### Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Deansgate Services Centre</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003500</td>
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<td>Centre county:</td>
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<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>David Kieran</td>
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<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O’Neill</td>
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<tr>
<td>Support inspector(s):</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
• to monitor compliance with regulations and standards
• following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
• arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 07 December 2016 12:30
To: 07 December 2016 21:15

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

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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 11. Healthcare Needs</td>
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<td>Outcome 16: Use of Resources</td>
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Summary of findings from this inspection
Background to Inspection.
This inspection was unannounced and took place over one day. The purpose of the inspection was to assess ongoing compliance in the centre and the provider’s governance and management of the centre which forms part of St. Patrick’s Centre, Kilkenny. The previous 2015 inspection of this centre have found good levels of compliance across a range of outcomes.

In May 2016 a new board of management had been appointed to St. Patrick’s Centre, Kilkenny. The board had been in place six months at the time of the inspection. The provider had been given a six month time frame to bring about substantial improvements within the overall service in order to demonstrate to the Chief Inspector their fitness to carry on their role as provider of the service.

The aim of this inspection was to follow-up on actions given in the previous inspection and to assess if the quality and safety of care had improved.

How we Gathered Evidence.
As part of the inspection, the inspector met with all residents and staff in the designated centre, the newly appointed team leader for the designated centre, a
recently appointed project coordinator, the quality and compliance manager and a member of the practice development team for the service. The inspector also met and spoke with parents of a resident in the services.

The inspector spoke to all residents they met during the inspection taking guidance from staff as to the particular way in which residents liked to interact. The inspector respected residents’ wishes at all times in their interactions with residents and took their lead in how they wished to converse with the inspector or participate in the inspection. The inspector also observed residents’ interactions with staff, their peers and their environment.

The inspector reviewed documentation such as personal plans, risk assessments, and assessment of needs, audits and minutes of board of management meetings, change management meetings, sub-committee meetings and training needs analysis for the centre.

Description of the Service.
This designated centre is a detached bungalow located in a suburban area and home to five adult residents with varying degrees of intellectual and sensory disabilities. This designated centre is the only community residential home operated by St. Patrick’s Centre, Kilkenny services.

Overall Judgment of our Findings.
The inspector found compliance had been maintained in most outcomes inspected with some improvements found in relation to governance and management of the centre and staff training and supervision provision. These improvements had been brought about by the appointment of key posts and ongoing governance meetings.

The provider had appointed two project coordinators, four community connectors and a staff training coordinator to drive improvements within the service. Improvements could be noted in the quality and standard of residents’ assessments of needs which had been completed by their allocated key workers.

The provider had also instigated plans to reduce institutional practices with regards to meal provision to all residents attending day services within St. Patrick’s Centre, Kilkenny. Residents would no longer receive their meals in the day service from a centralised kitchen and would now have their main meals cooked in their homes, i.e. the designated centre.

However, staff were concerned that there was inadequate budgeting and resourcing of the centre to adapt to these changes. The inspector did not find evidence that this was the case on this inspection. The inspector requested assurances from the provider and director of services that they were reviewing this and ensuring adequate resourcing for the centre to accommodate the positive changes they were implementing from a service perspective. This is further elaborated in Outcome 16 of this inspection report.

Overall, the inspector found good compliance on this inspection. One outcome met with moderate non compliance, Outcome 5; Social Care Needs. This related to
inadequate support planning evidenced in residents’ personal plans. Otherwise, all outcomes inspected met with compliance or substantial compliance on this inspection.

These findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end of the report.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

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

The inspector reviewed the actions from the previous inspection report in 2015 to assess if non compliances relating to management of residents' finances had been addressed. Overall, the inspector found there were improved financial management systems in place for residents. There were greater transparency measures in place which would ensure residents' monies were appropriately audited, recorded and accounted for. Since the previous inspection staff had attempted to support residents to secure their own personal bank accounts in their name.

This however, had proven difficult as some financial institutions would not agree to open a bank account for residents. A formal capacity assessment, by an appropriately qualified allied professional had not been carried out for residents to support them in accessing the services of financial institutions.

In these instances residents' finances were managed in a separate fund where each resident had a specific itemised statement issued to them each quarter indicating the money they had allocated to them and what expenditures occurred. These statements were maintained in residents' personal files and available for auditing purposes when required.

