<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Kells Court</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0001895</td>
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<td>Centre county:</td>
<td>Kilkenny</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Saint Patricks Centre (Kilkenny)</td>
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<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
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<tr>
<td>Support inspector(s):</td>
<td>Gary Kiernan (Day 2)</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
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<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 26 September 2017 10:00
       27 September 2017 10:00
To: 26 September 2017 19:00
     27 September 2017 17:30

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 announced registration inspection that took place over two days. The centre had previously been inspected in December 2016 when it formed part of a designated centre known as Mount Oliver's. Subsequently the provider divided up the three residential centres making up Mount Oliver's and made three designated centres from the residential units that comprised it. This centre was one of the original residential units that comprised Mount Oliver's designated centre.

The provider had applied to register this centre under Section 69 of the Health Act.
2007. The purpose of this inspection was to inspect the provider’s compliance with the regulations and standards and to assess if the provider had continued the positive improvements in compliance and outcomes for residents as were found on the previous inspection. 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, inspectors met with the recently appointed person in charge of the designated centre, nominated persons participating in management of the centre, staff, the director of services and the provider nominee. A number of management stakeholders attended the feedback meeting at the close of the second day of inspection.

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

As part of the inspection, inspectors observed practices and reviewed documentation such as risk assessments, behaviour support plans, personal plans, schedule 5 policies and financial statements. Inspectors also carried out an observational review of the premises both inside and out.

Description of the Service.
The centre comprises a one storey purpose built premises with three separate living areas, referred to in the report as residential units. The centre is located in the congregated campus setting of St. Patrick’s Centre, Kilkenny. The centre could accommodate up to 12 adult residents with varying degrees of intellectual disability and specific support needs in the management of healthcare, nutritional management, epilepsy and behaviours that challenge.

At the time of inspection there were only seven residents living in the centre. A number of residents had transitioned from the centre to new designated centres operated by St. Patricks’ Centre and located in the community. This was part of St. Patrick’s overall de-congregation planning which had begun earlier in 2017. St. Patrick’s Centre had opened three new designated centres since April 2017 each of which registered by HIQA prior to receiving residents.

There were further plans to transition residents from this centre to community residential designated centres and transition planning was underway at the time of inspection, a number of residential properties had been identified by the provider and they intended to make applications to register the properties as designated centres.

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 improvements had occurred in relation to fire safety measures in the centre and reconfiguration, refurbishment and upgrade of the premises to a high standard throughout all three residential units visited during the inspection. Residents’ homes were now supplied with a functional pleasant kitchen/dining space and separate living room which had been refurbished to a good standard and provided an improved homelike aesthetic to the previous institutional type premises.

The level of environmental restrictions in the centre had also decreased this was due to the improved re-configuration of the premises and discontinued personal risk management strategies required as a result of the de-congregation process underway.

Improved comprehensive assessment of residents’ social and healthcare needs, by a team of allied health professionals, had brought about significant improvement in personal planning for residents. This process now ensured support planning was evidence based to meet the assessed needs of residents. Through the assessment process some residents had been identified as requiring further medical investigations or treatment and this was being facilitated at the time of inspection through a person centred supportive process for those residents requiring such interventions.

Residents had also been identified as requiring specific behaviour support assessment and planning and at the time of inspection an assessment process was underway.

While residents were experiencing an overall improved quality of life improvements were required.

Staff training required improvement to ensure staff had knowledge and skills to meet residents’ assessed needs, for example a number of staff working in the centre were not trained in administration of emergency medication for the management of seizures related to epilepsy. Auditing systems for residents’ finances required improvement to ensure robust systems were in place to mitigate safeguarding risks. 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Residents living in the centre had their privacy and dignity supported to a reasonable standard in this centre. The capacity of residents living in the centre had reduced and residents still living in the centre were now experiencing greater freedoms and lessening of restrictions that they would have experienced previously. Greater rights promotion was still required. This related to facilitation of advocacy and consultation and the provision of activities and hobbies for the residents to engage in whilst spending time in their home.

The centre was situated in a congregated setting and while the provider had improved the overall living environment as much as possible, this living arrangement impacted on residents experiencing full integration with their local community. Improvements the provider had implemented included the removal of doors with windows for residents’ bedrooms, toilets and bathing facilities

Throughout, the premises had been redecorated and painted, structural reconfiguration had also occurred. Each of the three ‘wings’ to the centre, previously identified with a number, were now reconfigured into a self contained residential unit with separate front doors fitted with a doorbell for visitors to use before entering residents’ home. Large Perspex windows that separated the kitchen and living rooms in the centre had been replaced with a structured wall offering residents more privacy during mealtimes and reducing the institutional aesthetic of the premises overall.

