

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dinan Lodge
Centre ID:	OSV-0005621
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Saint Patricks Centre (Kilkenny)
Provider Nominee:	David Kieran
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 August 2017 12:00	01 August 2017 18:00
02 August 2017 10:20	02 August 2017 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to Inspection.

This inspection was an unannounced monitoring inspection that took place over two days. The centre had previously been inspected as a 'new build' centre in April 2017 for the purposes of registering so four male adult residents could move from St. Patrick's Centre, congregated campus setting to a community residential service as part of the provider's de-congregation plan for St. Patrick's Centre, Kilkenny.

The purpose of this inspection was to inspect the progress of residents since they had moved to the designated centre and assess if the provider was meeting the

needs of the residents to a good standard in compliance with the Regulations. All outcomes were reviewed during this inspection and actions from the previous inspection followed-up on to ensure the provider had completed them in line with their action plan response and timelines that had been agreed.

How we Gathered Evidence.

As part of the inspection, the inspector met with the recently appointed person in charge of the designated centre, nominated persons participating in management of the centre, staff, the quality and compliance manager and the provider nominee.

The inspector also met and spoke with all three residents in the centre during the two days of inspection. Residents' specific communication repertoires meant they could not speak with the inspector or describe the service they were receiving. The inspector at all times respected resident's personal choice to spend time with the inspector or not to during the inspection.

The inspector reviewed documentation such as risk assessments, behaviour support plans, personal plans, schedule 5 policies and financial statements. The inspector also carried out an observational review of the premises both inside and out.

Description of the Service.

The centre comprises one detached house, referred to in the report as the designated centre. The centre is located in 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 which is a condition characterised by an appetite for substances that are non-food items.

Overall Judgment of our Findings.

Of the 18 outcomes inspected 13 met with compliance or substantial compliance. Five outcomes met with moderate non-compliance.

Significant tangible improvements had occurred. Residents that had previously been considered for referral for palliative care due to their poor health were now engaged in regular daily activities outside of the centre, such as walking in local scenic areas and swimming.

Residents' nutrition had improved also. Some residents no longer required nutritional supplements they had previously been prescribed while living in their previous setting. Others had the quantity of nutritional supplementation reduced by their medical practitioner following a review and assessment that they were receiving adequate nutrition and maintaining a healthy body weight with a longer term plan for them to be discontinued completely. This was a significant tangible improvement in the healthcare of residents and an indication that they were achieving their best possible health.

Healthcare and nutrition was not the only area of improvement for residents. Some

residents now living in this centre had previously not left the campus in St. Patrick's Kilkenny for over 20 years but were now engaged in regular excursions and activities in their local community such as going to the pub or grocery shopping, for example and were in process of joining their local GAA club.

There were also improvements in relation to safeguarding. Some residents now living in the centre had previously required safeguarding planning to protect and support them from peer-to-peer assaults and abuse when they lived in the campus of St. Patrick's Centre, Kilkenny. These were no longer required. No such incident had occurred in the centre since their move and the risk of it occurring had reduced significantly. There were also low numbers of incidents of behaviours that challenge and some chemical restraint, prescribed to residents as part of a strategy plan to manage behaviours that challenge had been discontinued as it was deemed not necessary.

While these were significant improvements in residents' overall quality of life some improvements were required in relation to residents' access to advocacy, choice making and independence. Improvements were also required in relation to staff training to ensure they had received training in specific areas to meet residents' assessed needs. All schedule 5 policies required updating, review and revision in order to meet 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 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):

No actions were required from the previous inspection.

Findings:

Residents living in the centre had their rights, privacy and dignity supported to a good standard. Since moving to this centre residents were now experiencing greater freedoms and lessening of restrictions which they would have experienced in their previous living environment. Some improvement was required in relation to residents having independent access to the external premises of the centre, provision of information regarding their finances and facilitation of advocacy and consultation.

The complaints procedure was located in a prominent position in the centre and in an easy read format. The procedure was up-to-date and identified who the current complaints officer was and the person nominated to manage complaints in the centre also. The inspector reviewed the complaints log for the centre. There were no active complaints under review at the time of inspection. A non-compliance was found in relation to the complaints policy this is further discussed in outcome 18; Records and Documentation.

The inspector reviewed a sample of resident meetings. Residents' meetings had occurred twice since residents moved into the centre in April 2017. Items discussed however, did not provide residents with an opportunity to make choices or provide feedback with regards to the service they were receiving. Meetings had discussed residents' upcoming healthcare appointments and discussion regarding staff holidays, for example. Improvement in gathering residents' feedback and facilitation of choice was required. This was of particular importance in this centre given residents' specific support needs with regards to communication.

