In the event of an activation of a manual call point in the centre, the alarm is raised throughout the entire campus although the location of the activation is displayed on only one fire alarm panel in building 3. The staff in all other buildings hear the alarm but would not know where the location of the activation was and are dependent on being contacted by phone with this detail. This detail is imperative to direct resources to the correct location in the event of an evacuation being required and any unnecessary delay represents an increase in risk to the safety of residents. Staff indicated that they would use personal attack alarms in this situation but this is inappropriate as the purpose of these devices is to raise the alarm in the event of an assault on a staff member, not a fire. On the third day of inspection a fire alarm activation in another centre did occur and staff were unable to find the location of the fire alarm for a number of minutes.
The door fastenings and use of locking devices on escape routes was identified as a concern by inspectors throughout the centre. All final exit doors were secured with devices which required the use of a key in the direction of escape. Many but not all of these doors checked by the inspector had a copy of the key located in a break glass unit adjacent to the door for use in the event the person using the door to evacuate did not have a key. In addition to the key locks, some doors on escape routes had key code locks where the correct combination had to be entered in order to deactivate the locks. These locks were incapable of being over ridden in an emergency and furthermore were unnecessary on the doors already secured with another lock. The general principle with respect to doors on escape routes is that they should be easily open-able in the direction of escape in the event of an emergency. Many doors throughout the centre did not comply with this principle and would cause potential confusion and undue delay in the event of an evacuation.

While there were fire procedures in place, these were noted as not being displayed throughout the centre. Furthermore, the procedure read by the inspector took no account of the prioritisation of evacuating the area in which the fire was located. This may lead to the evacuation of residents in areas distant from the fire instead of evacuating residents in immediate danger. The procedure was also noted as being overly complicated in nature with multiple possible points of failure. Inspectors noted that personal evacuation plans had been developed for residents and that they contained the necessary detail as to the needs of the resident and duties of the staff. Inspectors also noted a regular programme of fire drills replicating day time conditions and staffing levels within the centre. However, there were no fire drill records in some buildings within the centre to indicate the adequacy of procedures and staffing in the event of a night time evacuation of the centre. Furthermore, the inspector noted that four non ambulant residents had not been provided with appropriate evacuation aids to facilitate an evacuation of the centre at night and the location of their sleeping accommodation all in the same area of the building could potentially place an unreasonable demand on staff in the event that part of the centre required to be evacuated. The inspectors also viewed records that documented that regular fire safety checks were being conducted on a nightly basis.

The inspectors noted multiple instances of inadequate storage of combustible and flammable material storage throughout the centre. This was due to a combination of poor housekeeping in some instances such as the accumulation of combustibles in unoccupied parts of the centre and also due to inadequate provision of suitable fire rated rooms and enclosures in which to store material and combustibles.

In summary while changes had been implemented in the fire safety management regime in place within the centre in light of the findings of the previous inspection by the Authority, further improvements were still required in this area.

The manual handling guidelines available to provide guidance for staff on lifting of residents did not have any input from staff qualified in manual handling. This could lead to unsafe practice in relation to manual handling. In addition assessments weren’t available in relation to the use of aids to daily living for residents, like for example the use of a standing hoist.
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

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
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**Findings:**  
Prior to the inspection the Authority had been informed of an allegation of physical and psychological abuse by a staff member against residents. The inspectors reviewed documentation in relation to this allegation of abuse and were not satisfied that the issues raised had been dealt with appropriately. In particular inspectors found that the allegation of physical and verbal abuse against a staff member was not investigated according to St Patrick’s guidelines for investigation and management of allegations of abuse (2015). The lead designated person for investigation of allegations of abuse in St Patrick’s service stated to inspectors that the final investigation report as provided to inspectors was not complete. The lead designated person for investigation of allegations of abuse in St Patrick’s service stated to inspectors that there were inconsistencies in the details of what was reported to her initially as the designated lead person and in the outcome of the final investigation report as completed by another manager at the request of the provider nominee. A fourth immediate action plan was issued as inspectors formed the judgment that the registered provider was not protecting residents from all forms of abuse.

In response to a review of restrictive practice and in particular the use of medication as a chemical restraint, the Authority had undertaken a focused inspection of restrictive practices in this centre on 26 May 2015. At that time it was found that:

- The least restrictive alternative to the use of chemical restraint was not always considered
- Residents views on the use of chemical restraint were not always documented
- Appropriate assessment of residents and the need for the use of chemical restraint were not always recorded
- The monitoring of resident when chemical restraint was used was not being recorded.