This premises restructuring represented a considered measure by the provider to provide residents with a living environment that resembled a home and in doing so
recognised residents’ right to dignity and privacy in their own home. This initiative by
the provider was to be commended and the premises were now almost unrecognisable
from the institutional premises that had been noted by inspectors on all previous
inspections.

While improvements in the layout of the centre had occurred review was required in
relation to long standing practices still occurring. Staff implemented two hourly night
time checks on residents. It was unclear the rationale for this practice given that most
residents presented as physically well and had not been assessed as needing such
checks. There was also documentary evidence that this practice woke some residents up
when staff opened the door to their bedroom. This practice required review to ensure it
happened in response to a determined rationale based on risk management, for
example.

The complaints procedure was located in a prominent position in the centre and in an
easy read format. Inspectors reviewed the complaints log for the centre. There were no
active complaints under review at the time of inspection. Since residents could not
independently log a complaint to the provider there was some improvement required to
ensure residents were supported to avail of the complaints process within St. Patricks’
Centre through advocacy by an independent person or staff supporting and advocating
for them.

Residents had access an independent advocate if and when they required. Information
and contact details were available in the centre.

The inspector reviewed a sample of resident meetings which had occurred, however
they lacked recorded evidence of residents’ feedback or choices through that process.
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.

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. Each resident
was issued with up-to-date bank statements which were maintained in their personal
plan folders. 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, shopping and
attending activities available in St. Patrick’s Centre, for example. There was however,
improvement required in relation to the personal interests and hobbies options available
for residents within the centre, their home.

**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. Improvement was required in relation to affording residents assistive technology to support their communication needs.

Residents’ communication needs had been identified in their personal planning documentation. Each resident had a communication passport setting out their individual communication styles. Staff working with residents understood their individual communication repertoires and endeavoured to meet residents needs if and when they expressed them.

Residents could avail of the services of a speech and language therapist (SALT) for the purposes of assessment of their communication needs.

Some improvement was required in to ensure residents' communication needs were supported with assistive technology and augmented systems where appropriate and following an assessment by a relevant allied health professional, for example SALT. This was of particular importance in relation to residents with sight impairment, for example.

**Judgment:**
Substantially 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:**
There were increased opportunities for residents to engage in activities outside of the congregated campus of St. Patrick's Centre. Some residents had recently experienced
activities in their community they had never experienced before.

A group of residents had recently gone for a short break from the centre which had afforded them the opportunity to engage in community based activities they had, in some instances, never experienced before. An inspector viewed photographs of residents' recent holiday. Residents had stayed overnight in a hotel, had gone bowling, went for dinner and lunches and had also went to the cinema. While on their holiday, residents had sent a postcard to their families supported by staff to do so.

While these experiences could be deemed ordinary to most people, for some of the residents it had been the first time they had engaged in any of these activities, for example some residents from the group had never been to the cinema before. Residents in the group were in their late 30's early 40's.

While there were efforts made by staff and the provider to ensure residents were experiencing more opportunities for community participation and integration, residents' natural experience of community living and integration were impacted upon due to the congregated campus setting the centre was located.

**Judgment:**
Substantially Compliant

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**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

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

**Findings:**
Each resident had been issued with a contract of care. However, these contracts had not been agreed by the resident and/or their representative.

The provider had revised residents contracts of care to reflect the services and terms and conditions of their contract with the provider. Fees payable by the resident were clearly outlined.

Inspectors reviewed residents' contracts of care to ascertain if they had been agreed with the resident and or a representative on their behalf acting in their best interests. 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.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The care and support provided to residents was consistently and sufficiently assessed and reviewed. Personal plans reflected residents' assessed social care needs. Person centred planning and goal setting for residents required improvement. The layout of residents plans were disjointed and were difficult to navigate.

The inspector reviewed a sample of personal plans which were found to be comprehensive and 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 residents' social care needs and allied health professionals' input, the flow of the personal planning was disjointed and difficult to navigate. While all elements to meet compliance in this outcome were in place they were located across a number of folders. In order to find evidence that residents’ assessed needs had an associated support plan in place it required cross referencing through numerous folders to find
them and link them together. The personal planning system required improvement to ensure staff working with residents were effectively informed of all support planning required to meet residents’ needs.