While residents' meetings required improvement, management and staff spoke respectfully of residents in all communications directly to the residents and inspector during the inspection. Direct line staff displayed kindness and a rapport with all residents during the inspection.

Residents had access an independent advocate if and when they required. Information and contact details were available in the centre. While this was in place, residents did not have the capacity to independently request a visit or meeting with the advocate and the advocate had not visited the centre since it opened, to meet with residents. The provider was required to facilitate residents in developing a meaningful connection with their independent advocate in light of their specific support needs.

The centre had adequate privacy options in place for residents. Most bedroom doors were fitted with an electronic device activated by finger print which meant only residents and allocated staff working in the centre could access those bedrooms. This measure had been put in place to manage a personal risk for one resident living in the centre. It meant residents could access their bedrooms, but the resident at risk could not. In light of the serious personal risk for one resident the inspector was assured the provider had tried to mitigate the risk but ensure freedom and privacy for residents in the least restrictive way possible using assistive technology. This is further discussed in outcome 7.

The organisation had a policy on personal property, personal finances and possessions which guided practice in the organisation with regards to these matters. All residents living in the centre required support in managing their personal finances. Financial ledgers, with documented monetary in and out balances, were maintained and receipts for purchases, bank withdrawals and deposits were also maintained.

While systems were in place, the inspector identified residents had not been issued with copies of their most up-to-date bank statements with the most recent statement available being April or May 2017. Therefore, while the provider had systems in place to ensure residents had control and access to information regarding their finances the implementation of the system needed improvement.

An inventory of each resident's personal property had been carried out and on this inspection was found to be detailed and up-to-date.

Activities available to residents were suited to their age and interests outside of the centre. Residents were supported to go on planned trips and excursions, local sporting events, shopping and attend activities available in St. Patrick's Centre day services, for example. There was however, improvement required in relation to the personal interests and hobbies options for residents while they were at home.

Overall, the inspector noted residents had greater freedom and experienced significantly less restrictions than they had in their previous living environment in the congregated campus setting of St. Patrick's Centre. While this was a significant improvement in residents' overall rights and freedom in their home they did not have independent access to outdoors. Due to the configuration of the house and the necessity to control access to one part of the house, in order to mitigate a personal risk for one resident,

residents were unable to independently access their back garden, for example.

This required improvement in order to facilitate residents with even greater freedoms and opportunities to appreciate and experience their new home both inside and out. Given that residents had not experienced independent access to the outdoors in their previous living environment the provider was required to review this and put measures in place.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents' communication needs were supported in accordance with their assessed needs and preferences.

Residents' communication needs had been identified in their personal planning documentation. Each resident had a communication passport setting out their individual communication styles.

Residents could avail of the services of a speech and language therapist (SALT). There was evidence that residents' had received a SALT assessment with regards to their communication needs and interventions had begun including the use of pictures to facilitate choice and information for residents.

Internet access was available in the centre as was a stereo and wall mounted television.

Staff working with residents knew residents very well and understood their individual communication repertoires.

Judgment:

Compliant

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

Residents are supported to develop and maintain personal relationships and links with

the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents' lives had transformed in a positive and remarkable way since moving to their new home from the St. Patrick's Centre congregated setting.

The four residents that had moved to this new designated centre in May 2017 had previously lived in the congregated campus setting of St. Patrick's Centre, Kilkenny. While living there they rarely left the campus grounds and in one instance a resident had not left the campus setting for almost 20 years. The move to this designated centre had transformed the residents' lives in relation to their experiences of life in the community and repertoire of experiences.

Residents were now involved in going to the local shop to buy groceries which was something they had never engaged in before. They had also visited a local pub for the first time and though initially had not wanted to stay for long, had, on the most recent visit, sat for a while and had a drink and a snack. Staff were also supporting residents to gain membership of their local GAA club and go for drives and walks in local scenic areas.

While these activities, in any other, context could seem regular or everyday; for the four residents that now lived in this new community setting, these were huge milestones in their lives and ones to be celebrated and regarded for the achievements that they were.

The provider was required to continue improving residents' lives in this way and afford them opportunities to take positive risks and experience community inclusion in the most full way possible on an ongoing basis.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The inspector reviewed residents' contracts of care to ascertain if they had been signed or agreed with the resident. It was noted that residents contracts were still being reviewed by their families and representatives and had not been signed at the time of inspection.