On this inspection it was found that appropriate actions had been taken to address
these issues. In addition a number of residents had recently started a programme of sensory integration with a qualified specialist.

**Judgment:**
Non Compliant - Major

<table>
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<th>Outcome 09: Notification of Incidents</th>
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<tr>
<td>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</td>
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**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The person in charge is required to notify the Chief Inspector within three working days of all serious adverse incidents. In relation to an allegation of physical and psychological abuse by a staff member against residents the Authority was not informed as per the timelines in the regulations.

When the person in charge was absent staff were not aware of how to report adverse incidents to the Chief Inspector. Staff were also not aware of what to report to the Chief Inspector.

**Judgment:**
Non Compliant - Major

<table>
<thead>
<tr>
<th>Outcome 11. Healthcare Needs</th>
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<tr>
<td>Residents are supported on an individual basis to achieve and enjoy the best possible health.</td>
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**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors reviewed a sample of resident healthcare files. Each resident had an up to date annual medical report completed by their general practitioner (GP). There was evidence in the healthcare records that the GPs were reviewing residents’ health needs
as required also. There was regular blood testing for residents on particular medications to ensure that the levels were within recommended ranges. There was evidence that residents were referred to consultant specialists for a review if required.

There was evidence of good access to specialist care by a consultant in psychiatry who liaised with the psychology department regarding residents’ needs.

A record was maintained of all referrals to and treatment by allied health professionals. A number of residents had swallow care plans recommended by a speech and language therapist. Many residents in building 3 had assistive seating and chairs as recommended by an occupational therapist.

Care practice as described by staff conveyed that at end of life, the dignity of residents was respected, that their comfort and well being was a priority and that whoever wished to be with them were facilitated to remain as long as they wished. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as nursing records and medication charts reviewed by the inspectors indicated that life sustaining procedures and symptom control was effective as evidenced in one healthcare file reviewed by the inspectors.

However, the inspectors saw that the personal plans did not address the topic of spirituality and dying in line with residents' emotional, psychological and physical needs. The end of life care plan did not coordinate and direct the care to be delivered to ensure that the autonomy of the resident was upheld at all times. While care needs were identified on admission and documented accordingly there was no evidence of any advance care planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell.

There was no policy for end of life to guide practice. There was no guidance for staff on care planning for end of life and in particular in relation to support factors such as advance health care directives, consent, refusal of treatment and how to provide support to other residents and relatives.

The provider had outlined that since the last inspection a full review of food and food choice available to residents was undertaken with the input of a dietician, external food consultant, the catering manager and person in charge. Inspectors observed that the presentation of food was in an appetising and appealing manner.

**Judgment:**
Substantially Compliant

**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):

Findings:
An organisational policy in relation to medication management was made available to
the inspectors which had been reviewed in May 2015. The policy was comprehensive
and evidence based. Guidance was included in the policy relating to ordering, receipt,
storage, administration and disposal of medicines.
Medicines were supplied by the pharmacy department in a local acute hospital. Staff
with whom inspectors spoke confirmed there was timely access to medicines and that a
pharmacist was available to meet with residents and their representatives if required.

Medications were stored securely. The inspector saw that medicines with additional
storage requirements were stored securely and documentation was completed
appropriately. Inspectors saw that the keyholding procedure was sufficiently robust to
ensure that the chain of custody was adequately maintained. This had been an issue on
the previous inspection.

A sample of medication prescription and administration records (MPARs) was reviewed
by an inspector. Medication administration sheets identified the medications on the
prescription sheet and allowed space to record comments on withholding or refusing
medications. The inspector observed that a medication administration sheet was blank
where medication was due to be administered. Therefore, this was not a complete and
accurate record of each medicine administered signed and dated by the nurse
administering the medicines. This remains an issue from a previous inspection.

Some residents required their medications to be crushed prior to administration and a
general authorisation to crush was identified on the front of the prescription record.
However, each individual prescription did not contain an authorisation by the prescriber
to crush the medicine prescribed. Inspectors saw that nursing staff were transcribing
medications. However, the practice of transcribing was not done in accordance with best
practice and could not guarantee the accuracy of the transcribed prescription. There was
no evidence that the transcriptions were signed and dated by the transcribing nurse
and co signed by the prescribing doctor within a designated timeframe. There was no
evidence that the practice of transcribing was subject to audit in accordance with best
practice in medication management.

