**Health Information and Quality Authority**
**Regulation Directorate**

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd |
| **Centre ID:** | OSV-0003496 |
| **Centre county:** | Kilkenny |
| **Type of centre:** | Health Act 2004 Section 38 Arrangement |
| **Registered provider:** | St Patricks Centre (Kilkenny) Ltd |
| **Provider Nominee:** | David Walsh |
| **Lead inspector:** | Ide Batan |
| **Support inspector(s):** | Kieran Murphy; Louisa Power |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 28 |
| **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 inform a registration decision. 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: |
|---|---|
| 22 June 2015 10:30 | 22 June 2015 17:00 |
| 23 June 2015 08:30 | 23 June 2015 17:00 |

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

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| 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**

This was an inspection of a centre which was part of St Patrick's Centre Kilkenny Limited. St Patrick's Kilkenny provided a range of day and residential services to children and adults with an intellectual disability. The centre was based in a campus style environment with other designated centres on site.

The centre provided a home to 28 residents with complex healthcare needs and a high level of support needs regarding behaviours, risk and healthcare related issues. Some residents also presented with visual impairments and dementia. Inspectors observed that all of the residents required a high level of assistance and monitoring due to the complexity of their individual needs. Incident forms, residents' records,

staff interviews and inspectors' observations indicated that inappropriate placements resulted in negative outcomes for some residents.

Overall, the centre was majorly non compliant with 17 out of 18 outcomes for residents. Inspectors were not assured that the health, safety, wellbeing and quality of life for residents in this centre was promoted and protected. Inspectors found that the provider was failing to ensure that the staffing levels were adequate in relation to the number and assessed needs of residents with due regard to the size and layout of the centre. Inspectors also found that the provider was failing to ensure that the staffing levels provided to one resident were adequate to ensure the safety of this resident during all waking hours.

Two immediate action plans were given to the provider following the inspection to address these staffing issues. Inspectors also found that the provider was failing to ensure that effective fire safety management systems were in place and a further immediate action plan was sent to the provider the day after inspection. The provider was given three days to submit a response to address the non-compliances identified in the action plans. The immediate action plans which the provider had been issued in relation to fire safety and staffing were returned within the designated timeframe. While there was a defined management structure it did not provide for effective governance, operational management and administration of this centre. There was significant non compliance in relation to fundamental and essential components of the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 including core components of governance:

- Management of alleged allegations of misconduct
- staffing level and skill mix
- reviewing quality and safety of care
- effective fire safety management
- restrictive practices
- risk management
- management of complaints and
- medication management.

Present governance arrangements are not effective in ensuring safe outcomes for residents and ensuring that resident's health and social care needs are met. Inspectors were not assured that where a concern arises for the safety of an individual the registered provider takes reasonable and proportionate interim measures to ensure the protection of all residents. Inspectors were not assured that the provider and management team were responding to risks and initiating change to ensure the care, safety and welfare of residents. The inspectors found that the person in charge did not have the capacity to have robust oversight of the centre to ensure that safe effective care was provided to residents. This was due to the extent of her remit in relation to the complexities of residents' needs and inadequate staffing levels and skill mix.

Inspectors found the premises to be substandard and very poorly maintained and not fit for its stated purpose. There were sinking floors in one unit and flooring in disrepair throughout all other units. Some items of furniture were held together with

duct tape and many wardrobes and other items of furniture requiring replacement. Paint was peeling from the window frames and chunks of wood were missing from some windows. Doors on the outside of the buildings and the walls in many areas inside required painting. Many doorways internally were in very poor condition as they were narrow and wheelchairs could not fit through with ease therefore door frames had been badly damaged. Ceilings in many areas were damp with water stains. The centre was visibly unclean in all areas. Visible layers of dust were present throughout the centre. The person in charge sent monthly reports to the management team. In a report to the management team dated 01 -18 May 2015 it stated that the "upkeep, maintenance and condition of the centre was unacceptable for residents to call their home." On the first day of inspection it was 20 degrees and humid. Inspectors noted that the heating was on in the centre. The person in charge said that it was not thermostatically controlled and could not be turned off. She stated that it was on all the time regardless of the weather.

Routines, practices and facilities placed undue restrictions on residents' activities of daily of living and impinged on their rights and civil liberties. Institutional care practices resulted in limited control and choice for residents over their lives in accordance with their preferences. Residents' independence was not actively promoted and maximised. Visitors could not be received in private. This will be further outlined in detail throughout the report.

The Action Plan at the end of the report identifies other areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

**Outcome 01: Residents Rights, Dignity and Consultation**
*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
The inspectors found that the arrangements in place in relation to protecting residents' rights were not satisfactory. Institutional care practices resulted in limited control and choice for residents over their lives in accordance with their preferences. Residents' independence was not actively promoted and maximised. Visitors could not be received in private.

There was a waste bin in all of the bungalows which were for aprons that had been used by residents while eating. There was a sign on all these waste bins which said "feeders only". This did not respect the residents being cared for by St Patrick's service. Inspectors insisted that this sign be removed from all waste bins on the first day of the inspection.

There was evidence that residents were not being protected in relation to the management of their own money. There were records to show that in 2015 one resident had purchased at their own expense a pine chest of drawers, a pine locker and a double bed. These items were all expensive and it was not in keeping with St Patrick's policy on residents' private property which outlined that it was "St Patrick's service responsibility to fund from its own resources the cost of necessary furniture, fittings and equipment". There were not any records available of discussion with or advice given to the resident in relation to these purchases. There was no record of any input from an independent advocate in relation to these purchases. There was no record of any rationale from the service provider as to the reason why these purchases were made by the resident.

Residents were not supported and encouraged to have control over their own finances. There was evidence of assessment carried out to ascertain the level of support required

by residents to manage their financial affairs. There was no evidence to suggest that where a resident lacked capacity to manage their financial affairs, that he or she was facilitated to access an advocate to assist them in making decisions. Bank accounts were not held in the name of the residents to whom the money belonged. The residents' money was instead held in a central account which was managed by the centre. Inspectors saw that monthly bank statements were being issued to residents and their families.

Limited private accommodation hindered residents' freedom to exercise choice and control with pursuing personal recreational activities. For example, the communal areas in each unit were multi-purpose and used for dining, activities and relaxation. Inspectors observed staff having lunch at the dining table as there were no staff rooms whilst residents participated in activities or watched television. There was no private space for residents to meet and socialise with their visitors.

Inspectors noted that residents did not have access to their personal possessions at all times. For example, a resident's wardrobe was locked at night time and the resident did not have free access to their clothing and other possessions. Routines, practices and facilities placed undue restrictions on residents' activities and daily living and impinged on their rights and civil liberties. Access to taps and drinking water was restricted to all residents as a control to mitigate behaviour that challenges. Access to the kitchen area was restricted to residents. In one part of the unit, the fridge was located within a locked staff office which restricted residents' access to meals and snacks. Residents were not supported in independent mobility and to enter and leave their home to enjoy the campus grounds independently. Some residents indicated that they would like to go for a walk but inspectors observed that they were not provided with support at the time.

Residents were not consistently afforded the opportunity to exercise personal autonomy and choice in their lives. Whilst inspectors observed some residents were offered simple choices in relation to food and beverage, this was not consistent and did not extend to most aspects of residents' daily life including access to the community, activities, living arrangements and communication. The inspectors spoke with staff in addition to making observations regarding resident's activation levels on the inspection and also reviewing the resident's progress notes. The inspectors found that residents had some level of activation however, improvements were required to ensure that the activities were meaningful, frequent and in line with resident's preferences.

