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<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd</th>
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<td>Centre ID:</td>
<td>OSV-0003497</td>
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<tr>
<td>Provider Nominee:</td>
<td>David Kieran</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
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<tr>
<td>Support inspector(s):</td>
<td>Gary Kiernan</td>
</tr>
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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 1 day(s).

The inspection took place over the following dates and times
From: 14 January 2016 09:30  
To: 14 January 2016 17:20

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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<td>Outcome 05: Social Care Needs</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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Summary of findings from this inspection
This was an inspection of a centre which was part of St Patrick’s Centre Kilkenny Limited. St Patrick’s Kilkenny provides a range of day and residential services to children and adults with an intellectual disability. The centre provides a home to 24 residents with complex healthcare and support needs. The centre is situated in a campus style congregated setting with other designated centres on site.

Inspectors carried out this inspection in response to communication from the provider nominee that 11 residents had moved from the centre to alternative accommodation while fire safety building compliance works were being undertaken in their home. The provider nominee indicated that the level of works that would be required would cause residents considerable disruption and a move to an alternative accommodation for a number of weeks would be in their best interests. The Chief Inspector was concerned with regards to this as the provider nominee had not actively engaged with HIQA to inform them of this decision prior to moving residents to an unregistered accommodation.
Inspectors visited the centre and both residential units to assure residents care and welfare were adequately supported with the change of accommodation. As part of the inspection, inspectors observed practices, reviewed documentation and carried out interviews with both the provider nominee and acting operations manager.

The new provider nominee had started his tenure in the service in October 2015. Inspectors noted on this inspection that the provider nominee had introduced a number of quality improvement systems to ensure residents were receiving a better standard of care and support. Some improvements they had introduced included the procurement of a multidisciplinary allied health professional team to work with residents and support their healthcare needs, for example. Both the provider nominee and acting operations manager were actively striving to bring about a quality assurance and review system for the service and had set up a quality management team tasked with improving practices within the service.

One of the residential units, part of the centre, had recently undergone fire building compliance works based on an engineer’s report from June 2014. Inspectors found there were improvements in fire safety arrangements for residents living in the residential unit. Windows had also been replaced and doors which meant the centre was warmer, previously staff informed inspectors the centre had been very drafty and cold.

While there were improvements on an operational level with regard to the management of the centre, inspectors were still significantly concerned with the lack of oversight and governance on behalf of the provider/Board of Management for the service. Inspectors could find little evidence of their involvement in the centre and support for the provider nominee, whose tenure was to end on 1 March 2016.

Equally, inspectors were concerned in relation to the significant resource issues the service was facing which could have a negative impact on residents’ care and welfare. A number of suppliers, for example, pharmacy and food suppliers, together with workforce agencies, had not received payment for services rendered resulting in them considering withholding services until they were paid. The provider nominee was equally concerned with regard to the financial shortfall in the service and inspectors reviewed emails which evidenced this concern together with the provider nominee’s attempts to manage this precarious financial situation.

Compliance was found in one Outcome, Outcome 17: Workforce, non-compliance was found in all other Outcomes inspected. These included:

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.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors reviewed aspects of this Outcome in both residential settings of the centre, the residential unit that remained open and the alternative accommodation setting.

Prior to residents' move to alternative accommodation, residents' families and their representatives had been consulted about the move. The provider nominee had arranged for a visit by parents/representatives to the accommodation to view the accommodation and receive feedback. Inspectors also reviewed letters which had been issued informing families/representatives about the move and giving assurances that residents would move back to the designated centre when fire compliance works had been completed.

In the residential unit of the centre that had not been closed, inspectors observed that residents' care was managed in a way that respected their rights and privacy. However, the showering/toilet facilities for residents in the unit were inadequate and due to their configuration could not meet the privacy and dignity needs of residents.

The room comprised of a shower, sluice, sinks, toilet, linen and incontinence wear storage space. To access the toilet, residents were required to mobilise past the shower and sluice to the back of the room. This arrangement could not ensure the privacy of residents engaging in personal hygiene, for example.