Audits in relation to medicines management were completed on a regular basis by the
person in charge. The person in charge said that a new medicines management audit
tool was being rolled out. Inspectors saw that a detailed medication review had taken
place on all residents by the pharmacist on 30 June 2015. Inspectors saw minutes of a
medication management review meeting which indicated that all staff were to have
completed e Learning medication management programme by 21 August 2015.

Judgment:
Non Compliant - Moderate
Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The inspectors outlined their concerns that the management arrangements could not ensure effective governance, operational management and administration of the designated centre concerned.

The centre was part of St Patrick’s Services which provided supports to children and adults persons with an intellectual disability in the Kilkenny areas. There was an executive committee of St Patrick’s Services which provided oversight of all the designated centres. The chief executive officer was the general manager who had been appointed in 2011 and he was the provider nominee for this centre. There was an assistant director of services who reported to the Director of Services. However, he was not available during both days of the inspection. The nominated person in charge was the acting senior clinical nurse manager. She was a registered nurse in intellectual disability and had a degree in supervisory management from Carlow Institute of Technology. She also had a qualification in management of challenging behaviour. She had worked in St Patrick’s Services since 1995.

As evidenced throughout this report there were deficiencies in the provider’s understanding of role and knowledge of the regulations. While three immediate action plans were given to the provider during the inspection to address the issues of fire safety management, the removal of keypad locks on doors had not been addressed by the provider by the second day of the inspection, 12 days after the deficiency was to have been remedied. In addition, there were a number of outstanding items from the inspection by the Authority in October 2014 which had not yet been implemented. This included maintenance issues, fire safety, contracts of care and complaints management. There did not appear to be any coordinated response to issues identified following the inspection.

Inspectors were not satisfied that there was effective communication between the provider nominee and the person in charge. The provider nominee outlined to inspectors that he had not formally met the person in charge since the inspection in October 2014.
The provider nominee had received a report from a consulting engineer in fire safety in June 2014. A copy of this report had not been given to the person in charge by the provider nominee. It was unclear why this was the case. This was also a finding in another centre for which the provider nominee had responsibility. In response to an allegation of abuse the provider nominee had arranged for an investigation to be undertaken. Inspectors were informed by the designated lead person for investigations of allegations of abuse that the record of the investigation provided to inspectors was not completed. Inspectors were also informed that the report had not been shared with either the person in charge or the designated lead person for the investigation of allegations of abuse.

Inspectors had concerns about the provider nominee’s role in ensuring the quality and safety of care of residents. The provider nominee had arranged for one unannounced visit to the centre in July 2015 to assess quality and safety as required by the regulations. An annual report of quality and safety of care and support for this centre had been completed for 2014. However, it was unclear who the person undertaking this report was. In addition in the documentation seen by inspectors there was no action plan generated to make improvements. It was also unclear if this annual report had been shared with residents and their families. This was also a finding in another centre for which the provider nominee had responsibility.

Judgment:
Non Compliant - Major

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

Findings:
The inspectors formed the opinion that the centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

This follow up inspection identified numerous examples where the centre had not been adequately maintained. In some areas the flooring was held together with duct tape; paintwork was peeling from the ceilings in a number of areas; the doors of some residents’ bedrooms were badly marked, most likely from the use of wheelchairs and assistive seating. The bathroom area in building 1 which was identified on the last inspection as having tiles and fittings removed by some residents was still in a poor
state of repair.

In addition, there were a number of outstanding items from the inspection by the Authority in October 2014 which had not yet been implemented.

**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):**

**Findings:**
Inspectors saw minutes of a meeting regarding the reduction of the designated night staff for one resident in an apartment in building 2. It was discussed in the minutes that the staff hours could be cut and other technology could be introduced to replace staff, like cameras, monitors and alarms. The provider nominee outlined to inspectors that similar arrangements were in place in other centres not managed by St Patrick's. Inspectors were of the opinion that based on the assessed needs of the resident concerned, the statement of purpose and the size and layout out of centre that the current staffing levels for this resident was appropriate.

Staff were being recruited who did not have the appropriate qualifications or skills to care for. Inspectors saw records that showed care staff sourced via a recruitment agency did not have any experience in the area of intellectual disability. There was also documentation to show that care staff sourced via a recruitment agency were not appropriately supervised or given an appropriate induction. This was particularly relevant in one unit which had residents with challenging behaviour.

**Judgment:**
Non Compliant - Major

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
It had been found on the inspection by the Authority in October 2014 that the risk management policy did not meet the requirements of regulations. This had been rectified. There was also a policy on the creation of, access to, retention of, maintenance of and destruction of records.