There were plans to introduce a monthly manager's audit of expenditure where each resident's monies would be audited and cross checked with ledgers and receipts.
maintained. This would ensure greater oversight and governance of residents’ monies ensuring safeguarding practices.

Judgment:
Substantially Compliant

**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):**
No actions were required from the previous inspection.

**Findings:**
This inspection found there were improvements with regards to the assessment and identification of residents’ social care needs. There was evidence to indicate allied health professional assessments of residents were taking place.

The inspector reviewed a sample of residents’ personal plans. Of the plans reviewed there was evidence that an assessment of residents’ social care needs were being implemented which were identifying residents’ specific needs and providing comprehensive person centred detail.

However, residents’ personal plan information was still located in numerous folders and files. For example, each resident had a daily observation folder, medical file and personal plan file. Information pertaining to residents was difficult to retrieve and in some instances the information provided was not clear.

All residents were now receiving a full allied health professional assessment from which their specific social care needs could be identified. This was bolstered by the assessment of needs residents’ key workers were implementing.

However, while residents' assessments of need were comprehensive there was inadequate support planning measures in place to manage or support the needs identified for residents. For example, in one instance where an identified need indicated a resident required supports for sensory processing no support plan or recommendations were in place to support that need. In other instances where a support need was identified for mealtimes and compromised swallow there was no
reference made to recommendations by the speech and language therapist, an allied health professional with specific expertise in the management of this social care need.

**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

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

**Findings:**

The systems to promote the health and safety of residents had improved since the previous inspection of the centre.

As was found on the previous inspection the systems for the review of accidents and incidents and identification of personal risks to residents had improved in the overall organisation. There were plans in place to introduce an electronic documentation system of incidents for the overall St. Patrick’s Centre, Kilkenny designated centres which could be accessed by all staff for the recording of incidents.

Personal risk assessments were in place for residents. While they had been carried out for risks identified, they presented as a confusing document with most of its content instructions for how it was to be completed leaving the reader unclear as to the actual risk posed to the resident or the control measures in place to address the risk. Staff spoken with confirmed that they found the document confusing and unclear. Personal risk assessments did not adequately set out in a clear way the control measures that were in place to prevent risks to residents.

Fire safety systems required some improvements. The fire alarm for the centre had received an up-to-date service and was functional. Each resident had a personal evacuation plan in place setting out the key supports they would require in the event of an evacuation. Fire drills had been carried out at least twice yearly as required by the regulations. However, keys were used in many of the fire evacuation doors of the centre, while a box with a spare key was located beside the doors this practice required review to ensure residents could evacuate the centre in the event of an emergency as independently as possible. There were no risk assessments in place to substantiate the use of keys in all evacuation doors in the centre. A tender of works for improvement of fire safety measures in the centre had been drafted and upgrading works were due to be carried out in the centre in the first quarter of 2017.

Infection control systems in the centre were adequate given the purpose and function of
the centre. Residents, visitors and staff had access to hand washing facilities which were supplied with adequate hand soap and hand drying facilities. Colour coded chopping boards were supplied in the centre to promote safe food safety practices.

A recent audit of the centre had identified there was a lack of cleanliness in the centre and actions had been given following the audit for a cleaning schedule to be implemented. This appeared to be working as the inspector found the premises to be visibly clean and hygienic the day of inspection.

No residents required the supports or use of a hoist. However, all staff had received up-to-date manual handling training.

Judgment:
Substantially Compliant

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

Findings:
The inspector reviewed if the actions from the previous inspection had been addressed.

The previous inspection had found inadequate training for all staff in the areas of vulnerable adult safeguarding training and also in the area of management and response to behaviours that challenge. On this inspection the inspector noted all staff had received training in both these areas. The actions had been adequately addressed.

Training in key mandatory areas such as vulnerable adults safeguarding and behaviours that challenge would be managed and kept under review by the newly appointed training co-ordinator for the service. This would ensure all staff would receive refresher training as required.

The inspector noted there were some restrictions in place in the centre such as locked exit doors. This is referred to in Outcome 7 with regards to evacuation doors to the centre being locked. There were inadequate risk assessments and restraint reviews for this practice despite staff indicating the necessity for same as a result of residents at risk
of absconding. An action for this is given in Outcome 7.

**Judgment:**
Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**
Health and Development

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

**Findings:**
Overall, the inspector found there were appropriate practices in place in the centre which would ensure residents had access to appropriate healthcare to ensure their best possible health.