There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests, capacities and developmental needs. In addition the inspectors also found that outings were mostly group based activities; one to one activities and outings were infrequent. Inspectors sat for a period of time observing care practices in communal areas. Overall, inspectors observed that activities were led by routine and resources not the resident and their support needs and wishes and there was very little meaningful engagement with residents.

There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents meetings or resident/relative surveys. While there were weekly house meetings between residents

and staff these meetings did not consistently afford residents/relatives opportunities to participate in communications or discussions about the running of the centre. The last house meeting had taken place on 22 April 2015. However there were no residents present at this meeting.

Inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint.

There was a local complaints policy and the centre did maintain a complaints log. However, the complaints log did not record if the complainant was satisfied with the outcome of the complaint. There was no second nominated person to respond and maintain complaint records as required under regulation.

**Judgment:**
Non Compliant - Major

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
Residents' communication abilities were not fully maximised and interventions were not provided to ensure communication needs of residents were met.
A policy in relation to communication with residents, last reviewed in January 2015, was made available to inspectors. The policy outlined the supports to be made available to ensure residents were facilitated to communicate. However, inspectors saw that these supports were not implemented in practice.

Inspectors reviewed a sample of communication assessments and profiles. The majority of residents were unable to communicate verbally. Assessments were not adequate; there was a lack of multi-disciplinary input and some areas were not fully completed, e.g. an assessment did not indicate if a resident was able to communicate verbally or could hold a conversation. Communication assessments did not indicate if assistive technology, aids and appliances had been considered and were required to promote residents' full capabilities in relation to communication.

Communication profiles lacked sufficient detail to guide staff to meet the individual requirements of each resident. Many profiles did not give examples of how residents would express their needs, emotions or wishes.

Inspectors observed staff interacting with residents and noted that regular staff members were familiar with residents' communication needs and responded appropriately. However, inspectors noted that unfamiliar staff struggled to communicate in a meaningful way with residents.

**Judgment:**
Non Compliant - Major

**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:**
Inspectors observed and were told by staff that there was minimal integration with the local community. There was a family forum group in operation. However, inspectors saw that the last meeting had taken place in July 2014. There was a policy on visiting and residents said to the inspector that families were welcome and were free to visit. A log was maintained of all visitors. However, there were no private spaces for residents to meet and socialise with their visitors.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
There were contracts of care in place for some residents signed by their relatives. However, details regarding the services provided, the type of accommodation and the

additional costs that may be incurred as part of their service were not fully outlined. For example the contract did not stipulate the weekly cost of residency in the centre. As outlined under Outcome 1 the centre was in breach of its own policy in relation to additional charges to residents. This was actioned under Outcome 1.

The admission practices and policies did not take account of the need to protect residents from abuse by other service users. The Authority was in receipt of unsolicited information in relation to this identified issue which was explored during the inspection. Inspectors reviewed documentation in relation to the unsolicited information such as care plans and medical records. The provider acknowledged that there were deficiencies in the protection of residents from peer on peer abuse.

**Judgment:**
Non Compliant - Major

**Outcome 05: Social Care Needs**
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
A major non-compliance was identified in relation to this Outcome as the designated centre did not meet the assessed needs of all residents. In addition the care planning process was not adequate.
The inspectors found that the designated centre did not meet the assessed needs of all residents as there was an unsuitable mix of residents with complex needs in the centre. Residents who had diverse and complex needs including behavioural support requirements were found to be living alongside residents whose activities of daily living and behaviour could detrimentally impact on others. This included incidents of injury and harm between peers, such as hair pulling, hitting out or biting occurring frequently. Inspectors noted a situation where a resident who chose to go to bed at 18:00 in order to avoid harm or injury as a result of such behaviour. For one resident records of multi-disciplinary team meetings indicated that an individualised living environment was required, specific to the assessed needs of the resident. An emergency placement meeting was to be arranged for a resident whose placement was negatively impacting on peers. However, this meeting had not taken place.

One resident had been placed in the centre as an emergency admission in March 2014 and was still living there. This resident was significantly younger than all other residents. This placement had been completed without any transition plan for the resident and without adequate supports in place for this resident. Staff said that they had received two days notice that this resident was coming to live in the centre. There was evidence of reviews of the resident by a consultant psychiatrist which stated that the effects of this unplanned admission had resulted in the resident being "highly stressed, anxious, angry and sad in the context of recent changes in his life."
Inspectors reviewed a sample of assessments and personal plans. There was a lack of evidence based tools used to assess the health, personal and social care and support needs of each resident on an ongoing basis. Many of the assessments reviewed did not have multi-disciplinary input. Assessments did not examine the supports required to maximise residents' abilities and personal development.
Personal plans did not sufficiently outline the individual needs and choices of each resident. For example, inspectors observed limited detail in relation to links with the community and friends/relationships sections. Information contained within personal plans did not reflect other care plans, e.g. intimate care plans. Residents were not supported to participate in the development of their personal plan. Personal plans were not updated when a resident's circumstances changed, e.g. change in mobility arrangements. Personal plans did not outline supports required for residents to maximise their capabilities. The personal plans were not made available to residents in an accessible format.
Personal plans did not outline measures to improve the quality of life and outcomes for residents. Goals were linked to activities of daily living and healthcare needs rather true aspirations that would improve the lives of residents.
Personal plans were reviewed on an annual basis and residents' families/representatives were consulted and involved in the review process. However, the review process was not sufficient:
• It was not multidisciplinary
• residents were not supported to participate in the review process
• names of those responsible for pursing objectives ain the plan within agreed timescales were not included.

**Judgment:**
Non Compliant - Major

**Outcome 06: Safe and suitable premises**
*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
The person in charge sent monthly reports to the St Patrick's management team. In a report dated May 2015 the person in charge stated that the "upkeep, maintenance and condition of the centre was unacceptable for residents to call their home." Inspectors found the premises to be substandard and not adequate for residents' needs.
The centre consisted of two distinct areas. The first area provided a home to 16 residents in three interconnected bungalows, called "sides". Most bungalows had a bin for incontinence pads at the front entrance. The flooring in side three had a slope running throughout the living/dining room. It was a clear trip hazard and also did not promote accessibility with reference to the residents living here, some of whom were wheelchair users. The doorway to this living room was badly damaged and inspectors observed one resident trying to get their wheelchair through this door and hitting the sides of the doorway. Again this did not provide an appropriate accessible living space for residents.
One of the bungalows in this area was home to five residents, nearly all of whom had a visual impairment. This bungalow had not been equipped with any appliances or aids to help people to move independently around their home. In addition, the main living room was used as a walkway between side 3 and side 1 with staff, other residents and delivery people coming into the living room unannounced throughout the two days of the inspection. This practice did not respect residents' privacy and dignity in relation to their living space.
Most of the soft furniture and chairs for residents throughout this first area was damaged and held together with duct tape. Flooring through this first area was also damaged and held together with duct tape. Inspectors noted that radiators were on even though it was a warm day. The person in charge advised that the heating cannot be turned off as it was used to provide hot water.
The second area provided a home to 12 residents in three separate bungalows side by side. The bungalows here were in a better condition and were bright and clean. The walls, while painted, were unplastered bare block walls.
Inspectors found that the centre had not been well maintained. The paintwork was peeling from wooden windows on the outside of most bungalows. A number of windows appeared to be in need of replacement. The wood in one window frame in a bathroom in side two was clearly damaged. The pathway leading to the entrance of one bungalow was extremely uneven. All the service users in this bungalow used wheelchairs when outside.
Inspectors observed that some parts of the centre were visibly unclean. For example there were cobwebs in the window of one resident's bedroom on side 3. The extractor fan from the kitchen in this area was covered with grime. One of the bathrooms had mould clearly visible on a wood panel and this bathroom did not have any hand washing or hand drying facilities.
In total there were 28 single bedrooms. Most of the bedrooms in sides 1, 2 and 3 had originally been designed for children and were quite small. In some of the bedrooms residents could not walk around their beds due to the size of the room. All bedrooms had beds, wardrobes and some had wash hand basins. However, some of the taps had been removed from the wash hand basin and so could not be used. Where the sinks had been taken out of these bedrooms the walls had not been repaired or repainted. One