**Judgment:**
Compliant

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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:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003499</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>15 July 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23 November 2015</td>
</tr>
</tbody>
</table>

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:
A number of corridors in building 1 were accessed via a coded door. While these coded doors opened automatically in the event of a fire, they prevented residents from moving freely throughout their living space.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Multidisciplinary input as part of a committee will be developed to review and develop plans for residents in this sector.
Review risk register on a monthly basis.
Positive behaviour support plans to be developed for individuals presenting challenging behaviour to ensure undue restrictive practices are not present.
Risk assessments to be completed to ensure the appropriate control measures are in place to reduce the risk of harm to residents.
All restrictive practices to be referred to the Human Rights Enhancement Committee.
PPIM will be attending a working group for Seclusion and restraint being organised by the National Federation.
A restrictive practices committee is being formed in St. Patricks to deal specifically with restrictive practices.
Phycology support hours will be sourced for this centre.

St Patrick’s Management and HSE have met to discuss MDT support. HSE have decided to appoint an Adult ID Team for the area and are currently recruiting senior positions in OT/Physio/SALT & Psychology. Members of this team will then be deployed to St Patrick’s as required. The SALT is already appointed and available to St Patrick’s 37.5 hours weekly.

Two digilocks remain in place due to the vulnerability of female residents that use the main foyer. When these residents move out to the community another digilock will be removed and the residents from that side will have full access to the foyer and this door will remain open, remaining digilock to be reviewed. Risk register is in place and at the moment all risks are being reviewed(18 updated) and transferred to new folders. New restrictive practices assessment form has been through QA and awaiting some more changes to be approved to same. Behaviour support plans are updated yearly and more often as needs change, to date 6 have been updated with 2 of them updated at least 3 times due to behaviours that challenge. Restrictive Practices will be reviewed by MDT and HRC in the coming weeks as emergency cases have been referred first to these bodies.

Proposed Timescale: 30/11/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents’ privacy and dignity while receiving intimate and personal care could not be ensured.
2. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Intimate and personal care to be provided, as per policy, to ensure the dignity and privacy of the individual are respected at all times.
Shower curtains are in place to ensure privacy 18/07/15.
Shower curtain is in place since date above 18/07/2015.

Proposed Timescale: 18/07/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre.

3. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
• Advice will be sought from the Speech and Language Therapist (SALT Commencing Sept 11th) and others to help staff support residents to participate in team meetings and discussions about the running of the Centre and to document same.
• A number of forums have been agreed to suit residents and family representatives to ensure this is an ongoing process.
• All residents/families will be issued with a family satisfaction survey.
• Training will be rolled out for staff on the role of keyworker to ensure they can best support and articulate on behalf of residents where needed and residents will be facilitated to access Advocacy services.

Salt training has begun. To date 8 staff have been trained and in Mt.Olivers we have had extra training from a private Deaf/Hear Consultant who was working alongside a Sensory Specialist. Lamh training has also begun. Family satisfaction surveys have gone out to families and we are awaiting same to be returned. Family forum took place on 21/10/2015 and dates to be sent out for rest of the year.

Proposed Timescale: 30/09/2015
Theme: Individualised Supports and Care
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no record of any input from an independent advocate in relation to purchases of items of furniture by residents. There was no record of any rationale from the service provider as to the reason why these purchases were made by the resident.

4. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
- Finance policy has been reviewed and amended to reflect the desire of residents to purchase their own possessions should they so choose.
- Protocol to be included in finance policy to ensure appropriate control measures are in place to protect residents from financial abuse and ensure an independent advocate is involved in the purchase of items over and above a stated amount.
- Policy is to be amended and reflected in practice that all purchases are to be agreed with the resident and family/carer (over 100 euros). Where a family/carer is not available this must be approved by an independent advocate.
A full review of all resident’s purchases to be carried out and appropriate action to be undertaken, as above, if required.

Proposed Timescale: 13/10/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence to suggest that where a resident lacked capacity to manage their financial affairs, that he or she was facilitated to access an advocate to assist them in making decisions.

5. Action Required:
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

Please state the actions you have taken or are planning to take:
- The Finance Manager has met with an Independent Advocate from the National Advocacy Service and a plan is being put in place that will enable residents that require access to the National Advocacy Service to be facilitated to do so.
Easy read guidelines will be put in place to explain options on the management of finances to each resident.

Finance manager has met with Advocate and guidelines are in the process of being
drawn up re:same.
Easy read guidelines are in the process of being finalised.