Residents’ personal plans provided evidence that residents were receiving assessment and review by allied health professionals as they required. Residents were supported to attend dental checkups and receive treatment when required.

Speech and language recommendations for residents were in place with all residents living in the centre requiring support with regards to modified consistency meals and compromised swallow which could lead to a risk of choking.

Residents attended their own General Practitioner (GP) in the community and were supported to attend all medical appointments by staff.

Food hygiene audits had been carried out recently with recommendations made following the audits which would ensure greater food safety and hygiene practices in the centre.

Residents’ weights were recorded regularly and healthy eating was encouraged in the centre. The fridges and cupboards were adequately stocked with foods and condiments for the preparation of meals and snacks for residents as required.

The inspector noted in recent months the provider had implemented actions to stop the institutional practice of centralised meal provision for residents across St. Patrick’s Centre, Kilkenny designated centres in an attempt to provide residents the opportunity to experience meals being prepared and cooked in their homes similar to their peers. However, staff had some concerns. This is further elaborated on in Outcome 16: Resources.
Judgment:
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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Since the previous inspection the provider had implemented a medication management improvement initiative which would bring about further improvements and ensure overall safety of medication management within St. Patrick’s Centre, Kilkenny services.

A project leader for practice development of medication management practices had been appointed since the previous inspection. They had instigated a number of initiatives within the service and the designated centre discussed in this report.

The quality and compliance manager and project leader had carried out medication management audits across a number of designated centres within St. Patrick’s Centre, Kilkenny. These audits were thorough and detailed and had brought about a number of improvements and changes with regards to medication management systems within the designated centre referred to in this report.

A local pharmacist had been contacted and would now supply medications to the designated centre in a pre-packed medication dispensing system. This would reduce the amount of medications stocked in the centre and reduce the risk of medication errors. This change over process was underway at the time of the inspection and was co-ordinated by the medication management project manager. This change in dispensing of medication practice would also include a revised easier to use medication administration and documentation chart for staff to complete.

The medication management policy for St. Patrick’s Centre, Kilkenny had also been reviewed and changes made to ensure it reflected up-to-date safe medication management practices and procedures.

Some improvements in the policy included the revised management of medication errors and the documentation of such errors which included a root cause analysis which would be carried out by the person in charge, for example to ascertain why the error may have occurred and the systematic changes required to improve practice following an error made.
Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
Previous inspections of St. Patrick's Centre, Kilkenny found systems of governance and management were not sufficient to ensure residents received a safe service and quality care. On this follow-up inspection, it was found the provider had instigated a significant suite of improvements across a wide range of areas. These improvements were recognised and identified by the inspector as pivotal in bringing about the significantly improved levels of compliance found on this inspection.

The provider had implemented significantly improved procedures for monitoring the quality of care provided to residents. Systems were in place to gather and analyse information which could be used to validate the quality and safety of care provided to residents. As a result, improved outcomes were observed for residents, as outlined in Outcome 1 (Rights, Dignity and Consultation), Outcome 5 (Social Care Needs), Outcome 8 (Safeguarding and Safety), Outcome 11 Healthcare needs and Outcome 12 Medication Management, for example.

Unannounced visits and audits by the provider, which are a requirement under Regulation 23, to gather information and assess the quality and safety of care had been carried out since the previous inspection. The most recent carried out by the provider nominee and director of services dated October 2016. This audit had identified a number of key areas that required improvements, for example, inadequate premises, social care planning and documentation and inadequate shift planning for staff when they reported for duty in the designated centre.

Systems to assess the quality and safety of care at the centre level had improved greatly since the previous inspection with the appointment of a quality and compliance manager, the appointment of key project co-ordinators with responsibility for assessing and supporting the implementation of actions identified in audits carried out and another project co-ordinator in the area of medication management and healthcare.
improvements and practice development in the service.

Each project manager was required to report to the Board of Directors for St. Patrick’s Centre, Kilkenny and update them on their progress in implementing improvements within the service. These updates were evidenced in the minutes of the Board of Management meetings which were provided to the inspector for review during the inspection.

As was identified on the previous inspection improved systems in place to review accidents and incident reports in order to improve safety arrangements for residents were ongoing. Incidents/accidents and risk were now a fixed agenda item on the newly established quality and safety committee.