resident showed inspectors her bedroom room and as with most of the bedrooms it was well presented with many personal items, including pictures of family.

**Judgment:**
Non Compliant - Major

**Outcome 07: Health and Safety and Risk Management**
*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
Improvement was required in relation to how the designated centre was managing risk, including health and safety, infection control and fire. Following the inspection an immediate action plan was issued as it was found that the provider was failing to ensure that there were effective fire safety management systems in place. In response to the deficits in fire safety, a single outcome inspection was scheduled to be undertaken by an inspector from the Authority with a specific remit for fire safety.

The provider had hired a consulting engineer to review fire safety arrangements. The consulting engineer's report dated June 2014 found that the premises were not divided into separate fire resisting compartments and recommended that all premises be subdivided into fire resisting sub-compartments. The report also recommended that bedroom doors should be fitted with self-closers which closed automatically. It had been recommended by the consulting engineer that each building would have a fire detection and alarm system installed. However, during this inspection inspectors was found that none of the buildings, which accommodated 28 residents in total, were fitted with an automatic fire detection or alarm system. In addition, none of the recommendations from the consulting engineer had been implemented to date. The inspectors were informed that a copy of this report from the consulting engineer had only been given to the person in charge in June 2015.
Throughout the premises there were locked final exit doors. Some of these doors had keypad digi-locks on them. These doors did not automatically open in the event of a fire which meant that people could not leave the building if they did not know the code to the keypad. Inspectors requested that suitable and safe evacuation arrangements be put in place in relation to operation of these fire exit doors.

Some of the final exit doors were locked and had keys hanging adjacent to the doors. Staff indicated that they did not carry keys on their person so that if the key could not be accessed people could not leave the building. Other final exit doors had keys in key boxes which were coded. As staff did not carry keys on their person if the key could not be accessed people could not leave the building. The review of these arrangements had

also been a recommendation from the consulting engineer's report in July 2014 which had not taken place.

While the registered provider did have in place a clear procedure to be followed in the event of a fire, there was no fire policy document outlining St Patrick's service commitment to ensuring fire safety in the premises. This had also been a recommendation from the consulting engineer's report in July 2014.

Records showed that all staff had received fire training including the use of fire extinguishers. However, inspectors were not satisfied that fire extinguishers were readily available to staff/residents. For example, in one house the fire extinguisher was being used as a curtain holder. There was a notice on the wall here saying not to cover the fire extinguisher. In another house the fire extinguishers were in the locked staff office. Inspectors also observed fire extinguishers in the corner of the office behind the medication trolley.

There were monthly fire evacuation drills being undertaken involving the residents. In the records seen by inspectors some residents had refused to leave the premises during the fire evacuation drills. The provider failed to demonstrate that all appropriate alternatives had been explored to evacuate residents in the event of a fire nor had input from a competent person in the area of fire safety been sought where required.

There were no records available of fire drills conducted either at night or simulating night time conditions in order to ensure night time staffing levels were sufficient for evacuation purposes. This was particularly relevant in as the response time to evacuate the premises in one recorded drills was over five minutes. In addition nearly all residents required support to exit their home.

Not all of the houses had fire procedure notices on display of actions to be taken in the event of fire. While there was escape signage available to direct occupants to final exits this required review. In one house in particular the exit sign was via the back door. However, staff said that in practice this door was not used. In addition, staff indicated that during fire evacuation drills they had never practiced leaving the building other than through the main entrance.

The inspectors saw evidence that suitable fire prevention equipment was adequately maintained by means of fire extinguisher servicing and inspection December 2014. Emergency lighting in all houses had been serviced in June 2015.

Staff had engaged in a process of identifying specific hazards relating to residents' lives. These were called individualised risk assessments and each included an analysis of what the issue was, the controls in place to manage the issue and what further controls were required. Inspectors found that this process of risk assessment was not understood by staff. Not all identified hazards had been assessed in accordance with an outline of whether it was a low risk, medium risk or high risk. Inspectors saw that most risk assessments relating to one service user had not been updated as required. For this resident most of the issues identified as requiring risk assessment were not related to hazards to the resident at all. In fact they were restrictions on his life like turning off all the water in the house. However, St Patrick's Centre had not recognised these issues as

restrictions.

The process for identifying and recording of incidents was not understood by staff. Inspectors reviewed the incident reporting from January 2015 to 22 June 2015 and saw records for 188 incidents:
• 85 incidents relating to behaviour that challenges
• 27 incidents where a resident or staff was struck by a resident
• 24 incidents were categorised as "OTHER". This included residents biting staff and other residents and residents pulling other residents' hair.
• 18 self injurious behaviour by residents
• 12 resident falls
• 12 unexplained injuries
• 4 incidents of violence and aggression
• 2 equipment issues
• 3 incidents of a hazard
• 1 incident of inappropriate behaviour
• 1 incident of choking
• 1 incident of resident absconding.

As can be seen from above table incidents were not being recorded in the same way all the time. For example inspectors saw that the same incident type was being recorded sometimes as a violent incident, sometimes as a resident striking another resident and sometimes being categorised as "OTHER". It was also unclear if these incidents were kept under review by the provider or if there was any formal learning being undertaken in response to the types of incidents being recorded.

Inspectors found that procedures, in line with the standards for the prevention and control of healthcare associated infection published by the Authority, were not consistently implemented. As outlined in outcome 10, residents with invasive medical devices were placed at risk. Processes for the management of invasive medical devices had not been developed and implemented. Even though some of the devices were managed by a community intervention team, staff were not trained to manage complications associated or may occur. For residents with a healthcare associated infection, measures were not in place to prevent, control and manage the infections. Hand hygiene facilities were not sufficient in number or readily accessible. Staff did not actively promote hand hygiene with residents. Care plans had not been developed to guide staff in the safe and effective management of residents with a healthcare associated infection in a person-centred, prompt and efficient manner in line with national guidelines and evidence based practice.

**Judgment:**
Non Compliant - Major

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

**Findings:**
There were inadequate measures in place to protect residents from being harmed or suffering abuse. Processes were not implemented to ensure that appropriate action was taken in response to allegations, disclosures or suspected incidents of abuse and neglect. Residents were not consistently provided with adequate emotional, behavioural and therapeutic support in a proactive manner that promoted a positive approach to managing their behaviours that challenged.