**Proposed Timescale:** 31/10/2015  
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Bank accounts were not held in the name of the residents to whom the money belonged. The residents’ money was instead held in a central account which was managed by the centre.

6. **Action Required:**
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

**Please state the actions you have taken or are planning to take:**
- The Finance Manager has made contact with a number of financial institutions, bank and Credit Union, to enquire about opening accounts for individual residents. It has been advised that the bank requires an Indemnity Policy to be put in place by the HSE stating who the residents guardian is and “stating clearly who has order over the person’s money”.
- The Finance Manager has been in contact with James Gorman, Finance Manager HSE PPPA & Fair Deal Finance Unit, who has advised that opening bank accounts where residents lack capacity to manage their own financial affairs, is not lawful under current banking legislation and that the requirement for residents to each have an individual bank account is unworkable.
- In light of the above scenarios the Finance Manager met with the Independent Advocate for advice on this matter and was informed of the following: “For those individuals who encounter difficulty opening individual accounts where the financial institution challenges the individual’s capacity the advocate of the National Advocacy Service will make representation on securing the entitlement on the person’s behalf.” Further meetings will be arranged with the Independent Advocate to discuss what options are open to residents regarding the possibility of opening bank accounts and how this can be managed in a clear and transparent and safe system.

National guidelines are being discussed around this issue.

**Proposed Timescale:** 31/10/2015  
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While complaints were being logged and followed up by the person in charge, the outcome of the complaint wasn’t always being recorded.

7. **Action Required:**
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
Complaints policy most recently updated on 25/07/15.
The outcomes of complaints and if the complainant is satisfied is now being recorded in the complaints log.

This was discussed again at QA meeting on 17/11/2015 and new Complaints folder is assembled at the moment and will be rolled out to all houses w/e 24/11/2015.Complaints forms are up and running .One complaint in October and same is being addressed.

**Proposed Timescale:** 20/07/2015

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**Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was not adequate communal space to receive visitors. This was particularly evident on the second day of inspection as the locks on a number of doors accessing a sitting room had been removed.

8. **Action Required:**
Under Regulation 11 (3) (a) you are required to: Provide suitable communal facilities for each resident to receive visitors.

**Please state the actions you have taken or are planning to take:**
Where possible unused bedrooms on each side of the centre will be developed into sitting rooms for each resident to receive visitors.
There is also a separate canteen area on campus that all families can access when they are visiting their relatives.

A family room will be developed on Side 1 but it cant be started until Phase 2 of fire safety works have been carried out.We are hoping that these works will begin before Christmas.

**Proposed Timescale:** 26/02/2016
### 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:**
Contracts of care did not outline additional charges like specialised diets or transport

**9. Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**
- Terms and Conditions of residency have been reviewed to outline transport charges. June 2015. The terms and conditions will be reissued to all residents and families for resigning.
- Residents who receive a special diet will not be charged.
- The residents who inadvertently incurred the charge for the special diet will be reimbursed.

Contracts of care have been issued to families and to date we have 18 out of 32 back. All families have said they are en route. Reimbursements have been made and are evident on bank statements.

**Proposed Timescale:** 14/10/2015

### Outcome 05: Social Care Needs

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some resident’s personal plans had not been updated since 2014 even though it is required to be updated annually or sooner if there was a change in need.

**10. Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that all resident’s personal plans are reviewed annually and more often if needed depending on the individual resident. Audits will be carried out on a regular basis. All personal plans are being updated and are in a new format. Audit on same being carried out w/b 23/11/2015.
Proposed Timescale: 30/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not comprehensive.

11. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
All personal care plans within this Centre will be reviewed by PIC and relevant MDT personnel as available and relevant to each resident.
St. Patricks Centre has recently employed a behaviour specialist and we will be sourcing private psychology consultations, A Speech and Language Therapist is due to commence on Sept 11th .
Social work support will be accessed through community care.
Occupational Therapists and Physiotherapists will be accessed through community care.
St. Patricks will continue to provide Psychiatry and Play Therapy staff.
This will provide a greater Multi-Disciplinary approach to care planning.
The PIC will ensure that each resident receives a comprehensive Personal Plan.

We have had at least 15 reviews with MDT and all plans have been adjusted to reflect this. Emergency cases and peer to peer issues have been referred to MDT as a priority.
New plans and files are in situ .

Proposed Timescale: 18/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inconsistencies in the completion and format of the assessments of residents needs.

12. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

<table>
<thead>
<tr>
<th>Outcome 06: Safe and suitable premises</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>• Cobwebs and spiders were observed in one bathroom</td>
</tr>
<tr>
<td>• the two sluicing areas in building 3 did not appear to be clean</td>
</tr>
<tr>
<td>• the exit flow from an assisted shower trolley in building 3 was visibly unclean</td>
</tr>
<tr>
<td>• the bath in one bathroom in building 2 did not appear clean and needed replacement</td>
</tr>
<tr>
<td>• there were what appeared to be food stains on the ceiling of the dining area in building 3</td>
</tr>
<tr>
<td>• mop heads appeared dirty and staff could not verify when the mop heads had last been changed</td>
</tr>
<tr>
<td>• there were no cleaning schedules in place</td>
</tr>
<tr>
<td><strong>13. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>• Cleaning schedules in place in all bathrooms and monitored.</td>
</tr>
<tr>
<td>• The service is committed to the introduction of a new systematic approach to cleaning across all areas including the introduction of new cleaning equipment(currently on order)and a customised audit system.</td>
</tr>
<tr>
<td>• Training for housekeeping staff has taken place to ensure improved hygiene standards in the designated centre.</td>
</tr>
<tr>
<td>• Cleaning schedules and audits will be completed by PIC.</td>
</tr>
<tr>
<td>Monitored by CNM1 in one house and PIC in other areas.</td>
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<tr>
<td>New approach in place.</td>
</tr>
<tr>
<td>New cleaning equipment in use.</td>
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<tr>
<td>One audit has been carried out and evidence is there.</td>
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<table>
<thead>
<tr>
<th>Proposed Timescale: 30/09/2015</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>Inspectors found that there weren’t suitable arrangements in place for the safe disposal of general and clinical waste. For example used incontinence pads were being left in open bins in one bathroom in building 3. In a second bathroom in this building used incontinence pads were being put in bins in a closed wooden cabinet which was not in</td>
</tr>
</tbody>
</table>
keeping with best practice for the control of infection. Staff were observed bringing these used bags of incontinence pads through the main living rooms to dispose of them outside.

14. **Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

**Please state the actions you have taken or are planning to take:**
- Bin that had been stored in wooden cabinet has now been relocated.
- All incontinence pads are disposed of in closed bins as from 06/08/15
- The practice of bringing incontinence pads in bags through the living rooms has been stopped immediately. 06/08/15

**Proposed Timescale:** 23/11/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A bathroom area which was identified on the last inspection as having tiles and fittings removed by some residents was still in a poor state of repair. As had been identified in the last inspection here was a bathroom/laundry/sluice area in building 2 which was visibly unclean. The person in charge agreed that this area was not fit for use.

15. **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:**
The bathroom in building 1 requiring maintenance/repairs/redecoration will be carried out as part of a phased maintenance plan.
Currently 3 bathrooms have been completed in this centre and plans are in place for further work to be completed in coming months once other building work is completed.

This work will commence when Phase 2 of fire safety works have been carried out.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Flooring was damaged and in some areas held together with duct tape.
16. **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:**
The flooring in all areas of the centre will be reviewed and replaced as required. A phased maintenance is focused on upgrading bathroom areas.

Replacement of flooring where required will begin following scheduled building work (fire safety).

**Proposed Timescale:** 31/01/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The heating cannot be turned off in building 3 as it was used to provide hot water.

17. **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:**
On review the heating system in building 3 can be turned off without affecting the hot water. This requires maintenance personnel to turn off the heating. Each individual radiator is fitted with a thermostatic control valve which is manually adjusted and allows radiators to be turned off.

**Proposed Timescale:** 01/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Paintwork was peeling from ceilings in many areas.

18. **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:**
Work will commence once fire safety works are complete.

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The doors of some residents’ bedrooms were badly marked, most likely from the use of wheelchairs and assistive seating.

**19. 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:  
Work will commence once fire safety works are complete.

**Proposed Timescale:** 30/11/2015

**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 manual handling guidelines available to provide guidance for staff on lifting of residents did not have any input from staff qualified in manual handling.

**20. 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 manual handling assessments will be reviewed by suitably qualified person and guidelines then written up in conjunction with keyworkers and staff that know and are familiar to the resident and their support needs.

**Proposed Timescale:** 30/10/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Evidence was not available that any adequate action had been taken to remedy any of
the fire safety related failings identified in the consulting engineers report commissioned by the provider and completed in July 2014.