The provider was in an active consultation process with regards to the contracts for residents and their representatives and hoped to have a resolution

Residents now had more disposable income from their disability allowance each week. Fees payable by residents had reduced due to their move to community residential setting which reflected the new long stay charges directive by the HSE. (Health Service Executive)

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:

The care and support provided to residents was consistently and sufficiently assessed and reviewed. Personal plans comprehensively reflected residents' assessed social care needs. While short term goals set had been achieved more work was required with regards to long term goals for residents.

The inspector reviewed a sample of personal plans which were found to be comprehensive, personalised, detailed and reflected residents' specific requirements in relation to their social care needs. Each personal plan provided evidence of comprehensive allied health professional review, assessment and recommendations on an ongoing basis. Some improvement was required in relation to goal setting, action

planning and reviews.

There was evidence of assessment implemented and ongoing monitoring of residents' needs including residents' interests, communication needs and daily living support assessments. Residents' assessment of needs included general likes and dislikes, nutrition, intimate care and personal hygiene, behaviour support planning and healthcare assessments.

Personal plans also contained information records such as personal risk assessments, support plans, daily reports, allied health professional recommendations and appointment updates.

While there was significant improvement in the level of assessment and detail with regards to allied health professionals' input, residents personal plans still contained a lot of documentation which was no longer relevant or out of date and in need of archiving.

While the inspector found residents' personal plans were comprehensive, a more formalised approach to goal setting was required to ensure when a goal was identified an action plan was developed which set out the steps required to achieve the goal, evidenced inclusion of the resident in establishing those steps, who was responsible to complete each step and by what timeline.

Judgment:

Substantially 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):

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

Findings:

The inspector reviewed in an action from the previous inspection report had been addressed relating to the boiler for the house. On this inspection it had been addressed the boiler was serviced before residents moved into the centre.

The inspector noted that some improvement was required in relation to the personalisation of residents' bedrooms.

The rear garden of the premises also required some enhancement in order to make it a

pleasant, and accessible space for residents to use. For example, at the time of inspection garden furniture located in the rear garden was broken and could not be used and presented as unsightly and took up space in the garden.

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):

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

Findings:

The health and safety of residents, visitors and staff to this centre was promoted and met to a good standard overall. Some improvement was required in relation laundering residents' clothes and linen and the storage of mops and buckets to ensure appropriate infection control systems were in place.

Fire safety works which were underway during the previous inspection had been completed by this inspection. Appropriate fire compliance and containment systems were in place in the centre. Fire safety checks were carried out regularly and were up-to-date. Fire drills with residents had been carried out and each resident had an up-to-date personal evacuation plan in place which set out supports required in the event of an evacuation of the centre being required. Some residents, though ambulant, required additional supports for evacuation purposes and were supplied with wheelchair maintained in their bedroom should it be necessary in the event they refused to co-operate in an evacuation.

A health and safety statement had been completed and a risk register was in place which detailed the risks and control measures specific to the centre and residents' personal risks also. Robust control measures were in place for management of absconding risks and missing persons strategies.

As referred to earlier in this report a resident with a significant personal risk of pica, a condition characterised by an appetite for substances that are not food items, had robust control systems in place to manage this risk. A full risk assessment of the centre had been completed before their admission to the centre and an electronic finger print access system had been fitted which allowed other residents and staff to access particular spaces in the centre which would pose a significant risk to the resident living with pica. This ensure the resident's personal pica risk was managed but in the least restrictive way for other residents in the centre.

Previous inspections of St. Patricks Centre have mentioned an electronic incident recording system was to be established this had not yet been established, a paper incident recording system was in place on this inspection. However, this system was found to be effective in the recording of incidents and accidents and the inspector noted a small number of incidents had occurred in the centre since residents had moved in, all of which were low risk incidents which did not require any investigation or significant review.

An incident and accident review and audit for all St. Patrick's Centre, designated centres was available to review on this inspection. It demonstrated low numbers of incidents occurring in this centre and other community residential designated centres in comparison to designated centres on the congregated campus setting of St. Patrick's which evidenced this community residential model of service provision helped to control health and safety risks to residents in a more effective way.

There was a policy on infection control available. Cleaning schedules were in place and completed by staff on an on-going basis. Hand washing facilities in the centre were adequate. Hand wash and drying facilities were 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.

At the time of the inspection these were stored in the garage, however the inspector was not satisfied that this promoted adequate infection control measures. The provider was required to review the location where the mops and buckets were stored and implement appropriate infection control measures. This was also required for residents' laundry space. At the time of inspection the washing machine and dryer were located in the garage but without a facility for residents or staff to manage, fold or store the laundry before returning it to residents. This required review.