Another sub-committee that reported to the Board of Management for the service was the quality and compliance committee. They met at least monthly to discuss actions set from the previous meetings, review current system changes that had been implemented and revise if required and provide a report for the Board of Management following each meeting.

Board of Management meetings were occurred at least monthly and the inspector noted an urgent Board of Management meeting had occurred following a meeting the deputy chairperson and provider nominee had attended in the Health Information and Quality Authority Dublin office in October 2016. The Board of Management meeting had discussed plans to address HIQA’s concerns with regards to the provider’s progress in demonstrating improvements within the six month timeframe which had been set by the Authority and was due to cease the end of November 2016. The Board of Management meeting set specific actions which included the appointment of key stakeholders with responsibilities for driving improvements within the service.

Overall, the inspector found significant improvements had occurred and these improvements had been brought about by the appointment of these key stakeholders and governance meetings. These included the appointment of project co-ordinators, community connectors, the appointment of a staff training co-ordinator, improved focused auditing, sub-committee teams and meetings and the regular change management meetings whose focus was to ensure system change was communicated to managers within the service supporting them to implement system changes on the ground which would ultimately improve outcomes for residents.

The inspector was assured the provider had implemented significant improvements and demonstrated a more compliant, comprehensive and robust management of the service focused on improvements in quality and compliance across a wide range of areas which in turn would bring about improved outcomes for residents which were already evident on the day of inspection.

The provider was required to continue with these improvements.

Judgment:
Compliant
Outcome 16: Use of Resources

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

Theme:
Use of Resources

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

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

The inspector did not note that there were resource issues which were impacting on residents on this unannounced inspection. The centre was adequately heated, there was a good supply of food in the centre and the centre appeared to be adequately staffed for both day and night. For example, two staff were allocated in the evening for five residents. Two waking night staff were allocated to the centre for the five residents.

At the close of the inspection, however, staff informed the inspector of changes that had been implemented by the provider in relation to day service meal provision for residents. The changes introduced meant residents would now have their dinner cooked in their home, rather than receiving their dinner in the day service from the centralised kitchen.

Staff were concerned this change may result in an inadequate resource of staffing to accommodate the cooking of residents' meals in the designated centre and also the food budget for the centre may also not be adequate to meet the changes.

The inspector spoke with the provider nominee and director of services at the close of the inspection and informed them of staffs' concerns. The provider and newly appointed person in charge were required to review the budget and resource management of the centre to ensure the needs of the residents were being provided for in light of the changes recently made to their day service.

Judgment:
Substantially Compliant

Outcome 17: Workforce

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

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

**Findings:**
The inspector found there had been a number of improvements implemented by the provider to ensure staff were appropriately trained to support residents' needs. Systems for supervision of staff would also improve with the recent appointment of a full-time person in charge for the centre. A key worker system had been implemented since the previous inspection.

Since the previous inspection the provider had appointed a staff training co-ordinator for St. Patrick's Centre, Kilkenny. Prior to their appointment there had been no person specifically appointed with this remit. This had resulted in an uncoordinated system of staff training and non-compliances found on a number of inspection reports for St. Patrick's Centre, Kilkenny with regards to inadequate training of staff to meet residents' assessed needs.

The inspector met with the newly appointed staff training co-ordinator during an inspection of another designated centre, within the organisation, the day previous. The co-ordinator had started their role in July 2016 and had audited staff training for all designated centres comprising St. Patrick's Centre, Kilkenny services. She had also compiled a training needs analysis for staff working with each designated centre and also for each residential unit that comprised the designated centres in the service.

From this training needs analysis the staff training co-ordinator had established a comprehensive staff training schedule with a schedule devised for the rest of 2016 and for 2017.

Staff training records for the designated centre were easily retrievable on the day of inspection. There were gaps in training that the co-ordinator had identified and had scheduled training dates for staff to attend. The person in charge was responsible for ensuring staff attended the training dates scheduled by arranging staff rosters accordingly and communicating with staff with regards to the training.

An initiative which had been implemented since the previous inspection was key worker training. This had brought about a significant improvement in the overall quality of personal planning and quality of life improvements for residents. All staff working in the service would be required to undergo key worker training. The inspector noted residents’ assessment of needs which had been carried out by their key workers were done to a good standard and included detailed person centred information.