There was a policy in place for the prevention, detection and response to abuse. The policy was comprehensive, evidence based and would effectively guide staff in the identification, reporting and investigation of allegations, disclosures incidents. However, as outlined in outcome 18 the policy available to staff did not contain an implementation or review date. The policy was not implemented which had resulted in residents not being appropriately safeguarded.

As outlined in outcome 5, incidents of injury and harm between peers, including hitting out and biting, occurred on an almost daily basis and was observed by staff. Measures that had been recommended by the multidisciplinary team, such as alternative accommodation, had not been put in place to protect residents.

The processes in place for the reporting, investigation and management of allegations, disclosures or suspected abuse did not adequately safeguard residents. Due to this, allegations of neglect were not always identified and followed up in a timely way. Inspectors saw evidence of a letter that outlined an allegation of neglect. This had not been identified as a potential allegation and had not been investigated in an appropriate manner in line with local and national policies.

As outlined in outcome 1, routines, practices and facilities placed undue restrictions on residents' activities of daily living. Many of the restrictions were not recognised as restrictive procedures and environmental restraint. Residents' egress from each premises was restricted by keypad locks that residents could not operate. Some residents did not have free access to food and water. Access to areas of the centre was restricted to resident; access to some residents' bedrooms was restricted by keypad locks and access to the kitchen was restricted by a safety gate. Staff outlined to inspectors that this was

used as a protective measure for vulnerable residents but inspectors saw that this unduly restricted their peers. Inspectors observed that residents were treated collectively rather than as individuals. For example there were signs on all these waste bins which read "feeders only".

Policies for the provision of behavioural support for residents and the use of restrictive practices were made available to inspectors that had been reviewed in January 2015. A human rights committee, a multi-disciplinary team, discussed and approved the use of restrictive practices. However, inspectors saw that referrals were not always sent due to a lack of recognition of restrictive practices. When referrals were sent, there were delays in discussions and subsequent approvals of restrictive practices. Therefore, restrictive procedures were used without a multi-disciplinary assessment.

Inspectors saw records that did not demonstrate that episodes of restrictive practices were considered only if there was potential benefit from use of a restrictive procedure to the resident and the risk involved if the procedure was not used, outweighed the possible negative effects on the resident subject to the procedure. There was also evidence that alternative interventions were not considered prior to the use of restrictive procedures. A full assessment of the resident prior to each episode of restrictive procedure, monitoring of each residents during any episode, adverse events resulting from the restrictive procedure and a detailed record of each episode were not documented. Restrictive procedures were not reviewed as outlined in residents' plans. In addition, when chemical restraint was administered, it was not recorded in the medication administration record.

Inspectors saw that plans for restrictive procedures outlined procedures that were deemed to be disproportionate. For example, a
plan to collect a sample of blood from a resident outlined that the resident would be physically restrained by three staff members whilst a fourth performed the procedure. There was no evidence that a least restrictive procedure had been considered.

Inspectors reviewed a selection of positive behaviour support plans, which had been reviewed at least annually. The plans were not sufficient to guide staff to support residents and many did not have multidisciplinary input. Clear strategies were not outlined to support residents to manage behaviour that challenges or that focussed on a proactive and positive approach. Strategies were not outlined to support residents in relation to all the behaviours specific to the resident. Positive behaviour support plans did not outline restrictive practices approved or prescribed for residents. The plans did not outline sufficiently the antecedents and communication functions of the behaviours displayed which, when identified promptly, would guide staff to support residents in preventing incidents of behaviour that challenged. Non-restrictive interventions were not always outlined to guide staff such as redirection, noise reduction, distraction and diversion. Overall, inspectors formed the judgement through observation, review of documentation and dialogue that institutional abuse had occurred due to poor care practices observed, inadequate responses to complex needs, inadequate staffing, skill mix and ineffective supervision of staff. These issues are referenced in detail throughout the report.

**Judgment:**
Non Compliant - Major

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
The centre had a log of incidents and accidents which the inspectors reviewed. The Authority had received notifications from the centre. However the Authority did not receive all necessary notifications including an alleged allegation of neglect within the designated timeframe as stipulated in the Regulations. Inspectors discussed this with the provider nominee at the feedback meeting post inspection.

**Judgment:**
Non Compliant - Major

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
Residents were not always facilitated to participate in an activities programme that was based on individual need, capacity and preference. During the inspection residents were observed spending long periods of time not engaged in any meaningful activities throughout their day. Residents were observed by inspectors sitting for long periods in their rooms and communal areas without any interaction with staff. It was unclear from reviewing resident's personal plans if their wishes and aspirations regarding training and education were known or that this was assessed or explored on behalf of the residents as there was no supporting documentation available.

**Judgment:**
Non Compliant - Major

**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:**
Inspectors noted that there was timely access to medical services and appropriate treatment and therapies. There were regular General Practitioner (GP) visits, annual medical reviews and staff confirmed that the GP service was timely and responsive. Residents had access to a consultant psychiatrist who attended the centre frequently. Referrals were made to specialist surgical and neurological services as required. Where treatment was recommended or prescribed by a medical practitioner, inspectors saw that this treatment was facilitated in a timely manner.

There was a lack of evidence based assessment tools to identify and assess residents' medical needs, for example mobility, skin integrity and pain. Some residents were observed to have needs in these areas. A number of allied health care services were available including physiotherapy, occupational therapy, dietetics, psychology and behavioural therapy. Staff with whom inspectors spoke reported that many of the allied health care services attended residents following a referral. Inspectors saw that where assessment tools were in place in relation to nutrition however, referrals were not made in line with the centre's policy, i.e. when a resident lost more than 1kg of weight in one month. Therefore, access to allied health care services was reactive to a clinical deterioration or event rather than proactively promoting a preventative approach to care and support.

Inspectors also saw evidence that the allied health care services available did not reflect residents' diverse and complex health care needs. For example, the speech and language service available to residents did not meet residents' needs as it did not provide a service to assess and support the residents who had significant communication needs.

Inspectors noted that residents' families and representatives were made aware of the care and support provided to residents from the healthcare team. However, inspectors did not see that accessible health information was made available to residents. Management of epilepsy was in line with evidence based practice. Individualised care plans were developed for residents which gave a background to epilepsy, past/present treatment, type and frequency of seizures and known triggers. Information in relation to

the individualised management of seizures was also included which would effectively guide staff in first aid and the administration of emergency medicine. However, as outlined in Outcome 12, some medicines included in the plans were not prescribed.

Unsuitable environment and inappropriate placement of residents negatively impacted on the provision of healthcare. Residents with complex healthcare needs lived with residents whose activities of daily living could place their peers at risk. There was a risk that invasive medical devices could be dislodged or displaced by peers which could place residents at risk of infection, blockage of the device, pain or bleeding.

A hospital transfer form was available to communicate relevant information when a resident was transferred to hospital. However, transfer forms were not completed in advance of transfer or contained inaccurate information. This failing could potentially cause a delayed transfer or inaccurate and incomplete information being communicated. Inspectors saw a form that had been completed in 2007 however, it contained contact information for another designated centre and had not been updated to reflect the resident's current needs. This non-compliance was actioned in Outcome 5.

The wishes of residents and their representatives had not been ascertained in relation to care at end of life. Discussions had not taken place to ascertain the actions to be taken that would be in each resident's best interest such as transfer to hospital, administration of intravenous medicines, artificial hydration and nutrition, admission to a critical care environment, ventilation or resuscitation. An automated external defibrillator (AED) was available however, the training matrix indicated that many staff had not received training or refresher training.