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):

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

Findings:

The inspector reviewed if actions from the previous inspection had been addressed and assessed the systems in place to monitor restrictive practices in the centre. This had occurred. Improvements were required however, in relation to staff training in the prevention, detection and management of allegations of abuse. Intimate care planning required review to set out residents' independence skills and ways in which staff could promote those skills. Systems for the prevention of financial abuse required improvement.

The provider had implemented a full and comprehensive review of all restrictive practices that were in place in the centre and had implemented a suite of strategies to implement risk control measures in the least restrictive way as possible. There had been a reduction in chemical restraint prescribed to some residents with evidence that it had been discontinued in some instances and not used since residents had moved into the centre in other instances. This was evidence that residents' new living environment was meeting their specific needs.

Each resident, where required, had a documented behaviour support plan in place to guide staff in the specific triggers that could cause behaviours that challenge and the various strategies both proactive and reactive to manage such behaviours that challenge. Staff informed the inspector that there had been a reduction in the number of challenging behaviour incidents since residents had moved to the centre. This was also evidenced through review of documented incidents in the centre and residents' daily narrative notes.

More encouraging was the cessation of residents being exposed to peer-to-peer safeguarding issues such as peer-to-peer assault, institutional abuse and violation of personal integrity. Some residents had experienced these safeguarding risks and experiences on a regular basis while living in their previous living arrangement on the campus of St. Patrick's Centre. There had been no peer-to-peer incidents since residents had moved into this new living arrangement. This further evidenced this environment was meeting residents' individual needs.

While there were overall improved tangible safeguarding measures in place for residents improvement was required. Not all staff working in the centre had received training in vulnerable adult safeguarding.

Each resident had an intimate care plan setting out specific detailed information to guide staff how to support residents with this specific need. While these plans were detailed they lacked information or assessment of the independent skills and abilities residents had. They also did not outline ways in which staff could promote or support residents to improve upon these skills.

Improvement was required in relation to the auditing of residents' personal finances to consistently and effectively monitor for financial abuse. As referred to in outcome 1 of this report, residents were supported to have access to financial statements and

balances and checks of residents' daily spending was carried out. However, no audits of residents' finances had been carried out at an operational level within the centre since their admission .

On review of residents' financial statements that were available, the inspector noted one resident was charged regularly for an exercise activity in their day service. It was also noted by the inspector that the cost varied each week and at one point the resident was still charged for this activity despite being in a minus balance in their bank account.

Staff and management of the centre were unclear as to what the activity entailed or if the resident did in fact participate in it or enjoy it. Due to the inadequate auditing of residents' finances at an operational level this issue had not been identified and therefore the resident was charged despite not having the actual funds to pay for the activity.

There were other examples of residents paying for chiropody appointments but no evidence that the provider had supported residents to receive this service through other means which would mean they did not have to pay. The provider was required to review these matters and refund residents for costs they should not have incurred if and where appropriate.

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):

No actions were required from the previous inspection.

Findings:

No notifiable incidents had occurred in the centre since residents had moved in. The person in charge and persons participating in management of the centre on an ongoing basis demonstrated a good understanding of incidents that would require notifying and the timelines.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Residents' opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall, residents' general welfare and quality of life had improved significantly since moving to the centre.

Assessments of residents' needs however, had not included an assessment relating to residents' employment and education needs in line with their abilities and interests. Given that residents now lived in a more optimum environment these goals and needs could be more meaningfully supported.

Judgment:

Substantially 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:

Significant improvements in the quality of medical and allied health professional assessment of residents' healthcare needs were still ongoing. Such were the improvements in some residents' health that they no longer required nutritional supplements and had greater stamina to engage in physical activities both in and out of the centre.

As mentioned in previous inspection reports for St. Patrick's Centre, residents' access to and assessment by allied health professionals had improved significantly. Each resident was afforded a monthly allied health professional review whereby each resident's support needs were discussed and reviewed by the relevant allied health professionals associated with their care. This systematic and thorough review of each resident was reflecting positive and improved healthcare outcomes for residents.

In 2016 some residents that had moved into the centre referred to in this report, had been under consideration for referral for palliative care such was their poor health at the time. Others had also experienced a significant number of falls in their previous living environment in St Patrick's Centre, some of which was considered attributable to the significant period of time they spent in bed. They had also required hospital admissions for treatment of severe chest infections and associated complications.