Residents who had moved to alternative accommodation had adequate privacy arrangements in place in the most part.
Each resident had their own en-suite bedroom and inspectors observed care practices were carried out with due regard for residents’ privacy and dignity. There were also added measures to ensure no unauthorised access to the alternative accommodation should occur. A procedure was in place which required all visitors to the accommodation to sign in and give photographic identification before entering. An alarm on the entrance door was in place to alert staff to visitors to the residence, further ensuring residents’ privacy.

However, one room, which was designated as a staff room, was also the location of one of the en-suites that had been adapted to support showering of residents. Inspectors were not assured that this arrangement would meet the privacy needs of residents and informed the provider that an alternative arrangement would be necessary.

The complaints procedure was not located in the alternative accommodation in a prominent location, therefore residents, representatives and visitors were not adequately informed of the procedures in place if they wished to make a complaint.

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

**Findings:**
The provider had begun to implement changes to the layout and content of personal files for residents within the service. This was to ensure residents had a comprehensive assessment with associated recommendations by allied health professionals.

While there was evidence that this had begun to take place, inspectors found there were inadequate care planning arrangements for a resident who presented with a behaviour which could result in serious self injury. The resident living in the alternative accommodation did not have a care plan to guide staff in how to manage their specific
needs with reference to their new residential setting.

**Judgment:**
Non Compliant - Moderate

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**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:**
Improvement was required in relation to how the designated centre was managing risk, including health & safety, infection control and fire. An immediate action plan was issued on the previous inspection as it was found that the provider was failing to ensure that there were effective fire safety management systems in place.

A consulting engineer’s report dated June 2014 undertaken in relation to fire safety in the centre found that there were considerable works required to ensure both residential units were suitably fire compliant.

At the time of this inspection fire safety works had been completed in one residential unit and were underway in the remaining unit. Inspectors visited the residential unit where works had been completed and reviewed the fire safety procedures in place. A fire alarm system and panel had been installed. There was adequate fire exit signage throughout. Fire-rated doors, which compartmentalised the unit, had been fitted with automatic self closers which activated and allowed doors to shut when the fire/smoke detector was activated. Fire evacuation routes in both residential settings were unblocked at the time of inspection. All staff had completed fire safety training since the previous inspection.

While staff had received training in fire safety management, a fire safety incident, which required the partial evacuation of one of the recently fire safety refurbished units, had occurred. The incident resulted in smoke which activated the alarm and required an immediate response from staff.

At the time of inspection there was no evidence to indicate this incident had been investigated and robust measures in place to ensure it did not occur again. Two staff had come from other areas in the campus could not enter the building to assist the partial evacuation as they did not have fobs to activate the doors and allow entry. However, the health and safety officer did assure inspectors that since then, all staff had been issued access fobs. Inspectors were shown documented evidence indicating this
had occurred on 21 December 2016.

On further review of incidents and accidents of the designated centre, inspectors found that follow-up and review of incidents was not adequate. Incidents were logged on an electronic system and reviewed by the person in charge or person participating in the management of the centre.

Reviews however, did not outline any steps taken and incidents were documented as ‘reviewed’ or ‘noted’. This did not demonstrate that there was active learning from adverse incidents in the centre with a view to introducing risk control measures to prevent them from occurring again.

Incidents were not analysed collectively as part of a review of the safety and quality of care for residents in the centre. Each incident was logged and recorded in isolation which meant there was no analysis of trends with regards to the type of incidents occurring in the centre. Therefore recurring risk trends for the centre were not being highlighted resulting in similar types of incidents re-occurring.

Fire procedure notices were on display in both residential units. Actions to be taken in the event of fire were clearly documented. However, the assembly point for one of the residential units referred to the unit that was closed at the time and designated a building site, meaning it was not a suitable assembly point. Notices had not been updated to signpost staff/residents and visitors where they could safely assemble in the event of an evacuation or fire.

Fire procedures for the alternative accommodation were also reviewed by inspectors. Residents’ personal evacuation profiles had been updated to reflect their new residence and staff working in the accommodation had been briefed on procedures for the accommodation.