Residents' lunch and supper were prepared at the central kitchen and were delivered in hot boxes to kitchenettes. Inspectors saw that a choice of meal was made available to residents and the meals were varied. Sufficient quantities of food were delivered and made available to residents. Inspectors saw that some residents sat with peers at the dining table and that independence was promoted. However, inspectors observed other residents who required additional support dined alone and that staff mixed components of a modified consistency meal so that the resident could not identify each individual component of the meal.

Sufficient supplies were available to prepare light meals and snacks on the unit. Snacks and drinks were offered regularly. Inspectors observed that staff were responsive to any requests from residents for snacks and drinks. Some residents enjoyed helping staff to do grocery shopping. However, as outlined in Outcome 1 and 8, some residents did not have free access to food due to restrictive practices.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
An organisational policy in relation to medication management was made available to inspectors which had been reviewed in May 2015. The policy was comprehensive and evidence based. Guidance was included in the policy relating to ordering, receipt, storage, administration and disposal of medicines. The policy was made available to staff who demonstrated adequate knowledge of this document.
A personalised plan in relation to medication had been developed for each resident and was reviewed on an annual basis. However, the plans were generic in detail and lacked sufficient personalised information in relation to residents' likes and dislikes in relation to medicines management. Plans had not been updated to reflect changes in medicines. For example, a recent prescription outlined that a medicine was to be taken before breakfast however, the care plan stated that medicines were to be taken with food. In addition, if the medicine were to be taken with food, the effectiveness would be reduced.
Medicines were supplied by the pharmacy department in a local acute hospital. Staff with whom inspectors spoke confirmed there was timely access to medicines and that a pharmacist was available to meet with residents and their representatives if required. Medications were stored securely. Staff confirmed and inspectors saw that medications requiring additional storage requirements were not in use at time of the inspection.
The medication management policy outlined that residents were encouraged to take responsibility for their own medication, in line with their wishes and preferences. A tool was available to guide staff in the risk assessment and assessment of capacity of residents who wished to take responsibility for their own medicines. Staff confirmed that no residents were self-administering medication at the time of inspection.
Inspectors reviewed a sample of prescription and administration records. Inspectors noted that the administration records identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, as outlined in Outcome 18, significant gaps were noted in administration records.
Inspectors observed unsafe medicines administration practices. Nurses were often distracted from the task by other residents, staff and telephone calls. Inspectors observed that medicines to be administered to residents were not equivalent to those prescribed. Ambiguous prescriptions had not been clarified with the prescriber to ensure that the correct medicine was being administered.
Some residents required their medications to be crushed prior to administration and a general authorisation to crush was identified on the front of the prescription record. However, each individual prescription did not contain an authorisation by the prescriber to crush the medicine prescribed.

Staff with whom inspectors spoke outlined the manner in which medications which were out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal.
Audits in relation to medicines management were completed on a regular basis. However, as outlined in Outcome 14, the audits were limited in scope and did not identify pertinent deficiencies.

**Judgment:**
Non Compliant - Major

**Outcome 13: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
While there was a statement of purpose (SOP) available it did not accurately describe the service provided in the centre and the manner in which care was provided. It was not centre specific to this designated centre and referred to St. Patricks throughout the document. It was not reflective of the resident population that lived in the centre as observed by inspectors and did not accurately reflect the care and support needs of this specific group.

Further development was required to ensure that the statement of purpose complied with the Regulations and further information regarding the services which the centre provided or facilitated to meet the care and support needs.

The SOP did not include all of the information required. The following was missing:
• a description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function
• an admission criteria, including emergency admission procedure
• it did not include the total staffing compliment in full time equivalents with the management and staffing compliments as required by Regulation 14 and 15.

A number of sections within the document refered the reader to other documents and there is no further information included in the SOP such as :
• individual Care Plan (Access to education, training and employment)
• the Mission Statement and Individual Care Plan (Respecting Privacy and Dignity)
• individuals Personal Outcomes (Separate Facilities for Day care)

Also it stated in the SOP that there was no social worker or psychologist employed by the centre but one could be arranged if necessary. The statement of purpose did not detail how this may be arranged or if there was an extra cost for this service. There was no implementation or review date on the document submitted for the application to register therefore it was not possible to ascertain if the information was up to date.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
The inspectors found that there was an organisational structure in place however, significant improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs. There was a provider nominee and a person in charge. There were 12 members on the board of management, none of these members which included the provider nominee had ever made an unannounced visit to the centre to conduct a review of the service. Inspectors were not assured that there was robust oversight of the centre or that staff were fully supported to carry out their roles effectively. The person in charge due to the extent of her remit in relation to the complexities of residents, needs and inadequate staffing levels and skill mix did not have the capacity to ensure that safe effective care was provided to residents.

Governance and management systems did not support staff to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. Staff with whom inspectors spoke to were committed to providing good, safe care and to improving the services that the centre provided. However, inspectors found that where concerns were raised by staff, there were unacceptable delays by senior management putting controls in place to meet residents' needs as evidenced in documentation reviewed by inspectors. Inspectors saw that the person in charge sent monthly reports to the management team. All reports raised concerns in relation to lack

of continuity of staff compromising residents care, nursing leave not being covered by nursing staff and the junior clinical nurse manager sometimes being the only senior nurse on duty with no extra cover being provided for her. Other staffing issues that were not rectified included only one nurse on duty between 18:00hrs and 21:00hrs which was unsafe and unacceptable practice given the complexity of needs of the resident population, as observed by inspectors.

There were deficiencies in the provider nominee's understanding of his role and knowledge of the regulations. This centre was the last centre to have a registration inspection under St. Patrick's Centre. Inspectors were not satisfied that there was effective communication between the provider nominee and the person in charge. Inspectors did not see any evidence of formal meetings between the provider nominee and the person in charge. There was no evidence of any shared learning across the campus from other inspections. Inspectors were informed by staff that there had not been any shared learning. The same repeated non compliances with Regulation cumulatively indicated that the centre was not managed or governed in a manner that supported the creation and continuous improvement of a safe person centered service that collectively met the needs of all residents. As evidenced throughout this report; the systems in place to manage risk were reactive and ineffective.

Inspectors were not assured about the provider nominee's role in ensuring the quality and safety of care of residents. An annual report of quality and safety of care and support for this centre had been completed for 2014. In addition, in the documentation seen by inspectors there were no improvements clearly demonstrated or corrective action plans generated. It was also unclear if this annual report had been shared with residents and their families. As outlined previously the person in charge sent monthly reports to the management team. Many of these reports viewed by the inspector indicated on-going concerns re unsafe staffing levels. The inspectors noted that no response was received from senior management in relation to some of the reports which did not create a transparent and positive governance environment.
Inspectors observed that although some audits had been conducted these were not regular or robust enough to indicate improvements required or give clear direction on evidenced based care. There was no evidence to support that a systematic, constructive and proactive culture and system was in place for reviewing the quality and safety of care and services provided to residents.

**Judgment:**
Non Compliant - Major

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
The person in charge had not been absent for 28 days or more since November 2013 and there had not been any change to the person in charge. The person in charge and the provider nominee were aware of the obligation to inform the Chief Inspector if there was any proposed absence of the person in charge.