The move to this new community residential setting had improved their health overall in a significant way. At the time of inspection all residents were engaging in daily walking activities in the locality and scenic locations nearby or swimming each week. The number of falls experienced by residents considered previously to be at risk had reduced and where they had occurred the resident had not sustained any injury unlike previously

Residents were enjoying a better quality of health and nutritional care since their move to the centre. Some residents while residing in their previous living arrangement had required nutritional supplements such as drinks and shakes to provide them with optimum nutrition and prevent weightloss, for example. Since their move to this centre residents had been discontinued from most of these supplements and vitamins by their GP due to their diet having improved and putting on or sustaining their weight at an optimum level.

This was a significant indicator that resident's nutritional health was improving and the quality of nutrition they were receiving was meeting their individual needs. Given that all residents living in this centre were aged in their 30s and 40s and had previously required such supplementation of their diet, there was clear and tangible evidence this move from their previous institutional environment was improving their quality of life and health.

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):

No actions were required from the previous inspection.

Findings:

The inspector did not review this outcome in its entirety on this inspection as it had been found compliant on the previous inspection. The aspects reviewed on this inspection related to the implementation of systems for safe medication management in

the centre at the time of inspection.

Safe and suitable storage space was in use in the centre at the time of inspection.

Staff spoken with were knowledgeable of appropriate and safe practices and described safe procedures to the inspector.

Only staff that had completed safe administration of medication training and competency assessments engaged in administration of medication in the centre. Staff had also received training in the administration of oxygen and buccal midazolam (emergency medication for the management of seizures).

Systems were also in place for the recording of medication errors.

Residents were now in receipt of their medication in a pre-dosed system from their local pharmacy. Due to this change in medication supply residents were now experiencing a more individualised pharmaceutical service.

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):

No actions were required from the previous inspection.

Findings:

The provider was required to submit a revised statement of purpose to reflect governance changes in the centre.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

The inspector did not review this outcome in its entirety on this inspection as it had been found compliant on the most recent inspection. There were however some improvements required in relation to the appointment of a full time person in charge for this centre and centre specific auditing of the quality of care on an ongoing basis.

Since the previous inspection the person in charge was no longer in position. The provider had notified the Chief Inspector of this change since the previous inspection and as an interim arrangement had appointed an appropriately qualified and experienced person in charge who met the requirements of regulation 14 to manage the centre as person in charge.

However, this person was also appointed as a community services co-ordinator and while they met the requirements of the role they were not appointed in a full time capacity and could not provide adequate oversight of the centre given the two roles they were assigned to in the organisation. At the time of inspection interviews for a full time person in charge were underway to fill this position.

While the provider for St. Patrick's Centre had developed improved auditing systems throughout the service there was a lack of auditing of the quality of service and care provided to residents at an operational level within the centre by the person in charge and staff. A number of non compliances found on this inspection had not been identified as part of any internal auditing system.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of their responsibility to notify the Chief Inspector of the absence of the person in charge.

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:

The provider was required to assess the manner in which they allocated staff resources in the centre to ensure residents' assessed needs were met.

The provider had proposed a responsive rostering schedule to meet residents' needs however, at the time of inspection this had not been implemented and subsequently sometimes residents could not attend their scheduled activities due to a lack of staff resources allocated at a given time to provide one-to-one support.

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:

While this outcome was found to be compliant on the previous inspection there were some improvements required.

On the previous inspection the inspector had been informed that all staff working in the centre would undergo a suite of training in particular mandatory training to ensure they had the necessary skills and training to meet the needs of residents and requirements of the regulations.

The inspector however, found this had not been implemented effectively and while most staff had received mandatory and additional training, not all had. An action relating to mandatory training in safeguarding vulnerable adults is referred to in outcome 8 of this report.

Training gaps were found in relation to management of dysphagia (compromised swallow), first aid, oxygen therapy administration for residents with epilepsy and food hygiene.

While a system was in place to ensure all staff received supervision meetings there were no documented supervision meetings available for review during the inspection. While the inspector was assured by staff they had occurred they were not available for review and therefore a non compliance was found in relation to this.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed schedule 5 policies in the centre and found all policies required updating, review and revision to meet the requirements of the regulations and provide

staff with appropriate guidance and information in how to do so. Some examples are outlined below.

The complaints policy met the requirements of the regulations however, it was out of date and did not reflect accurate information relating to the complaints officer for the organisation, for example.

While there was evidence that residents' communication needs were being supported and assessed the organisation's policy did not provide adequate information, guidance or examples of the types of communication support services it provided. It did not outline the use of assistive technology or alternative communication systems which could support residents.

