

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Dinan Lodge
<b>Centre ID:</b>	OSV-0005621
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Saint Patricks Centre (Kilkenny)
<b>Provider Nominee:</b>	David Kieran
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	0
<b>Number of vacancies on the date of inspection:</b>	4

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

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

From: 12 April 2017 10:00 To: 12 April 2017 19:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to Inspection.

This inspection was an announced new build registration inspection that took place over one day. The provider had applied to register a new designated centre for four adult male residents who would move from St. Patrick's congregated setting into a community residential dwelling as part of St. Patrick's de-congregation plan.

In May 2016 a new board of management had been appointed to St. Patrick's Centre, Kilkenny. The board had been in place 10 months at the time of this inspection. In May 2016 the newly configured provider entity was 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.

An intensive regulatory monitoring schedule was carried out of all designated centres comprising St. Patrick's Centre, Kilkenny following the six month period to assess if the provider had brought about improvements. Inspections carried out in November and December 2016 found evidence that significant improvements had occurred in all centres inspected.

The purpose of this inspection was to inspect the proposed designated centre and assess if the centre would be suitable to meet the needs of the proposed residents and to also assess that the provider and person in charge could meet their needs to a good standard in compliance with the Regulations.

#### How we Gathered Evidence.

As part of the inspection, the inspector met with proposed person in charge of the designated centre and nominated persons participating in management of the centre, the quality and compliance manager and the training manager for St. Patrick's Centre.

The inspector reviewed documentation such as personal plans, risk assessments, behaviour support plans, minutes of board of management meetings and reports from the Director of Services and project co-ordinators to the Board. The inspector also carried out an observational review of the premises with the Health and Safety Manager for St. Patrick's and a fire safety engineer who had also carried out an inspection of the premises and advised a schedule of works which were underway during the inspection.

#### Description of the Service.

The centre comprised of one large detached house, referred to in the report as the designated centre. The centre is located a short drive from Jenkinstown, County Kilkenny. The provider had ensured residents would have access to a range of local amenities such as shops, churches, restaurants, pubs, barbers, hairdressers. The centre could accommodate four adult residents with varying degrees of intellectual disability and specific support needs in the management of healthcare, nutritional management, epilepsy, behaviours that challenge and Pica, a condition characterised by an appetite for substances that are non food items.

#### Overall Judgment of our Findings.

Compliance was found in most outcomes inspected. Of the 10 outcomes inspected 7 met with compliance, three outcomes met with substantial compliance.

The provider was required to implement a review of risk management systems for the centre to ensure management of specific personal risks for residents would be robust to manage specific personal risks for some residents.

The provider had also not demonstrated at the time of inspection that they had carried out a review of restrictive practices that would be required in the centre when residents moved in to ensure they were the least restrictive and would be reviewed regularly in line with the Organisation's restraint management policy and procedures.

The statement of purpose required review to ensure it met the matters as set out in Schedule 1 of the Regulations.

The Action Plan at the end of the report identifies 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 (as amended) 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 04: Admissions and Contract for the Provision of Services**

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

**Theme:**

Effective Services

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

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

**Findings:**

New contracts of care had been devised since the previous inspection. The new contracts reflected changes in residents' fees in light of changes in long stay charges.

These contracts would be signed by residents and their representatives when they moved into the centre.

**Judgment:**

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):**

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

**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 and support planning to implement recommendations was evidence in residents' personal plans. Residents had identified goals set and there was evidence of goal reviews being carried out by residents' key workers.

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.

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.

The person in charge informed the inspector that residents' personal plans, including assessments of needs and person centred support planning would be updated by residents' key workers when they moved into the new designated centre to reflect their new living circumstances and reflect any changes.

Person centred goal setting had also begun and there was evidence to indicate a person centred planning meeting had been carried out with residents and goals identified with reviews of goals carried out and updating of action plans to achieve them.

Transition plans were in place and would be used to support residents in transitioning to their new home. These plans included a booklet with photographs and easy read formats for residents to use with their key worker in helping them to understand their transition to their new home.