There were arrangements to cover for the absence of the person in charge with the clinical nurse manager deputising as required. The clinical nurse manager was a registered nurse in intellectual disability.

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
The inspectors formed the opinion that the centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. For example as outlined under Outcome 14 and 17 the person in charge provided monthly reports to the assistant director of services. Copies of these reports were seen by inspectors and each report since January 2015 had made repeated requests for nursing staff resources and upkeep of the premises. As outlined under Outcome 12 the premises was significantly substandard.

Up to the date of inspection these requests had not been actioned. The provider nominee was made aware of fire deficiencies throughout the premises in June 2014 as a result of a report on fire safety from a consulting engineer. However, none of the recommendations from the consulting engineer had been implemented to date. It had been documented by members of the multidisciplinary team and nursing staff on various occasions that one resident required a full time personal assistant. To date the resident had not received this personal support which was imperative to maintain his safety and that of the other residents. The senior clinical nurse manager role was meant to be supervisory however, due to non-replacement of staff she was providing clinical care in addition to her own role.

In addition, household staff were on long term leave and not replaced. The centre was visibly unclean in all areas. The person in charge said the centre had been deep cleaned prior to inspection.

**Judgment:**
Non Compliant - Major

**Outcome 17: Workforce**
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
The inspectors found that significant improvements were required regarding the workforce to comply with the Health Act 2007 (care and support of residents in designated centres for persons (children and adults) with Disabilities) Regulations 2013 .

An immediate action plan was issued on the day of the inspection as it was found that the provider was failing to ensure that the staffing levels were adequate in relation to the number and assessed needs of residents with due regard to the size and layout of the centre. Inspectors also had significant concerns that the provider failed to ensure adequate staffing was provided to a resident during waking hours. Based on observation, review of relevant documentation and interviews, inspectors concluded that there were inadequate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. There was insufficient provision of suitable qualified staff to meet the needs of the residents. In addition, staff did not have up to date mandatory training. Staff were not supervised on an appropriate basis.

The inspectors reviewed the nursing hours over a three month period and found that it was wholly insufficient to ensure safe care to residents. Inspectors saw that there was 3.05 whole time equivalent nursing hours not replaced on the roster. Inspectors saw that on Saturday 27 June 2015 there would only be one nurse on duty to care for 28 residents with significant and complex needs. Rosters reviewed by inspectors indicated that on many occasions there was only one nurse on duty to safely care for 28 residents. Staff also confirmed this to inspectors. Inspectors were told on the days that there was only one nurse rostered on duty that there were times when care staff would be the only staff member supervising very vulnerable residents as the nurse would have

other duties to attend too. The inadequate numbers of staff resulted in residents not receiving assistance, interventions and care in a respectful, timely and safe manner. There was evidence of negative outcomes for residents. As outlined in Outcome 1, residents were observed to not be facilitated to attend activities as staff were not available to support them.

There was a resident who had significant behaviours that challenge. Inspectors observed on the days of inspection that meaningful activity for this resident was extremely limited due to inadequate staffing. It had been identified by staff on regular occasions to the management team that this resident required 1:1 care and supervision during all waking hours. However, this still had not been put in place despite the resident engaging in self harm and living in an environment which was not suitable to meet his needs.

In addition, inspectors were told that the nurse would have to administer in excess of 800 medications to 28 residents the days that she worked alone. These practices are unsafe and inspectors were not assured that the provider and management team were responding to these risks and initiating change to ensure suitable care, safety and welfare of residents.

As referenced throughout this report residents were found to have complex care needs which the staff did not appear to have the appropriate qualifications or skills to manage. Staffing arrangements, supports and working conditions did not take cognizance of the complex cognitive, physical, psychological and social needs of residents. Inspectors saw that a resident with dementia spent many hours in his room alone as staff did not have time to engage with him. It was also noted that there were no staff tea rooms on the units and some staff worked long shifts commencing at 08:00hrs and finishing at 21:00hrs. Inspectors observed that staff took their tea breaks with residents. If staff needed to leave the unit it lessened the staff complement to a totally unsafe level as observed by inspectors.

Staff had received some mandatory training as required by Regulation. However, not all staff had received "Management of Actual or Potential Aggression" (MAPA) or safeguarding residents and the prevention, detection and response to abuse. Inspectors did not observe that the staff training and development records maintained the skills of the workforce and ensured that staff could meet the changing needs of residents. No staff member had cardiopulmonary resuscitation training.

Overall, the skill mix was insufficient due to the absence of whole time equivalent nursing staff. On some occasions nursing staff were replaced with non nursing staff which is unsafe due to significant complex needs of this resident population.
During the inspection staff were observed respecting residents' dignity by the manner in which they engaged with residents and it was obvious to inspectors that staff knew residents and their individual style of communication well.

Appropriate supervision and guidance for qualified and unqualified staff was not found to be in place due to the lack of a robust management structure within the house. Inspectors saw that suitable and sufficient care was not provided to some residents and this indicated that there was a culture of poor care practices embedded in the service as

inspectors observed many residents alone for long periods with no meaningful engagement. As outlined under Outcome 11 there was limited evidence of multidisciplinary team involvement for some residents, there were no structured activities or meaningful engagement available to residents. Inspectors observed that some residents spent long periods in the house with limited or no activation at all.

Inspectors reviewed a sample of staff files and found that they were compliant with Regulation. However, inspectors requested the file of a work placement student and found that none of the items listed in the Regulations were available which included:

Roles and responsibilities set out in a written agreement
No supervision or support records
No vetting disclosure in line with the National Vetting Bureau(Children and Vulnerable Persons).

Overall, inspectors were not assured that there were systems in place to support and promote the delivery of quality care services or that there were systems in place to effectively manage risk

**Judgment:**
Non Compliant - Major

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
While there was a copy of the residents' guide available in the reception areas however, it did not include how residents could access previous inspection reports by the Authority.

A directory of residents was maintained in the centre and was made available to the inspectors. However, it was not in accordance with Regulation. As outlined in Outcome 12, inspectors observed that medication administration sheets were left blank at a

number of times where medication was due to be administered. All of the administration records examined contained at least one ommission. Therefore, there was not a complete and accurate record of each medicine administered signed and dated by the nurse administering the medicines.

As outlined in Outcome 11, records in relation to resident observations, oral intake and weight were not consistently and accurately completed. Records of food provided for residents did not contain sufficient detail to determine if the diet was satisfactory and if special or modified diets were adhered to.

Policies in relation to food and nutrition and safeguarding were not implemented which had resulted in residents not being appropriately safeguarded and receiving care that was in line with evidence based practice. The policy for nutrition was not sufficient as it did not outline the monitoring and documentation of nutritional intake. The risk management policy did not meet the requirements of regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents. The policy in relation to safeguarding available to staff on the unit did not have an implementation or review date.

**Judgment:**
Non Compliant - Major

## 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:*

Ide Batan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by St Patricks Centre (Kilkenny) Ltd |
| **Centre ID:** | OSV-0003496 |
| **Date of Inspection:** | 22 June 2015 |
| **Date of response:** | 29 July 2015 |

## 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:**
There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre.