The safeguarding vulnerable adults policy for the organisation adopted the National safeguarding vulnerable adults policy. Evidence indicated all allegations of abuse, investigations and safeguarding planning followed this policy and associated procedures. However, there was no St. Patrick's Centre specific localised procedures detailed. The policy was a photocopy of the National Safeguarding policy with a St. Patrick's Centre cover page. This was not adequate.

Judgment:

Non Compliant - Moderate

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 report¹

Centre name:	A designated centre for people with disabilities operated by Saint Patricks Centre (Kilkenny)
Centre ID:	OSV-0005621
Date of Inspection:	01 and 02 August 2017
Date of response:	12 September 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 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:

Residents were unable to independently access their back garden. This required improvement in order to facilitate residents with greater freedoms and opportunities to appreciate and experience their new home both inside and out.

1. Action Required:

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

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

•A fire compliant Patio door has been installed in the Living Room to facilitate unrestricted independent access by residents to the back garden. Photographic evidence will be sent to the Inspector on 12/09/2017.

Proposed Timescale: 24/08/2017

Theme: Individualised Supports and Care

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

Improvement in gathering residents' feedback and facilitation of choice was required. This was of particular importance in this centre given residents' specific support needs with regards to communication.

2. Action Required:

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

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

- Resident's house meetings are held monthly.
- Resident's views and preferences will be sought using their preferred method of communication as outlined in their communication passports.
- SALT has been invited to attend the next residents meeting to support staff facilitate meeting in a meaningful way.

Proposed Timescale: 30/09/2017

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

While the provider had systems in place to ensure residents had control and access to information regarding their finances the implementation of the system needed improvement.

3. Action Required:

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

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

•Monthly financial audits by PIC/Team Leader in order to review quality of spend and transparency.

•PIC/Team Leader is responsible for ensuring that monthly financial statements are issued to residents quarterly and will also ensure that these statements are up to date and filed appropriately.

Proposed Timescale: 30/09/2017

Theme: Individualised Supports and Care

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

Improvement was required in relation to the personal interests and hobbies options for residents while they were at home.

4. Action Required:

Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

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

•A full review of resident's meaningful day plan has taken place with a view to engaging residents in house hold chores and independence skills which reflect residents needs and capacities.

•The PIC/Team Leader and Keyworker will devise skills teaching/task analysis in the area of household chores/independent living skills and implement same. This will be overseen by the Community Service Manager.

•The PIC/Team Leader will audit resident's meaningful activity levels on a monthly basis and report on same to Community Service Manager.

•The PIC/Team Leader made a referral to the OT seeking advice on how best to support residents. Assessments were conducted by OT who recommended the introduction of Assistive Technology to support residents to turn on and off kitchen appliances. Visual aids to support residents better understanding of programmes will be introduced.

Proposed Timescale: 30/11/2017

Theme: Individualised Supports and Care

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

The provider was required to facilitate residents in developing a meaningful connection with their independent advocate in light of their specific support needs.

5. Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

•The PIC/Team leader has made contact with the newly appointed Sage Advocate and an invitation to visit the centre and meet the residents has been extended. While the advocate has committed to meet with the residents, she could not at the time of this report confirm a date. It is hoped however, that the visit will take place before the date set out below.

Proposed Timescale: 30/11/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

While residents had been issued a contract of care they had not been agreed with residents' representatives at the time of inspection.

6. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

•Residents have been informed of the contents of the contracts of care through use of easy read versions, which were developed in co-operation with the Speech & Language Therapist.

•St Patrick's Centre Social Worker is available to support residents and / or representatives with any queries / concerns emerging.

•Residents representatives are sent service agreements for information purposes.

•Sample Contracts of Care have been reviewed by Inclusion Ireland – a representative body for parents and friends of people with disabilities.

•Sample Contracts of Care have been shared with members of St Patrick's Centre, Inclusion Ireland facilitated, Family forum.

•In the absence of the Capacity Act legislation being enacted Contracts of Care will be reviewed by the Human Rights Committee and/or a legal representative to ensure the contracts are fair and reasonable.

Proposed Timescale: 01/09/2017

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:

Residents' personal plans still contained a lot of documentation which was no longer relevant or out of date and in need of archiving.

7. 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:

- Each file will be audited by PIC/Team Leader-monthly
- The Community Service Manager will audit each file-6 monthly
- Recommendations from file audits will be discussed at Team meetings and an action plan agreed with relevant keyworkers.

Proposed Timescale: 30/09/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A more formalised approach to goal setting was required to ensure when a goal was identified an action plan was developed which set out the steps required to achieve the goal, evidenced inclusion of the resident in establishing those steps, who was responsible to complete each step and by what timeline.