While there were adequate fire safety measures in place for the alternative accommodation premises, staff spoken with could not adequately outline the steps they would take in the event of the fire alarm sounding. Different responses were given by staff when questioned. There was no designated person for coordinating a fire evacuation procedure of the alternative accommodation. No staff had been delegated this responsibility.

Inspectors attempted to review the risk register for both residential units. However, they were not available in either setting. In one residential unit the risk register folder had blank pages. In the alternative accommodation, while the provider nominee and health and safety officer asserted a full environmental risk analysis had taken place, there were no documents available to review and substantiate this. However, there was evidence that steps had been taken to mitigate risk. For example, a new safe floor surface had been introduced throughout the alternative accommodation and in one of the bedrooms padding and radiator guards had been installed to protect the resident.

Judgment:
Non Compliant - Moderate
Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Not all aspects of this Outcome were reviewed on this inspection.

The provider nominee had introduced a quality/risk assurance system in relation to the use of restraint in the centre whereby all restraints used by residents, such as bedrails or lap belts, should be prescribed and reviewed by a relevant allied health professional, such as an occupational therapist. Previously restraints had not been reviewed or prescribed and there had been a distinct lack of clinical oversight of their use and risk precautions in place.

However, an inspector noted while reviewing a resident’s medication administration documentation that the resident was prescribed chemical restraint for ‘agitation’. There was no associated administration criteria care plan to guide staff. In the absence of this or similar controls there was a potential for an overuse of this type of restraint. While there was no evidence to suggest in the medication administration documentation that the resident had excessively received the medication there was no clear indication for why they might need it other than ‘agitation’. Equally there was no comprehensive documented criteria for when they had received it. Therefore, it was not clear if the least restrictive alternative was used at all times for chemical restraint prescribed for this resident.

A further non-compliance related to this is given in Outcome 9: Notifications.

Steps had been taken by the provider nominee and person in charge to ensure residents staying in the alternative accommodation were safe. A signing-in procedure was in place for all visitors which restricted access to specific personnel and inspectors were required to adhere to this when entering the alternative accommodation. An alarm system was fitted to all access and exit points of the accommodation alerting staff that someone was entering or leaving the accommodation. Staff working in the centre had received mandatory training in safeguarding and the protection of vulnerable adults.
Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

Theme:
Safe Services

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

Findings:
The use of chemical restraint had not been notified to the Chief Inspector in quarterly notifications.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Inspectors reviewed aspects in this Outcome to ascertain if residents that had moved to alternative accommodation were having their health and nutritional needs met.

Arrangements had been put in place to ensure residents had their nutritional needs met. All residents required modified diets. Meals were delivered from the main campus kitchen to the alternative accommodation site. This would ensure residents requiring modified or specific consistency meals received them as per their prescribed nutritional plan and speech and language recommendations.
Other residents received their nutrition by percutaneous endoscopic gastromy (PEG). Inspectors noted there were adequate stores of PEG nutrition and sterile water in the alternative accommodation to meet residents' needs. Small fridges also stored nutritional supplements to provide residents with snacks, for example, between meals.

Some residents required additional hydration which was administered subcutaneously with an electronic pump. The provider had ensured that the electronic pump had been transferred to the alternative accommodation. An inspector observed the electronic pump in a resident's bedroom which had been used the night previously.

An inspector spoke with a dietician during the inspection. They informed the inspector that there were plans to review residents' nutritional needs while they stayed in the alternative accommodation.

While inspectors found evidence of residents' nutritional needs being met, there was no evidence that the temperature of food, after it had been delivered, was checked to ensure it was at the correct temperature before serving. This was important as the transport time from the main campus kitchen to the alternative accommodation site was longer, which could result in residents' meals losing heat during transit.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
There were medication management policies and procedures in place. These had been reviewed on a previous inspection. Inspectors found medication management practices in both residential settings were adequate. However, in the alternative accommodation there were inadequate systems in place to store or manage excess stock or out of date/returned medications.