Community transition co-ordinators identified for residents proposed to move into the centre had carried out detailed transition plan assessments of residents and the needs and supports they would require when they moved into their new home. These were of a good standard and included principles of social role valorization and person centred planning assessments across a range of areas.

**Judgment:**

Compliant

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The centre comprised of a large, detached house located just outside Jenkinstown, County Kilkenny. The premises and facilities within the centre would provide for residents in line with the statement of purpose to a good standard. The boiler for the centre would require a service before residents moved in.

At the time of inspection the centre was undergoing a suite of upgrading refurbishment works to the centre prior to the proposed residents moving into the centre. The inspectors viewed the premises during the inspection and noted that most of these works had been completed or were in the process of being completed to a good standard. A completion date was set for all refurbishment and fire safety works to be completed 19 April 2017..

The centre contained two bathing/showering and toileting facilities all of which were undergoing an upgrade which would provide residents with aids, appliances and accessibility to meet their assessed needs. One shower area was to be converted to a 'wet room' which would provide residents with accessibility and promote independence during bathing.

The inspector viewed intended residents' bedrooms during the inspection. Residents would each have their own bedrooms each fitted out with room for storage of personal items and space to engage in personal activities. Bedroom would be decorated to the taste and personal preference of each resident. Bedrooms had already been painted with a tasteful colour which was age appropriate and in line with residents' personal preferences.

The centre also had a well equipped and spacious kitchen and dining space. Laundry facilities were available in a specific utility room equipped with a washing machine, dryer and space to store laundry products and manage soiled and clean laundry. There would also be suitable arrangements in place for the safe disposal of general waste for the centre.

The external premises were well maintained with ample parking to the front and side of the property. Residents had access to a pleasant back garden which was secured to meet the risk management needs of residents. The external premises also contained a large shed which contained the boiler for the centre. The inspector was advised by the health and safety officer that this shed would be locked at all times and only accessible to staff or maintenance personnel as it contained some structures and equipment that would not be safe for residents to access.

Maintenance records would be maintained in the centre detailing servicing of equipment in the centre and ongoing maintenance works where necessary. The boiler for the centre would require servicing prior to residents moving in. The provider advised the inspector that this was factored in as part of the process for preparing the centre prior to residents moving in.



**Judgment:**

Substantially Compliant

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

The health and safety of residents, visitors and staff would be promoted in the centre following completion of fire safety works which were underway at the time of inspection. While there was evidence that appropriate risk management systems would be in place the provider was required to review their systems for the management of personal risks to residents that presented with Pica.

The risk management policy met the requirements of the Regulations and would be implemented throughout the centre and cover the matters set out in Regulation 26 including identification and management of risks, the measures in place to control identified risks and arrangements for identification, recording, investigation and learning from serious incidents.

A health and safety statement would be drawn up when refurbishment and fire safety works were completed which address areas of health and safety including accidents and incidents, fire management plans, training needs, servicing of fire equipment, and identification of risks.

A risk register for the centre was in the process of being drafted, it would be finalised when the fire safety and refurbishment works were completed. It would incorporate identification of personal risks for residents and other measures for the management of risks for example, chemicals, cleaning products, medication storage, road awareness and safety, hazards in the external premises management and prevention of risk of poisoning or choking, risk of scalds.

Personal risks for residents had been identified and were analysed with control measures in place to mitigate risks. These risk assessments were maintained in residents' personal plans and referred to their current living arrangement. However, at the time of inspection the provider had not carried out a robust and thorough risk assessment of this new designated centre in order to manage the personal risks for residents that presented with pica, a condition characterised by an appetite for substances that are non food items. This was required prior to residents moving into the centre.

The fire policy and procedures available on the day of inspection were centre-specific and up to date. Fire safety plans were reviewed by the inspector and found to be comprehensive. These were to be placed at key locations in the centre. Regular fire drills would take place and staff would carry out a fire evacuation 'dummy run' prior to residents moving into the house and a further drill following their arrival to the house. Subsequently, fire evacuation drills would be carried out at least quarterly.