8. 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:

- Visioning (future planning) meetings/P.C.P. meetings for each resident were completed by Community Transition Coordinators and arising from this process, long and short-term goals will be established. Each goal will have an action plan with responsible persons identified along with agreed timeframes.
- An assessment tool (conditions of success form) will be used to assess resident's engagement and preferences, which will in turn guide the direction of meaningful

activities for residents.

- The PIC/Team leader to monitor individual goals monthly.

Proposed Timescale: 31/10/2017

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 inspector noted that some improvement was required in relation to the personalisation of residents' bedrooms.

9. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

- Keyworkers will assist residents to personalise and decorate their own bedrooms in a way which reflects their individual likes, interests and personalities.
- Once resident's preferences are identified, each resident will go shopping with the support of staff and/or family to purchase individualised items, reflective of their likes, interests and personality.

Proposed Timescale: 31/10/2017

Theme: Effective Services

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

The rear garden of the premises required some enhancement in order to make it a pleasant, and accessible space for residents to use. For example, at the time of inspection garden furniture located in the rear garden was broken and could not be used and presented as unsightly and took up space in the garden.

10. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

- Broken furniture has been removed.
- The PIC/Team Leader has requested OT to assess the layout of the garden and advise staff on how to best provide a pleasant and accessible space for resident's use.

•An environmental risk assessment will be conducted by the PIC/Team Leader with regard to the resident with PICA and if suitable/appropriate edible plants and shrubs will be sourced.

•Funding has been approved for a Polly tunnel and 4 bird chicken coop.

•General upkeep and hazard prevention will be managed through the cleaning and health and safety audits and included in the risk register.

Proposed Timescale: 30/11/2017

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:

Colour coded mops and buckets were not stored in a way that promoted effective infection control.

Residents' laundry facilities required improvement to ensure laundry could be managed and stored in a way that promoted effective infection control.

11. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

•A steel lockable cupboard has been installed in the garage for the safe storage of mops and buckets.

•A Work station for resident's laundry has been installed.

•Hygiene & Infection Control Audits will include assessment of resident's laundry.

Proposed Timescale: 31/08/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Improvement was required in relation to the auditing of residents' personal finances to

consistently and effectively monitor for financial abuse.

12. Action Required:

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

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

- Monthly financial audits will be conducted by the PIC/Team Leader to ensure effective monitoring to prevent financial abuse.
- Financial statements will be issued to residents quarterly.
- The Community Service Manager will conduct quarterly financial audits which will include a review of spending.
- St Patrick's Centre Finance Department carry out 6 monthly audits as per audit schedule. A scheduled Audit was conducted on 11/09/17.
- The Finance Department have been requested to provide training to the staff team to ensure they are all able to conduct audits including the cross checking of receipts and bank statements to minimise the risk of financial abuse.
- Safeguarding residents from Financial abuse will be discussed at the next Team meeting between the Community Service Manager, PIC/Team Leader and the staff working in the centre.
- The Director of Service will work with those delivering Safeguarding Training to ensure the issue of Financial Abuse is being addressed in a comprehensive manner.

Proposed Timescale: 31/10/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all staff working in the centre had received training in vulnerable adult safeguarding.

13. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

- Safeguarding Training is provided monthly across the organisation and all staff have to complete Refresher Training every 3 years. This training is currently delivered by the Senior Social Worker.
- Staff in this centre will attend the next scheduled training in Safeguarding Vulnerable

adults on 29/09/17.

- The Training Coordinator is responsible for scheduling all training and notifies the PIC/Team leader of training gaps through a Monthly Training Report issued to all houses/centres.
- Where gaps are detected, the PIC is responsible for booking staff on to the relevant course.
- Monthly Training Reports are issued by the Training Coordinator to all PIC's/Team Leaders.

Proposed Timescale: 30/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

On review of residents' financial statements that were available, the inspector noted one resident was charged regularly for an exercise activity in their day service. It was also noted by the inspector that the cost varied each week and at one point the resident was still charged for this activity despite being in a minus balance in their bank account.

There were instances of residents paying for chiropody appointments but no evidence that the provider had supported residents to receive this service through other means which would mean they did not have to pay.

The provider was required to review these matters and refund residents for costs they should not have incurred if and where appropriate.

14. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

- An Internal Notification has been submitted to the Designated Officer and a preliminary screening is currently underway.
- The PIC/Team Leader will be submitting an NF06 in due course.
- Residents deemed to have had money deducted inappropriately for activities and/or treatments will be reimbursed accordingly.
- Quality of spend and value for money will form part of each financial audit for each resident.