An improved 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):
No actions were required from the previous inspection.

**Findings:**
As referred to in outcome 1 of this inspection report, the provider had undertaken a significant refurbishment and reconfiguration of the premises in order to improve the living environment for residents. Inspectors noted the provider had done so to a good standard and the premises was almost unrecognisable from how it had presented on prior inspections.

An inspection report from December 2016 had identified at that time the provider was implementing a suite of works in the premises in order to bring it into a fire complaint standard and also to provide residents with a dignified and homely environment which could provide for their privacy also. Inspectors viewed the three residential sections that made up the centre.

Each residential unit within the centre had been repainted with tasteful furnishings and pictures fitted throughout. Each residential unit now contained a separate fully functioning kitchen/dining space for residents. Previously, these areas presented as institutional in nature, were inaccessible for some residents and contained a Perspex wall separating them from the living room space. They now provided residents with a pleasant space to enjoy their meals in privacy with seating options provided.

Residents' bedrooms had also been refurbished. Each bedroom was decorated and furnished in line with residents personal preferences and in line with their specific needs
in relation to personal risk management in some instances.

Overall, inspectors noted a significant improvement in relation to the cleanliness of the centre. Previous inspections of the centre had found improvements were required in relation to this, in particular bathing and toilet facilities for residents.

Each residential unit comprising the centre, were supplied with adequate toileting and bathing facilities. In some instances the provider had upgraded the shower facilities for residents. While toilet and bathing facilities still presented as somewhat institutional in nature, measures taken by the provider now ensured they better provided for residents' privacy and ensured residents' experience using them was improved.

Each residential unit was now supplied with a washing machine and dryer for the purposes of laundering residents' clothes and bed linen.

Each residential unit comprising the centre also afforded residents with living room spaces all had been refurbished with some fitted with an and electric operated fire which added created a more homely aesthetic. Each living room was supplied with a television and comfortable furniture for residents to use.

Improvement had also been implemented to the rear garden space for the centre. Some residents had been assessed as requiring sensory specific equipment by an occupational therapist. This equipment was located in the rear garden of the centre. An inspector observed some gaps in the fencing surrounding the rear garden space.

The provider was required to improve the security of the fencing to safely support residents using the garden space independently if they wished.

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.

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. Each residential unit within the centre was fitted with a functioning fire alarm which had been serviced on a quarterly basis. Fire safety checks were carried out regularly and were up-to-date. Fire drills with residents had been carried out on a regular basis 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, these were documented in their personal evacuation planning. The provider had also ensured an adequate number of staff worked in the centre at night time to support effective evacuation of the centre in the event of an emergency, for example a fire.

An up-to-date 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. Inspectors identified an issue with regards to the fencing to the rear garden of the centre that compromised risk management measures for the prevention of absconding. An action relating to this is given with regards to outcome 6; safe and suitable premises.

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.

Also, evident was the review of incidents by a manager shortly after they occurred to assess how they had been managed and if any further interventions were required. For example, following some incidents related to behaviours that challenge, a manager made a referral for positive behaviour support assessment and intervention in order to manage the ongoing incidents. In other instances where some residents had experienced frequent falls, review of the incidents had resulted in the resident receiving a falls risk assessment and prevention measures put in place, for example referral to their General Practitioner, there was evidence which indicated the frequency of falls experienced by the resident had reduced.

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.

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

**Judgment:**
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. Improvements had occurred. Overall, there had been a significant reduction in relation to environmental restrictions for residents. Residents were in the process of receiving positive behaviour support assessments. Improvements were required however, in relation to staff training in the prevention, detection and management of allegations of abuse. Systems for the prevention of financial abuse required improvement.

Previously, residents had experienced significant environmental restrictions in the centre and could not access a number of areas within the centre, for example access to the kitchen in some parts were restricted due to the need to manage a personal risk for a resident. A number of environmental restrictions had been discontinued, residents had unlimited access to all rooms in their homes, access to kitchen areas and food was also discontinued.

Some restrictions were still in place to manage a specific challenging behaviour risk in one residential unit within the centre, which resulted in residents’ experiencing restricted access to their wardrobes and personal belongings in one residential unit within the centre. Through behaviour support planning it was hoped that this restriction could be reduced. Assessments were underway at the time of inspection.