Photographic identification was available on the drugs charts for each resident. This ensured the correct identity of the resident receiving the medication and reduced the risk of medication errors. The prescription sheets reviewed distinguished between PRN (as needed), short-term and regular medication. The maximum amount of PRN medication to be administered within a 24 hour period was stated on all of the drug charts reviewed.
Suitable storage was also available in both residential settings for medications that required storage refrigeration. Inspectors found medication fridges in both settings. They were locked, temperature checks were carried out daily and up-to-date records were documented of these checks.

Storage of medications in the alternative accommodation was safe in the most part; however, excess stock was kept in an unlocked press in the designated staff room. This was not in line with safe storage procedures for medication kept in a designated centre.

A large paper bag with out-of-date or returned medications was kept in the unlocked press. This was not in line with organisation policies and procedures for the safe management of such medicines and was not in accordance with relevant national legislation or guidance.

**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:**
Overall operational management arrangements in the centre had improved since the previous inspection with the appointment of a new provider nominee in October 2015. He had initiated positive steps towards improving quality and standards of the service provided to residents. For example, he had secured a team of allied health professionals to provide services to residents, which had not been place previously.

While these measures were instigated and overseen by the provider nominee, his tenure was only until 1 March 2016. Inspectors were concerned that there were no definitive arrangements in place for the governance and management of the centre thereafter. There was a tripartite memorandum of understanding in place between the provider, the Health Service Executive and another independent provider organisation. The aim of this document was to support the provider to address concerns raised at previous inspections and to put sustainable governance and management arrangements in place.
There were on-going concerns regarding sustainable governance and management arrangements. Inspectors remained concerned in relation to the provider and board of management’s lack of operational involvement and oversight in relation to governance, operational management and administration of the service.

Inspectors were not satisfied that there were effective structures for communication between the provider nominee and the board of management. Since starting his tenure, the provider nominee had attended one board meeting. In total there had been two board meetings since October 2015 with minutes available for one of those meetings.

There were no formalised procedures in place for reporting to the board of management with regard to the safety and quality of service they were providing to residents in the centre.

Matters of non-compliance identified at previous inspections were discussed with the provider nominee to ascertain if they were being addressed. Inspectors found that a number of positive steps had been taken. They had increased staffing numbers in the service. Residents now had access to a multidisciplinary team of allied health professionals. Care planning had been reviewed and a revised care planning template had been drafted which would ensure residents’ needs were comprehensively assessed and reviewed. Staff would require training in implementing the care plans and this had started at the time of inspection.

A quality management team had also been established along with a multidisciplinary allied health professional team. Both teams met regularly to discuss the safety and quality of care provided to residents in the service. A health and safety officer had also been recently appointed to the service for the oversight of risk-based procedures in the service and a remit for reviewing that they were in place and ensuring quality in their implementation.

The provider nominee had made regular visits to both residential units of the designated centre since commencing his role in October 2015. These visits had also included the alternative accommodation.

On this inspection, inspectors also reviewed the governance and management arrangements for the person in charge of the centre. She had been involved in ensuring safety arrangements were in place for residents relocated to the alternative accommodation. For example, an alarm system was in place on the three exit/entry doors to the alternative accommodation. There was also a robust signing-in and -out procedure for all visitors.

She arranged for her time to be on site in both residential locations during her working shifts. There were adequate arrangements on both sites to ensure the person in charge could access the electronic incident/accident recording system and her email, ensuring she was well informed of any updates with regards to residents’ care.
While there was evidence to indicate operational management of the centre had improved with the provider nominee demonstrating comprehensive oversight arrangements and knowledge of the centre. A major non-compliance was found in this Outcome. This relates to the lack of governance oversight and involvement by the provider in the operational management of the service and arrangements in place to support the provider nominee in carrying out their function.

**Judgment:**
Non Compliant - Major

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**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 centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

There had been considerable budgetary constraints and financial shortfalls for the service provider in December 2015. Some creditors had threatened to remove services, which would have had an impact on residents. An emergency cash fund had been procured which mitigated this; however, the provider nominee said that they remained concerned in relation to their budget and identified that there could be financial difficulties again.

**Judgment:**
Non Compliant - Moderate

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

Findings:
A number of actions were found related to this Outcome on the previous inspection. On this inspection, inspectors did not follow up on them as they were included in the matters as set out in the notice of proposal to refuse registration of the centre.