•Chiropractic referrals have been made to community care services. Referrals to Chiropractic will be made through GP to ensure access to appropriate services.

Proposed Timescale: 15/09/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Assessments of residents needs, had not included an assessment relating to residents' employment and education needs in line with their abilities and interests.

15. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

- Referrals will be made to the relevant members of the Multidisciplinary Team to assist the PIC/Team Leader and staff team to conduct assessments to determine residents needs in relation to education, training and employment.
- Skills sampling will be introduced and relevant skills teaching programmes commenced to enhance resident's access to wider opportunities.
- Monthly Audits of meaningful activities conducted by the PIC/Team Leader will identify levels of activity and any negative variance must be explained to the Community Service Manager.

Proposed Timescale: 30/11/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The provider was required to submit a revised statement of purpose to reflect governance changes in the centre.

16. Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

- Updated SOP completed and will be sent to regulator with all amendments.

Proposed Timescale: 30/09/2017

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:

The person in charge of the centre was not appointed in a full time capacity and could not provide adequate oversight of the centre given the two roles they were assigned to in the organisation

17. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

- New fulltime PIC/Team Leader appointed.
- She will take up her post 18th September and the Community Service Manager will be registered as PPIM.
- SOP will reflect this change.
- NF30 will be submitted before PIC/Team Leader takes up position.

Proposed Timescale: 30/09/2017

Theme: Leadership, Governance and Management

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

While the provider for St. Patrick's Centre had developed improved auditing systems throughout the service there was a lack of auditing of the quality of service and care provided to residents.

18. Action Required:

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

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

- The Team Leader/PIC will carry out regular in-house audits and will monitor all aspects

of care provided to residents.

- The organisational audit schedule has been designed to facilitate 'cross auditing' of houses by PICs/Team Leaders and Community Service Manager.
- The centre is planning to introduce a new and comprehensive Management Information Project which will require Team Leaders/PIC's and Community Service Managers to submit monthly, quarterly and annual reports to Senior Management into all aspects of service delivery including the numbers of incidents/accidents, the number of residents meetings, compliance in relation to the centre's WTE allocation, quality of spend (residents & budget allocation), complaints (including resolution), staff training, number and quality of meaningful activities, communications with families, health & safety issues, safeguarding and notification matters etc

Proposed Timescale: 31/12/2017

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 was required to assess the manner in which they allocated staff resources in the centre to ensure residents' assessed needs were consistently met.

19. 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:

- Staff rosters in Dinan Lodge have been reviewed by Community Service Manager and PPIMs.
- Skill mix and a more appropriate roster system will be in place by end October. At least 2 members of staff will be on duty at all times during the day and 3 at times when planned activities/appointments are scheduled. The protocol of 2 staff on duty at night is currently being reviewed and risk assessed to determine if this "second" staff can be redeployed on to day duty to greater enhance community integration opportunities.

Proposed Timescale: 31/10/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Training gaps were found in relation to management of dysphagia (compromised swallow), first aid, oxygen therapy administration for residents with epilepsy and food hygiene.

20. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- The following programmes are arranged to address the training gaps identified;
- Safeguarding Vulnerable Adults – 29/9/17
- Dysphagia Training – 21/9/17
- First Aid – 30/10/17, 06/11/17 & 13/11/17
- Basic Life Support – 31/10/17
- Oxygen Therapy – 14/11/17
- Food Hygiene – Date TBC

Proposed Timescale: 31/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

While a system was in place to ensure all staff received supervision meetings there were no documented supervision meetings available for review during the inspection.

21. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

- Supervision records have since been located and are in a locked press in the Centre.
- Supervision schedule in place for all staff.

Proposed Timescale: 24/08/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

All schedule 5 policies required updating, review and revision to reflect the requirements of the regulations and guide staff in appropriate evidence based practices.

22. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

- All schedule five policies will be reviewed and updated to reflect the regulations and evidenced based practice.
- St Patrick's Centre has applied for Social Reform Funding (SRF) to support the transition from Institution to Community for Residents and Staff.
- A specific role which has been identified for funding is a person to comprehensively review all Policies and Procedures (commencing with Schedule 5) in consultation and co-operation with appropriate MD personnel to ensure that they are fit for purpose.
- Once policies are in draft there is an internal Policy Pathway, through which they progress prior to final sign off by the Board of Management. A copy of this Pathway is available.

Proposed Timescale: 30/03/2018