Individual personal evacuation management plans were documented for residents and would be further reviewed on their move to the centre to reflect centre specific guidelines for staff and residents.

Fire evacuation doors would be fitted with a thumb turn mechanism and the inspector noted this was the case for fire exit doors that had already been installed. This would ensure residents, staff and visitors could evacuate from the premises without the necessity of a key but still ensuring that the premises was secure. It had been identified that the front door of the premises would require a wider door for evacuation purposes. This was factored in as part of fire safety works for the centre. This door would remain locked to provide for residents' personal safety but would be fitted with a mechanism that could be used to evacuate the premises quickly in the event of a fire.

The premises had been fitted with emergency lighting and a new fire alarm with connected smoke and fire detectors at key locations in the building. Fire extinguishers would also be placed at strategic points in the premises.

The inspector noted the presence of smoke seals on all doors in the centre. All doors in the premises also appeared to be heavy set fire compliant doors. This promoted good fire containment measures in the centre. Some doors had been identified as requiring stay open devices to allow residents easy movement throughout their home but in line with fire compliance guidelines. All fire safety works were due for completion by 19 April 2017.

There was a policy on infection control available. Cleaning schedules were in place and would be completed by staff on an on-going basis. Hand washing facilities in the centre were adequate. Hand wash and drying facilities would be available to promote good hand hygiene. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces.

Safe and appropriate practices in relation to manual handling were in place. All staff had attended up to date 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):**

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

**Findings:**

The inspector noted there had been an improvement in the quality of behaviour support planning for residents that would move into the centre.

Behaviour supporting planning now set out information with regards to potential triggers which may cause a resident to engage in behaviours that challenge. The environment within which residents were living in on the campus of St. Patrick's Centre had been identified as contributing to residents engaging in behaviours that challenge.

A move to this residential setting would provide residents with a low arousal setting which was identified as a requirement as part of the overall management and support for residents displaying behaviour that is challenging.

To manage some risks associated with specific behaviours and conditions residents presented with, restrictive practices were required. However, an assessment of the level and type of restrictive practices that would be required in the designated centre when residents moved in had not been carried out.

There was a lack of evidence that an assessment and ongoing review framework for the management of restrictive practices had been developed to ensure restrictive practices were the least restrictive and in place for the shortest time possible.

All staff identified to work in the centre had received training in safeguarding vulnerable adults. As part of the transition process all staff identified to work in the centre would undergo a further suite of training to meet the needs of residents. Safeguarding vulnerable adults training would be rolled out again to ensure staff were up-to-date on the policy and procedures for reporting and managing abuse allegations and identifying signs of abuse.

**Judgment:**

Substantially Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

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

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

**Findings:**

Overall, the inspector found there had been significant improvements in the quality of medical and allied health professional assessment of residents' needs, ongoing review and timely intervention. There was evidence that improved health outcomes were being brought about from this significantly improved input.

Residents' personal plans provided evidence that residents were receiving regular assessment and review by allied health professionals as they required. The inspector noted the quality of allied health professional assessment, review, evaluation and regular follow-ups had improved for residents significantly.

Speech and language therapy (SALT) recommendations for residents were in place for all residents living in the centre requiring support with regards to modified consistency meals and management of compromised swallow which could lead to a risk of choking. Associated care plans had been drafted and were maintained in residents' personal plans which made reference to residents' SALT recommendations.

All residents intending to move to the centre had received an annual health check and were scheduled to receive a further medical check up with their GP prior to moving into the centre.

Epilepsy care planning was in place and set out clear criteria for the use of emergency medication to manage seizures which also included the use of oxygen. Care planning also set out guidelines for staff to follow in the event of an emergency where a resident may not respond to emergency medication administration and may require transfer to emergency services.