**1. 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.

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

**Please state the actions you have taken or are planning to take:**
•Resident meeting to occur on a weekly basis, be agenda driven and attended by residents should they choose to attend or evidence of their views being elicited through the key worker system.
•Quarterly family / carer meeting to occur and be attended by the CNM2 (Person In Charge, Director of Services and General Manager (Provider Nominee / HSE).
•First Family / Carer meeting took place on 7 July 2015
•Annual resident / family survey to be conducted. Quality / service improvements acted upon based on findings.

**Proposed Timescale:** 09/10/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not supported to make decisions about their care and support

**2. Action Required:**
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

**Please state the actions you have taken or are planning to take:**
•Residents to be actively engaged in the person centred planning process with the appropriate support from key worker and CATTS (Speech and Language Therapists)
•Family participation to be sought and supported by the CMN2 and staff.

**Proposed Timescale:** 06/11/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Routines and practices did not promote residents' independence or choice

**3. Action Required:**
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:**
•Through the person centred planning process, change management programme to be implemented to promote human rights, advocacy and best practice in supporting individuals with intellectual disability to live a good life of their choice as part of the wider community.

•Person centred planning process to be agreed 8 September 2015
•All staff / management to receive PCP training to ensure a clear understanding of the process. 6 October 2015
•Person centred planning meetings for each resident to be carried out by key worker, family and multi disciplinary team (where appropriate). Several meetings with individual residents may be required due to the complex needs, degree of intellectual disability and communication styles. 5 February 2016
•PCP will inform staff of residents preferences in relation to choice of activity, community involvement, living arrangements, menus etc..
•PCP to be implemented, reviewed on a six monthly basis and /or amended in the event of any change in the individual residents circumstances/preferences.
•Human Rights Committee to be re-activated to review human rights restrictions.
•Currently working with National Independent Advocate to promote advocacy and rights.

**Proposed Timescale:** 26/02/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Routines, practices and facilities placed undue restrictions on residents' activities of daily of living and impinged on their rights and civil liberties.

**4. Action Required:**
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

**Please state the actions you have taken or are planning to take:**
•Positive behaviour support plans to be developed for individuals presenting with challenging behaviour to ensure undue restrictive practices relating to access to water, food, clothing and other possessions are not present.
•Risk assessments to be completed to ensure the appropriate control measures are in place to reduce the risk of harm to residents in accessing freely, choices in relation to clothing, food and water.
•All areas including the kitchen and fridge to be made accessible to all residents at all times, appropriate supports to be provided to individuals if required.
•Recreation support plans to be developed as part of the person centred planning process with the individual resident, key worker and family to identify preferred meaningful activities including access to the community on an individualised basis as well as meaningful activities on campus in accordance with their interests, capabilities and developmental needs.
•An assessment of need, inclusive of a review of the individuals medical needs, personal care, behaviour support, communication, recreational support and personal needs to be completed on each resident. The dreams, wishes and aspirations of the individual, as dictated to by the person centred plan to be given equal consideration as the clinical needs in this assessment of need. This process will ascertain the required staffing levels to be provided to facilitate individualised support plans this assessment to be

completed by the CNM2, and multi disciplinary team.
•Training for staff in best practice relating to community inclusion and human rights to be provided.
•Recruitment of staff with the appropriate skills to deliver community and recreation opportunities to all residents.
•Three additional Personal Assistants have been allocated to three individuals identified in recent weeks.

**Proposed Timescale:** 11/12/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no private space for residents to meet and socialise with their visitors.

**5. 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:**
•As an interim measure, until resident's transition to the community, a room is to be made available on the campus to facilitate private consultations, family meetings, clinical assessments.
•A social room is close to completion which will provide additional recreational space for residents to participate in recreational activities.
•Intimate and personal care to be provided, as per policy, to ensure the dignity and privacy of the individual are respected at all times.

**Proposed Timescale:** 18/12/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was a sign on all these waste bins which said "feeders only.

**6. 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:**
All signs are removed.

**Proposed Timescale:** 22/06/2015

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents did not have free access to their clothing and other possessions.

**7. 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:**
•A register of the personal property of each resident is held on each individuals file.
•The finance manager has met with an Independent Advocate from the National Advocacy Service.
•A plan will be put in place that will enable residents that require access to the National Advocacy Service to be facilitated to do so.
•Risk assessments to be completed on individual residents to determine whether a choking / trip hazard exists if residents have access to their possessions.
•Appropriate control measures to be put in place to reduce risk and enable residents to access their belongings.
•Multi disciplinary input and behaviour support to be involved in developing and implementing the plan following assessment.

**Proposed Timescale:** 07/08/2015

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no record of any input from an independent advocate in relation to purchases of items of furniture by residents. There was no record of any rationale from the service provider as to the reason why these purchases were made by the resident.

**8. 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:**
•Finance policy to be reviewed and amended to reflect the desire of residents to purchase their own processions should they so choose.
•Protocol to be included in finance policy to ensure appropriate control measures are in place to protect residents from financial abuse and ensure an independent advocate is involved in the purchase of items over and above a stated amount.
•Policy is to be amended and reflected in practice that all purchases are to be agreed with the resident and family/carer. Where a family/carer is not available this must be approved by an independent advocate.

•The resident to be refunded the cost of the furniture purchased without their knowledge.
•A full review to be all resident's purchases to be carried and out and appropriate action to be undertaken, as above, if required.

**Proposed Timescale:** 25/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to suggest that where a resident lacked capacity to manage their financial affairs, that he or she was facilitated to access an advocate to assist them in making decisions.

**9. Action Required:**
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

**Please state the actions you have taken or are planning to take:**
•Finance policy to be reviewed and amended by the Policy Review Group to include the requirement of an independent advocate to assist individuals to make decisions around their finances.
•All residents will be supported if they lack capacity to manage their financial affairs by front line staff, family and an independent advocate. All appropriate control measures to protect residents from financial abuse will be put into place.
•The Finance Manager has met with an Independent advocate from the National Advocacy Service and a plan is being put in place that will enable residents that require access to the National Advocacy Service to be facilitated to do so.
•Easy read guidelines with the assistance of CATTS will put in place to explain options on the management of finances to each resident.

**Proposed Timescale:** 25/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Bank accounts were not held in the name of the residents to whom the money belonged. The residents' money was instead held in a central account which was managed by the centre.

**10. Action Required:**
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an

account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

**Please state the actions you have taken or are planning to take:**
•The finance manager has made contact with a number of financial institutions, bank and credit union, to enquire about opening accounts for individual residents. It has been advised that the bank requires an Indemnity Policy to be put in place by the HSE stating who the residents guardian is and "stating clearly who has order over the person's money".
•The finance manager has been in contact with finance manager HSE PPPA & Fair Deal Finance Unit, who has advised that opening bank accounts where residents lack capacity to manage their own financial affairs, is not lawful under current banking legislation and that the requirement for residents to each have an individual bank account is unworkable.
•In light of the above scenarios the finance manager met with the Independent Advocate for advice on this matter and was informed of the following:
"For those individuals who encounter difficulty opening individual accounts where the financial institution challenges the individual's capacity the advocate of the National Advocacy Service will make representation on securing the entitlement on the person's behalf." Further meetings will be arrange with the Independent Advocate to discuss what options are open to residents regarding the possibility of opening bank accounts and how this can be managed in a clear and transparent and safe system.
•Currently all cash transactions relating to individuals are recorded in an IT System that allocates each residents money, including monies managed and held in the central bank account, to an individual named statement. Statements issue monthly to residents and all items are individually itemised.