21. **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:**
Funding has been provided and work has commenced in the centre to remedy the fire safety related failings identified in the consulting engineers report commissioned by the provider that was completed in July 2014. This will be completed by December 2015. Contractors are on site.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The means of escape from the centre were identified as being inadequate in the following respects:
- The means of escape were not adequately protected with fire resistant construction and/or fire doors where necessary to ensure residents can safely evacuate in the event of fire.
- A number of escape routes were identified as being unsuitable for the residents that would be expected to use them in the event of a fire either due to their narrow nature or the lack of a ramp where the surface level changes.
- Many doors on escape routes were not readily open-able in the direction of escape in the event of fire. The locking devices on many doors required operation in a manner that would potentially cause undue delay or confusion in the event of an evacuation.
- Some doors on escape routes were obstructed by curtains/drapes.

22. **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:**
A programme of works has been developed to respond to the issues identified in this report and previously identified in St Patrick’s own Audit. Funding has been provided and work is ongoing in this Centre with contractors on site.

Fire safety works are ongoing the first phase of which has been completed. The closure notice issued to the centre by the Chief Fire Officer has been revoked following the completion of these works. Extra staff have been added to the rota for fire safety precautions. Doors now open automatically when alarm is activated.
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no adequate arrangements in place for the containing of fire in that there was an absence of fire resistant construction where required throughout the centre. There were no adequate arrangements for detecting fires within the centre in that there was no adequate automatic fire detection system within most of the centre.

23. 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:
A programme of works has been developed to respond to the issues identified in this report and previously identified in St Patrick’s Audit. Funding has been provided and work is ongoing in this centre with contractors on site. The Installation of a L1 fire detection and alarm system has commenced which will be completed and commissioned on or before 7th September in building 1. A fire detection alarm system for Building 2 is in progress of installation for urgent completion, contractors are on site completing works.

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedure for giving warning in the event of fire was inadequate.

24. Action Required:
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
Procedures to be reviewed to ensure that prioritisation of evacuating the area in which the fire may be located. Currently installing alarm will be central aid to this process as panels will be addressed to each room. Contractors are on site completing action plan.

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The evacuation procedure did not represent best practice. The evacuation procedure was unnecessarily complicated due to the lack of an adequate fire alarm system. Non ambulant residents were not provided with appropriate evacuation aids to facilitate their timely evacuation from the centre.

25. **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:**
A new L1 addressable fire detection and alarm system is currently being installed across the centre.
The evacuation needs of each resident will be planned and outlined in their personal evacuation plan. Staff will continue to be trained in evacuation strategies.
Duvet evacuation training is being rolled out to staff in this centre commenced in St. Patricks.

PEEPS are in place for all residents and up to date.
In our area 53 staff are up to date with Fire Training,1 is on S/L and 3 are waiting to do it.Fire trainining is scheduled for 18th December.

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no fire drill records to indicate the adequacy of procedures and staffing in the event of a night time evacuation of the centre in some buildings within the centre.

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

**Please state the actions you have taken or are planning to take:**
Night time fire evacuations have commenced and records of same are in Fire folder St. Patricks has reviewed the staffing levels to ensure adequate staffing in the event of a fire evacuation.

Fire drill records are up to date and in register. Drills carried out once a month at different intervals.

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The fire procedures were not displayed in prominent locations throughout the centre.

27. 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:
All fire procedures are now displayed in prominent locations throughout the Centre. All staff are familiar with fire procedures within the centre.

Proposed Timescale: 23/11/2015

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors formed the opinion that the registered provider was not protecting residents from all forms of abuse.

28. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
An external consultant with expertise in the area of safeguarding vulnerable adults and children has been engaged by the organisation to carry out a full investigation into the allegations of physical and psychological abuse by a staff member against residents. This investigation has been initiated and Terms of Reference have been shared with appropriate parties.
In addition, this external consultant has initiated a review of the protocols, policies, procedures and systems regarding safeguarding including the scope and functions of the Designated Team and will provide recommendations on developments and improvements where appropriate.
Status updates to be provided to HIQA on an ongoing basis.
Investigation to be concluded eight weeks from first interview.

An action plan involving contribution from members of the Multidisciplinary Team including an independent advocate has been put in place to support the residents involved.

The new safeguarding/designated team is currently being expanded to include new social worker and frontline managers. External social worker advising the new team in developing new safeguarding policy. New training programme based on new policy to be rolled out to staff commencing December 2015. Members of the new team attending
Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In relation to an allegation of physical and psychological abuse by a staff member against residents the Authority was not informed as per the timelines in the regulations.

29. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
All personnel deputising for PIC will be made aware and supported on how to inform HIQA in the designated time frame.
In the absence of the PIC the ADOS will be responsible for overseeing this process.

In the absence of PIC it is the CNM1 and then Senior Staff Nurse and Staff Nurse.

Proposed Timescale: 23/11/2015

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:
End of life wishes and decisions had not been made to ensure that each resident receives care in line with their best interests.

30. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
• Consultations with residents and families will take place in relation to their end of life care as identified and in line with our own End of Life Policy.

This process has begun where needed. In our area we have one resident with a clear diagnosis of dementia and a new care plan is in place as discussed with her next of kin.
New End of Life Policy developed by Dementia Champion and currently being introduced across the service.

**Proposed Timescale:** 15/12/2015

### Outcome 12. Medication Management

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medications were not individually signed off by the prescriber to be crushed prior to administration by staff.

#### 31. **Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
Prescribing doctor is signing off on all medications to be crushed prior to administration. This is completed.

Medication management and administration currently under review across the centre. Pilot project to address all medication management issues just commenced in another sector/centre and will re rolled out to all sectors/centres ASAP.

**Proposed Timescale:** 13/08/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The practice of transcribing was not done in accordance with best practice. There was no evidence that that the transcriptions were signed and dated by the transcribing nurse and co signed by the prescribing doctor within a designated timeframe.

#### 32. **Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
Two nurses to transcribe in accordance with NMBI guidelines and in line with St. Patrick’s Medication Management policy to ensure all are signed off by prescribing
doctor.

This is done as needed in each house and will be evidenced in the individual MPARS.

**Proposed Timescale:** 23/11/2015

**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:
Items from a previous inspection report undertaken by the Authority in February 2014 had not been addressed.

33. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The remaining keypad lock (located in building 2) was removed immediately 06/08/2015.
Work on fire safety issues has commenced and contractors are on site.
Contracts of care have been reviewed on 14/07/2015.
Complaints policy has been reviewed on 25/07/15.
The outcome of the complaints will be recorded on the log (C4-008) and the complaints form (C4-007).
The nominated provider will meet formally on a monthly basis with the PIC and relevant personnel in order to provide a coordinated response following inspections.
All meetings to be agenda driven and minuted, with action plans recorded, person responsible for actions named and completed dates for these actions recorded.

Contracts of care have been signed and returned by 18 families, families contacted and all will be returned.
New update on the Complaints Policy has just been finalised and approved by QA, same to be signed off on and circulated and training will commence on same in the coming weeks. New Complaints folders are being structured and will be sent out to the houses w/b 23/11/2015.

**Proposed Timescale:** 30/09/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no effective communication between the provider nominee and the person in charge.
### 34. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
With immediate effect there will be a scheduled monthly meeting with the Person in Charge and the Provider. This will be a review and planning meeting and all core provider support personnel will be present at this meeting. A monthly report will be presented, agreed action plans will be developed and minutes will be kept. The minute taker will be the line manager.

Regular meetings now taking place between all PIC’s and Senior Management.

**Proposed Timescale:** 30/09/2015  
**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 of quality of care it was not effective.

### 35. **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:**
Implement a more effective and robust system of reviewing quality of care. The provider nominee will arrange for a review of the quality of care to be carried out and will have an action plan to generate improvements.

Organisation has adopted a new “Annual review Of Quality and Safety of Care” format and the first review will be conducted by the end of the year.

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

### 36. **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 and Support for the designated centre will be compiled following consultation with residents and their representatives. It will also be shared with residents and their representatives.

Following the review in December the information will then be disseminated to all residents and their representatives in early 2016.

Proposed Timescale: 31/01/2016

Outcome 16: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not being well maintained.

37. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
A refurbishment programme will be developed for this centre that will address the issues raised. This will include repainting the centre upgrading bathrooms and will commence on completion of phase 1 fire safety works.

Proposed Timescale: 28/02/2016

Outcome 17: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were also documentation to show that care staff sourced via a recruitment agency were not appropriately supervised or given an appropriate induction. This was particularly relevant in one unit which had residents with challenging behaviour.

38. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.
Please state the actions you have taken or are planning to take:

Within the service
• Inductions to be more robust and thorough to ensure all incoming staff are aware of positions they are filling and what is expected of them.
• Induction checklist is introduced for all new staff.

Recruitment of staff is ongoing and it is hoped to replace all agency staff as soon as possible. While agency staff continue to work in the centre they are “regular” agency staff well known to the residents and other staff. There is an in house /unit specific induction in place.

Proposed Timescale: 23/11/2015