Some residents' health had improved significantly in the previous months whereby they had spend almost all their time in bed, presenting with muscle wastage and a high risk of falls each time they left their bed to use the toilet for example. Such was their poor health they had been treated in hospital for severe chest infection complications which required significant medical interventions. At the time of this inspection their life was evidenced to have improved greatly, they were now spending the majority of their day up and about, going for walks outside, visiting local parks and towns. Something they had not done in over 20 years.

Residents would be supported to attend healthcare appointments and hospital passports were in place for all residents which would be used to in the event of a hospital appointment or admission.

Residents' weights were recorded and their body mass index (BMI) was also recorded each time on a monthly basis. There was ongoing input from residents' dietician and there was evidence to indicate enhanced dietetic input and an improvement in residents'

current living environment had brought about positive improvements for residents. For example, a resident assessed as underweight had been reviewed by a dietician in August 2016 whereby the resident had been identified as a significant nutritional risk.

Around that time St. Patrick's management instigated a suite of improvements within all its designated centres to improve residents' nutrition and move away from institutional practices such as the centralised kitchen where all residents had received their meals from. At the time of inspection, the resident was now assessed by their dietitian as being at no nutritional risk and was within a healthy body weight.

**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):**

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

**Findings:**

The proposed medication management policies and procedures for the centre were found to be appropriate and in line with the regulations.

The centre had a medication management policy in place. The aim of the policy was to ensure the safe administration and management of medication for all individuals living in the centre. The inspector reviewed the policy which was comprehensive and gave guidance to staff on areas such as medication administration, medications requiring strict controls, ordering, dispensing, storage, administration and disposal of medications. The policy was also informative on how to manage medication errors.

From a sample of files viewed the inspector noted all staff identified to work in the centre had undertaken a medication management training programme which included competency assessments.

Safe storage facilities would be provided in the centre. Residents' medication would be stored in a locked press in a designated area which could only be accessed by staff using a key.

Audits would also be undertaken to ensure compliance with the centre's policy and that all required documentation is correctly completed and up to date.

Established links with a local community based pharmacy were in place and residents

would continue with this service when they moved into the centre. A pre-packed medication dosage system would be used. Each resident's medications would be dispensed to the centre in a pre-packed individualised dosage system from which staff would administer medication.

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The statement of purpose met the matters as required in Schedule 1 of the Regulations.

It accurately reflected the proposed services and facilitates the centre would provide.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

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 registration inspection, it was found the provider had continued to implement 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 newly appointed person in charge demonstrated a good understanding of her responsibilities within the Regulations. She was also a person in charge for a designated centre within St. Patrick's Centre. Four of the residents that resided in that centre would move to this new designated centre as part of the de-congregation plan for St. Patrick's.

She would be supported in her role by two team leaders for the centre. They would be instated in persons participating in the management of the centre roles and manage the centre in the absence of the person in charge. The provider had also identified the need for a more senior management role for which persons in charge could report directly to within St. Patrick's and would provide another layer of governance and improved reporting structures within St. Patrick's Centre. Interviews for these posts had been carried out and the posts would be filled within the next couple of months.

The provider had implemented improved procedures for monitoring the quality of care provided to residents in all designated centres within St. Patrick's. Systems were in place to gather and analyse information which could be used to validate the quality and safety of care provided to residents.

Unannounced visits and audits by persons nominated by the provider, which are a requirement under Regulation 23 to gather information and assess the quality and safety of care, would be implemented. Additional ongoing auditing of the centre would be implemented by the Quality and Compliance Manager also once the centre was registered and residents moved in.

Systems to assess the quality and safety of care in St. Patrick's Service has improved greatly in the previous six months 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.

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 occurred at least every two months, previously they had occurred more frequently in order to establish governance systems to improve services within St. Patricks. The various newly established sub-committees and project co-ordinators must provide a report to the Board which is reviewed at each Board meeting. The inspector noted this reporting mechanism was ongoing at the time of inspection and proving to be effective in driving positive change.