Most residents living in the centre required behaviour support planning in order to meet their assessed needs. As mentioned assessments were underway to identify the triggers which could cause residents to engage in behaviours that challenge and prescribe strategies for staff to implement in order to prevent the likelihood of them occurring and safely manage them if and when they did occur.

Given that most residents living in the centre could display behaviours that challenge on a regular, sometimes daily basis, such assessments were of critical importance. While positive behaviour support planning was not in place for all residents, inspectors acknowledged the provider was making efforts to address this through the recently commenced assessment process by a behaviour support specialist. Behaviour support planning would be reviewed on the next inspection.

Not all staff had received training to ensure they were appropriately skilled in the
management of behaviours that challenge.

Safeguarding policies and procedures were in place and designated officers were assigned within St. Patrick’s Centre with responsibility to manage reported allegations of abuse and carry out preliminary screening and notification to the HSE safeguarding team. At the time of inspection all safeguarding plans had been reviewed and updated. Staff spoken with demonstrated a good understanding of safeguarding reporting procedures and could identify the designated officers within St. Patrick’s Centre.

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.

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' spending was carried out, but not frequently enough to identify discrepancies to ensure timely action was taken to address discrepancies or identify a pattern of financial abuse, for example.

On review of residents' financial statements available, an inspector noted two residents had paid for sensory equipment recommended by an occupational therapist. The provider was required to review this 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
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 to the Chief Inspector and the timelines by which they were required to be notified.
All incidents requiring notification had been submitted.

**Judgment:**
Compliant

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**Outcome 10. General Welfare and Development**
*Resident’s 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:**
The recent reconfiguration and refurbishment of the premises coupled with the reduction in residents number in the centre and reduction in environmental restrictions had resulted in an improved quality of life and general welfare for residents.

Comprehensive assessments of 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

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**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:**
Improvements in the overall comprehensive medical and allied health professional assessment of residents' healthcare had occurred and were still ongoing. Through this
comprehensive medical assessment process, some residents had been identified as requiring further medical assessments and investigations and residents were supported to undergo these with the support of staff through a supportive and person centred process.

As mentioned in previous inspection reports for St. Patrick's Centre, residents' access to and assessment by allied health professionals had improved significantly in the last year. 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.

For example, a resident had been identified through their medical assessment of need as requiring further investigations. Strategies through a person centred process were underway to support the resident in participating in the assessment. During the inspection, staff informed inspectors of the methods they were implementing in order to teach the resident the purpose of the assessment and develop coping and tolerance skills in order for the important assessment to be completed. This was evidence of a person centred, comprehensive approach in supporting residents to achieve their best possible health.

Previous inspections of the designated centres on the congregated campus setting of St. Patrick’s Centre had identified an institutional model of meal provision for residents which compromised residents’ in being able to experience the most optimum mealtime experience and the participation in preparation and anticipation of meals, for example.

On this inspection the inspector observed residents were having an improved mealtime and nutrition experience within the centre. Food diaries maintained documented residents engaging in home baking as part of an overall activity and sensory experience within the centre. This inspection was the first inspection that the smell of cooked food was present. This was a significant improvement as it provided residents with a sense of anticipation for their meals and a sensory experience akin to any home environment of which they had not been afforded previously.

Not all meals provided to residents were prepared in the centre and residents received their main meals from the centralised kitchen within St. Patrick’s Centre. The provider was required to continue with the improved meal provision for residents and strive towards a cessation of institutional meal provision going forward.

**Judgment:**
Substantially Compliant

**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

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

Findings:
Since the previous inspection the provider had implemented a medication management improvement initiative throughout all St. Patrick’s Centre designated centres which had brought about improvements to ensure overall safety of medication management within St. Patrick’s Centre, Kilkenny services. Medication management systems on this inspection were found to be in compliance.

A project leader for practice development of medication management practices had been appointed since the previous inspection. They had instigated a number of initiatives within the organisation. One initiative implemented was the review of stored medications in the centre. Excess stock of medication in the designated centre was identified as a risk and all surplus and/or out-of-date medications were returned to the pharmacy as per the organisation’s returns of medication policy and procedures.

A local pharmacist now supplied medications to the designated centre in a pre-packed medication dispensing system. This reduced the amount of medications stocked in the centre which in turn reduced the risk of medication errors from occurring and medication mismanagement. A revised easier to use medication administration and documentation chart was also in place identifying medications prescribed residents and the times administered by appropriately trained staff.