Inspectors reviewed staffing rosters for both residential settings to ensure residents’ care and welfare needs were being met at that time in relation to staffing numbers. Inspectors also assessed if staff mandatory training needs had been met since the previous inspection.

The provider nominee had increased the staffing numbers within the whole service since commencing his tenure in October 2015. There was evidence to indicate there were adequate numbers of staff allocated to both day and night shifts to meet the needs of residents in both residential settings. The provider had increased the staffing numbers in the alternative accommodation with due regard to the different environmental arrangements which would be in place for a number of weeks.

Inspectors were satisfied that the staffing/resident ratio, as documented on the planned and actual rota for the alternative accommodation, could meet residents’ care and welfare needs during their stay.

A staff training matrix reviewed by inspectors indicated gaps in staff mandatory training; however, training had occurred but the matrix had not been updated to reflect this. On further review, inspectors were subsequently assured that the provider nominee had provided all staff working in the centre with appropriate mandatory training.

Judgment:
Compliant
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:

Ann-Marie O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

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<td>14 January 2016</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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:

The showering/toilet facilities for residents in the unit were inadequate and due to their configuration could not meet the privacy and dignity needs of residents.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
One room, which was designated as a staff room, was also the location of one of the en-suites which had been adapted to support bathing and showering of residents. This arrangement did not meet the privacy needs for residents.

1. **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:**
Extra room booked from hotel to facilitate staff breaks, this was done on day of inspection.

The bathroom in the unit has been assessed by our architect and is scheduled for reconfiguration to ensure the privacy and dignity of residents. Funding for same is currently being sought.

**Proposed Timescale:** 30/04/2016

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was not located in the alternative accommodation in a prominent location, therefore residents, representatives and visitors were not adequately informed of the procedures in place if they wished to make a complaint.

2. **Action Required:**
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
Complaints procedure notice now prominently displayed on entrance to accommodation.

**Proposed Timescale:** 18/01/2016

**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:
Inspectors found there were inadequate care planning arrangements in place for a resident who presented with a behaviour which could result in serious self injury. The resident living in the alternative accommodation did not have a care plan to guide staff
in how to manage their specific needs with reference to their new residential setting.

### 3. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

**Please state the actions you have taken or are planning to take:**
Pica guidelines and care plan updated to support and reflect the new environment.

**Proposed Timescale:** 15/01/2016

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#### 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:**
Inspectors attempted to review the risk register for both residential units; however, they were not available in either setting.

Incident reviews did not outline any steps and incidents were only ‘reviewed’ or ‘noted’. This did not demonstrate that there was active learning from adverse incidents in the centre with a view to introducing risk control measures to prevent them from occurring again.

Incidents were not analysed collectively as part of a review of the safety and quality of care for residents in the centre. Each incident was logged and recorded in isolation which meant there was no analysis of trends with regards to the type of incidents occurring in the centre.

### 4. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
All Accident/Incident forms will be reviewed by the Health & Safety Officer. The H&S Officer will provide an A/I update report for the regular SMT meeting. Reports re the trends of Accidents/Incidents are recorded on the IT system. These trends will then be analysed/discussed at management meetings and recommendations and actions agreed. Once implemented all recommendations/actions will be reviewed monthly for at least 3 months.

**Proposed Timescale:** 31/03/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assembly point for one of the residential units referred to the unit that was closed at the time of inspection and designated a building site, meaning that it was not a suitable assembly point. Notices had not been updated to signpost staff/residents and visitors where they could safely assemble in the event of an evacuation or fire.

5. 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:
Notices to show new assembly point are displayed

Proposed Timescale: 15/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff spoken with in the alternative accommodation could not adequately outline the steps they would take in the event of the fire alarm sounding with different responses given by staff when questioned.

A designated person for coordinating a fire evacuation procedure of the alternative accommodation was not in place. No staff were delegated this responsibility.

6. 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:
Staff delegated with fire duties daily.

Staff training in relation to fire evacuation completed in alternative accommodation.