The inspector had met with the Deputy Chairperson of the Board during an inspection of another community residential centre in March 2017. This meeting provided the inspector with assurances that the provider had and was continuing to implement significant improvements. The Deputy Chairperson of the Board emphasised his and the Board's commitment to improve services throughout St. Patrick's entire Centre. The Deputy Chairperson demonstrated a comprehensive understanding of the financial scope required by St. Patrick's Centre in order to implement and sustain improvements. They also demonstrated a good understanding of the improvements that had been made and the matters that still required improvement. They discussed with the inspector the Board's strategic plans to drive improvement in certain areas that still needed improvement.

The provider was required to continue with these improvements

**Judgment:**

Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Systems in place indicated that staff had been recruited, selected and vetted in accordance with best recruitment practice. There would be a full-time team leader in place to ensure staff were appropriately supervised. Before residents moved into the centre all staff proposed to work in the centre would receive a suite of training specific to meet the identified assessed needs of residents.

The inspector reviewed a sample of staff files and saw that they met the requirements of Schedule 2 of the Regulations.

A sample roster was reviewed. This indicated there would be adequate numbers of staff allocated to support residents during the day with a waking staff compliment in the centre at night time. The provider nominee informed the inspector that the staffing ratio would be adjusted based on the needs of residents at any given time. The planned staffing arrangements were in line with the statement of purpose.

Staff identified to work in the centre were undergoing a suite of training which would



ensure they had the skills and knowledge to support residents and their specific identified needs.

Staff were attending training in areas such as the management of behaviour that challenge, safe administration of medication, manual handling, fire safety training, safeguarding vulnerable adults, basic life support and use of oxygen, food safety, management of dysphagia. On speaking with the training officer for St Patrick's Centre she informed the inspector that she intended to identify training for staff in the management of Pica.

There were no plans in place to have volunteers in the centre. Should that change, the provider nominee was aware of the requirements of the Regulations in this regard.

Staff supervision would be ongoing with scheduled supervision and appraisals sessions for all staff once they started working in the centre. The person in charge of the centre had completed training in supervision of staff and would use these skills in carrying out supervision sessions with staff. The persons participating in management of the centre would provide direct line supervision of staff working in the centre at all times and report any practice issues, for example to the person in charge if required.

**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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Saint Patricks Centre (Kilkenny)
<b>Centre ID:</b>	OSV-0005621
<b>Date of Inspection:</b>	12 April 2017
<b>Date of response:</b>	17 May 2017

### 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 06: Safe and suitable premises

**Theme:** Effective Services

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

The boiler for the centre would require servicing prior to residents moving in.

#### 1. Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain

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

equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

- The boiler was serviced before the residents moved in.

Proposed Timescale:  
Completed (24/4/17)

**Proposed Timescale:** 17/05/2017

**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:**

At the time of inspection the provider had not carried out a robust and thorough risk assessment of this new designated centre in order to manage the personal risks for residents that presented with pica, a condition characterised by an appetite for substances that are non food items. This would be required prior to residents moving into the centre.

**2. 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 Assessments to manage the personal risks for the resident who presents with Pica are now in place. As a result, finger print scanners have been installed on the resident's bedroom doors and also on the pantry door. This is to protect the resident with Pica and to allow access for the other residents.
- All carpet removed in bedrooms and in main reception area.
- Standard Operating procedure in place for the management of Pica and of the finger scanner system.
- 36 risk assessments with copies of relevant ones in each resident's files.

Proposed Timescale:  
Completed (25/4/17)

**Proposed Timescale:** 17/05/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

There was a lack of evidence that an assessment and ongoing review framework for the management of restrictive practices had been developed to ensure restrictive practices were the least restrictive and in place for the shortest time possible.

**3. 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:**

- The Risk Assessments, SOP's and Finger Scanner System has effectively eliminated all restrictive practices in relation to the management of the resident who presents with Pica.
- Thumb turn locks now in place on external doors.

Proposed Timescale:

Completed (25/4/17)

**Proposed Timescale:** 17/05/2017