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

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

Staff spoken with during the inspection demonstrated a good understanding of safe and appropriate medication management systems including the management of out-of-date and unused medications. Safe storage arrangements were in place for each residential unit that comprised the centre. Medication criteria planning was in place for all prn (as required) medications to ensure it was only administered when specific criteria was met.

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 had produced a statement of purpose which reflected the services provided within the centre.

There was some revision required so that it reflected the most up-to-date governance arrangements in the centre. The capacity numbers for the centre also required revision to reflect the application to register made by the provider.

The provider was required to submit the revised statement of purpose to the Chief Inspector when the document was revised.

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:
Overall, St. Patrick’s Centre provider had introduced a significant suite of systems to ensure the safe and effective management of all designated centres within St. Patrick’s Centre. Reporting structures to the Board for St. Patrick’s Centre were now well
established and provided assurance to the Board that services were being effectively monitored and managed. There were improvements required in relation to the appointment of a full-time person in charge for this centre.

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 the Regulations 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.

The provider had met their regulatory requirements in relation to six monthly provider led auditing and review. While provider led audits were comprehensive they did not always set out an action plan, persons responsible for addressing the action plan and by what time. A quality and compliance management team were in position within St. Patricks’ Centre with responsibility for the oversight of auditing within the service and bringing about systems to ensure compliance with the regulations and standards.

Inspectors reviewed these systems during the course of the inspection and found overall there was a comprehensive system both at an organisation level and operational management level within the centre to ensure key quality indicators were reviewed through the auditing processes. Some individual audits required improvement to ensure they assessed practices in the centre in enough detail, for example, financial auditing in the centre did not review the actual logs and balances maintained for residents’ personal monies.

The provider had also produced an annual report for the service which set out information about the centre from the previous year.

**Judgment:**
Substantially Compliant

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**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 any absence of the person in charge longer than 28 days.

Two team leaders operationally managed the centre and reported to the person in charge. In the absence of the person in charge they assumed responsibility of the centre.

Judgment:
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 16: Use of Resources</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</em></td>
</tr>
</tbody>
</table>

| **Theme:** |
| Use of Resources |

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

| **Findings:** |
| The centre was appropriately resourced in most aspects in order to meet the assessed needs of residents. |

One of the transport vehicles for the centre was no longer in use. The provider was required to review the transport resources for the centre to ensure residents social care goals and community integration planning could be effectively met.

At the time of inspection, due to the lack of transport resources available some residents were unable to participate in activities outside of the campus of St. Patrick’s Centre due to the vehicle being used to transport residents to medical appointments, for example.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 17: Workforce</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>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.</em></td>
</tr>
</tbody>
</table>

| **Theme:** |
| Workforce |

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

| **Findings:** |
| The centre was appropriately resourced in most aspects in order to meet the assessed needs of residents. |

One of the transport vehicles for the centre was no longer in use. The provider was required to review the transport resources for the centre to ensure residents social care goals and community integration planning could be effectively met.

At the time of inspection, due to the lack of transport resources available some residents were unable to participate in activities outside of the campus of St. Patrick’s Centre due to the vehicle being used to transport residents to medical appointments, for example. |
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 this inspection.

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 oxygen therapy and administration of emergency medication for management of seizures for residents with epilepsy and food hygiene.

The impact of staff not having necessary training to administer residents medications for the emergency management of seizures meant residents with epilepsy could only travel outside the campus of St. Patrick's Centre with a nurse accompanying them. Otherwise, any journeys or activities they engaged in outside of the campus could only take place within a five minute drive of the congregated setting. This had a serious impact on the opportunities for residents to engage in activities outside the campus.

The person in charge had extensive experience in the implementation of supervision and had begun to introduce a supervision system in the centre. An inspector reviewed records for supervision meetings that had occurred. These were of a good quality and had focused on reflective practice with the staff supervised and identification of initiatives required to improve service provision and supports for residents in the centre. While this was evidence of a supervision system having begun in the centre not all staff had received a supervision meeting, this required continuing improvement.

A planned and actual roster was available in the centre on the day of inspection. Due to the reduced number of residents now living in the centre the whole time equivalent numbers had also reduced. There were occasions when staff from other designated centres on the campus were required to work in the centre to meet the needs of residents. The person in charge confirmed this happened from time to time.