Proposed Timescale: 18/01/2016
### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A resident was prescribed chemical restraint for 'agitation'. There was no associated administration criteria care plan in place which, without this could lead to an overuse of this type of restraint.

7. **Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
- Review by GP on 11/02/16 recommended continued use of this medication.
- Medication prescribed also reviewed by psychiatrist on 15/02/16. Decision made to continue use of prescribed medication only after a series of other strategies have been tried to include the following:
  - Create a quiet area
  - Listen to gentle music/ ocean sounds
  - Offer to go out for a drive
- These alternatives tend to address the service user’s distress, if these fail only then should the use of PRN medication be contemplated.
- The use of PRN medications was discussed at MDT meeting on 15th Feb with the decision that a working group is to be formed to examine new protocols around the use of PRN strategies.

**Proposed Timescale:** 11/02/2016

### 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:**
An unplanned evacuation of the centre was not notified to the Chief Inspection within three working days of the event.

8. **Action Required:**
Under Regulation 31 (1) (c) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.
Please state the actions you have taken or are planning to take:
Staff briefed on the importance of submitting notifications within the specified timeframe. A notification is to be prepared by the senior person on a shift when a notifiable event occurs and sent to PIC / director of services for review

**Proposed Timescale:** 11/02/2016  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
The use of chemical restraint had not been notified to the Chief Inspector in quarterly notifications.

9. **Action Required:**  
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:  
Full review of all chemical restraints underway with MDT. Updated list will be notified to chief inspector in quarterly notifications. Next quarterly review due by end April 16

**Proposed Timescale:** 15/02/2016

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There was no evidence that the temperature of food, after it had been delivered, was checked to ensure it was at the correct temperature before serving.

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

Please state the actions you have taken or are planning to take:  
Correct protocols (in alternative accommodation) now in place in relation to food safety as per policy.

**Proposed Timescale:** 16/01/2016
<table>
<thead>
<tr>
<th><strong>Outcome 12. Medication Management</strong></th>
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<td><strong>Theme:</strong> Health and Development</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Excess stock was kept in an unlocked press in the designated staff room; this was not in line with safe storage procedures for medication kept in a designated centre.

11. **Action Required:**
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
All medication now stored in locked press in office area. This press is kept locked at all times. All service users’ medication is kept in their individual boxes in locked trollies. Excess stock is stored in a locked press. This is kept locked and the nurse on duty carries the key. Any returns for pharmacy are in designated container and return monthly or more often if necessary.

**Proposed Timescale:** 14/01/2016

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<th><strong>Proposed Timescale:</strong> 14/01/2016</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Health and Development</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A large paper bag with out-of-date or returned medications was kept in the unlocked press. This was not in line with organisation policies and procedures for the safe management of such medicines and was not in accordance with relevant national legislation or guidance.

12. **Action Required:**
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

Please state the actions you have taken or are planning to take:
Correct returns container received from pharmacy for storage of out of date or returns medication.

**Proposed Timescale:** 15/01/2016
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:
There was a lack of governance oversight and involvement by the provider in the operational management of the service and poor arrangements in place to support the provider nominee in carrying out their function.

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

Please state the actions you have taken or are planning to take:
1. The Provider nominee has regular and frequent communications – telephone / email and meetings with the Chair of the BOM particularly since the beginning of 2016.
2. There are weekly monitoring meetings with the HSE in addition to regular and frequent operational contacts.
3. The Provider nominee has proposed an Agreement in Principle (AIP) to the HSE to provide clarity and confidence to the role as well as both complementing and supplementing the existing MOU.
4. The Provider Nominee continues and will continue to raise current and emerging matters of concern with the BOM, the HSE and the local service provider (involved in the existing MOU).

Proposed Timescale: 25/02/2016

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

14. 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:
1. Negotiations/Consultations commenced on 11/1/16 with the HSE in relation to the Service Level Agreement for 2016. The Operational Management Team will be making the case strongly for a significant uplift in the annual budget.
2. The Provider Nominee will not be recommending to the BOM to ‘sign off’ on a budget that does not adequately fund the proposed operations of St Patrick's for 2016.

**Proposed Timescale:** 25/02/2016