The training comprised how to carry an assessment of need for residents, the development of personal planning for residents, the type of detail required in personal planning. The training also included topics such as social role valorization, residents’ rights, management of residents’ finances and other topics.
The recently appointed full time person in charge for the centre was also an improvement in the governance and supervision of the centre since the previous inspection. This would ensure all staff received appropriate supervision and guidance from a full-time appointed manager for the centre.

**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
Provider’s response to inspection report

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<td>Centre ID:</td>
<td>OSV-0003500</td>
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<td>Date of Inspection:</td>
<td>07 December 2016</td>
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<td>Date of response:</td>
<td>02 February 2017</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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A formal capacity assessment, by an appropriately qualified allied professional had not been carried out for residents to support them in accessing the services of financial institutions.

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 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:
- A formal capacity assessment was completed in 2015 with all residents. This assessment tool has been developed by the Finance Manager, Operations Manager and the Quality Manager (attached) and will be completed with all residents in the centre.
- Capacity assessments will be conducted by the PIC and an Independent Advocate.
- Residents will be supported by staff to attend finance department to manage their financial affairs and access to private funds. This recommenced 25/01/17

Proposed Timescale: 03/02/2017

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:
While residents' assessments of need were comprehensive there were inadequate support planning measures in place to manage or support the needs identified for residents.

2. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
- Recommendations arising out of each personal plan will be reviewed to ensure all identified support needs have corresponding care or support plans in place and that they are reviewed in accordance with agreed timeframes.
- Each resident will have a “picture” timetable which clearly identifies their weekly schedule and the support they require to complete same.
- The daily shift planner will identify each day who is responsible for ensuring residents are supported to attend planned activities.
- Personal Plans will be reviewed quarterly or sooner if required.
- Sampling of new experiences being introduced and implemented.
- Community involvement being encouraged daily in line with social role valorisation principles.

Proposed Timescale: 28/02/2017

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:**
Personal risk assessments did not adequately set out in a clear way the control measures that were in place to prevent risks to residents.

3. **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:**
- Risk Management Policy has recently been reviewed and updated and now reflects matters as set out in Regulation 26 (e).
- Centre specific risk assessments are currently being conducted and will be included in the risk register when completed. The current risk assessment form and process has been revised which has made it more user friendly and now sets out in a clear way the control measures that are in place to prevent risks to residents.
- New Electronic Incident Reporting System will be piloted in the centre in the coming weeks and expected to be fully operational by the end of February.

**Proposed Timescale:** 28/02/2017

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**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no risk assessments in place to substantiate the use of keys in all evacuation doors in the centre.

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

**Please state the actions you have taken or are planning to take:**
- Risk assessments in relation to the use of keys in evacuation doors have been completed (attached). The additional control’s introduced as a result is to issue keys for all evacuation doors to all staff who must keep them on their person while on duty. Risk Assessments are ongoing to determine whether keys will be issued to all residents.

**Proposed Timescale:** 04/02/2017
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 provider and newly appointed person in charge were required to review the budget and resource management of the centre to ensure the needs of the residents were being provided for in light of the changes recently made to their day service.

5. 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:
• PIC completed food audit (9/12/16). The audit identified that there was substantial food stores present in the centre (attached).
• Finance Manager and PIC audited (8/12/16) budgets and household requirements. Receipts for the previous 3 months (when the lunchtime meal arrangements were changed) were reviewed which confirmed that the weekly household budget of €375 was adequate (attached). However, the review highlighted that too much was being spent on snacks, treats and ready meals. This is currently being addressed by the PIC.
• The PIC conducts a monthly financial audit and signs off on same. Any issues concerns are raised with the Finance Manager and/or Director of Services.
• PIC met with senior management (14/12/16) to review staffing levels and we are satisfied that the centre is adequately resourced to ensure the effective delivery of care and support as outlined in the Statement of Purpose. In particular, we reviewed the needs of the residents and the staffing levels required to meet those needs. While we are satisfied that a ratio of 2 staff to 5 residents is adequate we believe we can manage our staffing resources better. As a result, we have developed a new “Responsive Roster” for the centre (attached) which will see staff working shorter but more frequent shifts*. This coupled with the reconfiguration of night time staffing levels will see 3 staff on duty at varying times throughout the week which will enable staff to support residents to access community facilities etc far more frequently.
• *Please note that this new responsive roster is subject to negotiation with the respective unions.

Proposed Timescale: 14/12/2016