As residents transitioned from the centre to other designated centres within St. Patrick’s Centre or into new designated centres opening in the community, a staffing complement from St. Patrick’s Centre transitioned with them. The provider was addressing the staffing resource issue in an effective way through forward planning and staff resource allocation from within the campus.

Staff inspectors met during the inspection demonstrated as compassionate, enthusiastic and hard working persons with excellent knowledge of residents and dedication to ensure their needs were met. Some staff spoken with told inspectors they were looking forward to working in community designated centres St. Patrick’s Centre were planning to open and had been involved in viewing potential residences as part of the de-
congregation process.

Staff working in St. Patrick’s Centre had experienced a significant level of change in the previous year. Inspectors acknowledged this and noted improved outcomes for residents were in part as a result of staffs’ willingness to engage in the process on behalf of residents they supported.

**Judgment:**
Non Compliant - Moderate

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**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:**
A directory of residents was available in the centre.

Insurance documents for the centre were up-to-date.

A residents’ guide was also available in the centre and in an easy read format.

Inspectors 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.

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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Saint Patricks Centre (Kilkenny)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001895</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>26 &amp; 27 September 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 December 2017</td>
</tr>
</tbody>
</table>

Requirements

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

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) 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.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (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:
- St Patrick’s communication policy is currently being reviewed and updated. Advice from the Speech and Language Therapist will be sought to support staff in introducing more visual prompts such as talking tiles for those who are visual impaired and seek advice on the use of objects of reference.
- All residents will be receiving an iPad in the coming weeks and months to facilitate amongst other things improved opportunities for communication.

**Proposed Timescale:** 30/03/2018

**Theme:** Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While improvements in the layout of the centre had occurred some review was required in relation to long standing practices still occurring, for example, two hourly night time checks.

2. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
- Night time checks will only be conducted on residents whose risk assessment indicates the need. All night time care plans will be updated to reflect this

**Proposed Timescale:** 31/12/2017

**Theme:** Individualised Supports and Care

The Registered Provider (Stakeholder) 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.

3. **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 schedule of in house activities devised with the support of the OT will be sent to all staff through practice development. Staff will support residents to sample these
activities a number of times before completing conditions for success forms. This information/data will aid in the development of a meaningful individual day for each resident.

Proposed Timescale: 31/01/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvement required to ensure residents were supported to avail of the complaints process within St. Patricks’ Centre through advocacy by an independent person or staff supporting and advocating for them.

4. Action Required:
Under Regulation 34 (2) (c) you are required to: Ensure that complainants are assisted to understand the complaints procedure.

Please state the actions you have taken or are planning to take:
• All residents have been referred to an independent advocate.
• The organisations new human rights process commences in January 2018 which will see all residents reviewed/interviewed in relation to any potential infringements on their human rights. Issues such as restrictive practice, medication, safeguarding, meaningful day etc will be looked at and any concerns referred to the Human Rights Committee.

Proposed Timescale: 31/01/2018

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvement was required in to ensure residents' communication needs were supported with assistive technology and augmented systems where appropriate and following an assessment by a relevant allied health professional, for example SALT.

5. Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
• All residents will have an iPad and staff will be educated on the different approaches/opportunities that can be utilised using the iPad in the coming months.
• All residents will be referred to SALT to help develop augmented communication systems for each person.
Proposed Timescale: 30/03/2018

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

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents natural experience of community living and integration were impacted upon due to the congregated campus setting the centre was located

6. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
• 6 out of the 7 seven residents of Kells Court will have moved to the community and be in their new homes by Christmas 2017. This will naturally help each person experience community living and become a member of their local community.
• The Team Leader/Staff Team will devise a new schedule for the resident not moving to the community to ensure his daily schedule offers opportunities for community inclusion.

Proposed Timescale: 31/01/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider (Stakeholder) 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' and/or their representatives at the time of inspection.

7. 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:
• Contract of care has been reviewed and amended and approved by the Human rights Committee.
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<tr>
<th><strong>Proposed Timescale:</strong> 15/12/2017</th>
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### 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:**

An improved 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:**

- New goal setting system is now in place where the goals are meaningful and a detailed plan to support each goal is outlined including who is responsible for each step of the plan. This will be reviewed and re-evaluated every three months.

<table>
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<tr>
<th><strong>Proposed Timescale:</strong> 15/12/2017</th>
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</table>

### Outcome 06: Safe and suitable premises

**Proposed Timescale:** 31/01/2018
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider was required to improve the security of the fencing to safely support residents using the garden space independently if they wished.

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:
• Maintenance was contacted to repair fence and this work will be completed by the end of December 2017. All staff are to continue to be observant and report any repair work both inside and outside Kells Court as soon as this is observed

Proposed Timescale: 31/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training to ensure they were appropriately skilled in the management of behaviours that challenge.

11. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
• Training schedule is now in place that has remaining untrained staff booked into the training that is scheduled over the next 2/3 months.

Proposed Timescale: 30/03/2018

Theme: Safe Services

The Registered Provider (Stakeholder) 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.

Two residents had paid for sensory equipment recommended by an occupational therapist. The provider was required to review this and refund residents for costs they
should not have incurred if and where appropriate.

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:**
- New financial pathway has been developed and is currently in place for all residents. This involves two staff daily checking the balance and quality of spend. The manager/team leader will complete monthly audits for quality of spend with a six-monthly audit from the finance department.
- All equipment recommended by MDT deemed therapeutic is now funded by the organisation. The residents concerned will be reimbursed.

**Proposed Timescale:** 05/01/2018

**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:**
- Large amount of training has been underway over the past month and booked in for the next two months all staff should be up to date by end of February 2018

**Proposed Timescale:** 28/02/2018

**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.

14. **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:**
• An external consultant has commenced a review of our day services and will produce a report to inform a Strategic Plan for Day Services in line with New Directions. This will include an assessment relating to resident’s employment and education needs in line with their abilities and interests.

**Proposed Timescale:** 30/03/2018

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The provider was required to continue with the improved meal provision for residents and strive towards a cessation of institutional meal provision going forward.

**15. Action Required:**
Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

**Please state the actions you have taken or are planning to take:**
• All meals are now prepared in the centre. A record of the choice offered to the residents is recorded daily and reviewed by the Dietician to ensure staff are providing a varied and healthy diet.

**Proposed Timescale:** 15/12/2017

### Outcome 13: Statement of Purpose

**Theme:** Leadership, Governance and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was some revision required so that it reflected the most up-to-date governance arrangements in the centre.

The capacity numbers for the centre also required revision to reflect the application to register made by the provider.

**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:**
• An updated Statement of Purpose will be submitted to the authority reflecting the most up to date governance arrangements including the capacity numbers.
### Proposed Timescale: 22/12/2017

#### Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The role of the person in charge was not full time and they had a number of responsibilities within St. Patrick's Centre which impacted on their time to carry out their specific person in charge role in this centre.

**17. Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
- There are now 2 Team Leaders in position who are responsible for the day to day running of the centre and report directly to the PIC/CSM (Community Service Manager). The office of the CSM is located in the same building and she provides effective governance through regular meetings with and supervision of her Team Leaders. All Team Leaders and CSM’s attend fortnightly Change Management Meetings with Senior Management.
- Documentation relating to the registration of a new PIC in the centre has been submitted to the authority for consideration.

### Proposed Timescale: 20/12/2017

**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While provider led audits were comprehensive the did not set out an action plan, persons responsible for addressing the action plan and by what time.

Some individual audits required improvement to ensure they assessed practices in the centre in enough detail

**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 provider Led Audit Template will be reviewed and updated to ensure that the
Proposed Timescale: 31/01/2018

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The centre was not adequately resourced with transport vehicles to ensure residents’s social care needs and goals could be met at all times.

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:
• Funding has been allocated under the Decongregation programme to provide for suitable transport for all centres/houses in the organisation.

Proposed Timescale: 15/12/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A staff supervision system was not effectively up and running at the time of inspection, not all staff had engaged in a supervision meeting.

20. 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:
• Team Leader will now undertake supervision; they will provide all staff with a schedule of supervision and as the date approaches a time and date will be booked that suits both staff and team leader in a quite environment.

Proposed Timescale: 31/01/2018
Theme: Responsive Workforce
### The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff working in the centre had not received training in areas specific to meet the needs of residents living in the centre.

#### 21. 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:
- A comprehensive training schedule has been planned for December, January and February 2018 with the aim that all staff will attend training that they require to meet the needs of each person they support.

**Proposed Timescale:** 28/02/2018

### Outcome 18: Records and documentation

#### Theme: Use of Information

**The Registered Provider (Stakeholder) 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 5 policies are currently being reviewed and updated over the coming months with a number completed and in draft from awaiting approval form the board of management

**Proposed Timescale:** 31/03/2018