**Proposed Timescale:** 12/03/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint.

**11. Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
•Complaints Policy to be reviewed and amended by the Policy Review Group with the assistance of CATTS to include an appropriate and easy to follow complaints process to facilitate residents and their families to make a complaint.
•With the support of CATTS, Easy read complaints form to be in every sitting room.
•Pictures and contact numbers of the management to be displayed in each bungalow to ensure family, friends and visitors are aware of who to contact with compliments,

complaints or concerns.

**Proposed Timescale:** 03/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was evidence that the provider did not put in place measures required for improvement following a complaint.

**12. Action Required:**
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**
•Policy to be reviewed and amended by Policy Review Group, with agreed time frames for action to be completed following a complaint, with a clear reporting structure to ensure the manager can monitor trends, take appropriate action and review ensure quality improvement measures are achieved.

**Proposed Timescale:** 24/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints log did not record the outcome of the complaint or if the complainant was satisfied with the outcome of the complaint.

**13. Action Required:**
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
Complaints Policy and Complaints Log to be reviewed and amended to include;

1.The outcome of the complaint
2.record if the complainant was satisfied with the outcome.
•training to be provided to ensure all staff have a clear understanding of the complaints procedure.

**Proposed Timescale:** 24/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no second nominated person to respond and maintain complaint records as required under regulation.

**14. Action Required:**
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Please state the actions you have taken or are planning to take:**
•Second nominated person to be identified to respond and maintain complaint records.
•complaints Policy to be amended to reflect changes.

**Proposed Timescale:** 24/09/2015

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Communication profiles and assessments did not outline sufficient detail to ensure that residents are assisted and supported to communicate

**15. Action Required:**
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

**Please state the actions you have taken or are planning to take:**
•Engagement of private Speech and language consultants, CATTS to carry out individual speech and language therapy assessment for each resident.
•These assessments in conjunction with the person centred plan will inform staff on how to support residents to express their needs, emotions and wishes.

**Proposed Timescale:** 31/10/2015

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Communication profiles and assessments did not outline sufficient detail to guide staff in meeting residents' communication needs.

**16. Action Required:**
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

**Please state the actions you have taken or are planning to take:**
•CATTS to provide training for all staff on communication strategies based on individual SLT assessments. This to include the following:

1.Speech and Language assessments commencing on 29th July for each individual, assessments to be completed by 31October 2015
2.Training Phase: Training will be overlapped with the assessments, initial Staff Training delivered by CATTS Therapists (Communication Toolkit and Sensory Needs).
3.Mentoring Phase: Mentoring to all staff over a defined time period (e.g. 12 months). Full SLT & OT assessment at the start for residents and follow-up training with staff to tailor specific strategies to be used with each resident in their care.
CATTS Team will continue support after training, phasing out over a set period of time.

**Proposed Timescale:** 31/10/2016

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Unfamiliar staff were unable to communicate with residents in a meaningful way

**17. Action Required:**
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

**Please state the actions you have taken or are planning to take:**
•All staff to receive induction training prior to commencement in Our Lady's Unit inclusive of but not limited to communication strategies.

**Proposed Timescale:** 10/10/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Communication assessments did not indicate if assistive technology, aids and appliances had been considered and were required to promote residents' full capabilities in relation to communication

**18. 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:**
•Based on SLT assessments, residents to be provided with appropriate communication systems including, assistive technology, if required.
•All staff to be trained in these systems and trained in how to support resident's communication methods.
•Assessments will be completed on an individual basis, all appropriate communication aides and staff training will be provided based on the individual needs of each resident as opposed to centre specific.

**Proposed Timescale:** 18/02/2016

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

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no private space for residents to meet and socialise with their visitors.

**19. Action Required:**
Under Regulation 11 (3) (b) you are required to: Provide a suitable private area, which is not the resident's room, to a resident in which to receive visitors, if required.

**Please state the actions you have taken or are planning to take:**
•Transition to community living for individuals over a phased basis to be commenced in order to provide additional facilities for residents to receive visitors in private in their own home.
•Consultation with residents, their families and key workers where appropriate in depth transition plans to be developed and implemented to ensure the safety and welfare of the resident is central in decision making.

**Proposed Timescale:** 18/02/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed and were told by staff that there was minimal integration with the local community.

**20. 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:**
•Community Integration Programme to be implemented, this includes the re-engagement of the Family Forum Group for consultation, active participation of service users in their person centred plans, real implementation of these plans by key workers.
•Community connectors to be employed to develop and support residents to maintain relationship in the community and build new ones.
•Local amenities to be accessed through recreation support programme with immediate effect.

**Proposed Timescale:** 18/12/2015

**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:**
The provider acknowledged that there were deficiencies in the protection of residents from peer on peer abuse.

**21. Action Required:**
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

**Please state the actions you have taken or are planning to take:**
•Admissions policy to be reviewed and amended by the Policy Review Group to include protocols to protect residents from peer to peer abuse
•Safeguarding of Vulnerable Adults from abuse to be reviewed and amended to include control measures to protect residents from peer to peer abuse.
•Training to be provided to all staff on the above policies to ensure actions are taken as per policies.

**Proposed Timescale:** 23/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contract did not stipulate the weekly cost of residency in the centre.

**22. Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**
•Contracts of care to be reviewed and amended to include the weekly cost of residency in the centre.
•All contracts to be forwarded to family for co signature returned to service and filed in residents individual file.

**Proposed Timescale:** 28/09/2015

**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:**
There were a number of residents inappropriately placed in the centre.

**23. Action Required:**
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
•Full review and assessment to be completed by a Behaviour Support Specialist, in conjunction with Studio III specialists to identify the needs of each resident and inform the decision in relation to alternative accommodation to the multi-disciplinary team.
•Immediate review of one resident placed as an emergency to consider appropriate living options, process has begun, consultation with family has taken place, referral to appropriate service closer to the resident's home has been made on 17 July15
•Appropriate living environments to be secured for other residents identified as being inappropriately placed and funding to be agreed for this process with the HSE.
•Appropriate works to be completed to ensure compliance of house with Fire and Building Regulations and Schedule 6, Health Act 2007.
•Consultation with residents and families re: relocation to new home to be completed by the person in charge and a Social Worker.
•A Transition Planning process to be introduced appropriate to the needs of the resident group, specifically aimed at meeting the individual needs of each resident and their requirement when transitioning from and between services. This process to be agreed with families, residents and multidisciplinary team by 11September 15
•Date for move to be agreed with residents and families.
•Appropriate staffing levels and skill mix to be determined, agreed and recruitment process to commence.
•All relevant details as set out in Schedule 2, Health Act 2007, to be secured for each staff member prior to commencement of employment
All relevant training to be provided to staff.
•commence move.
•monitor and review to be undertaken as set out in the transition plan.
•actions identified during review to be acted upon within agreed timeframes.

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

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Names of those responsible for pursing objectives in the plan within agreed timescales were not included.

**24. 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:**
•Name of staff member responsible for pursuing objectives to be recorded on the individuals personal plan.
•Timescale for completion of objective to be agreed and recorded on the individual's personal plan.

**Proposed Timescale:** 09/10/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was a lack of evidence based tools used to assess the health, personal and social care and support needs of each resident on an ongoing basis.

**25. Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
•The appointment of a multi disciplinary team with a remit to determine appropriate evidence based assessment tool to assess the health, personal and social care needs of each resident.
•Commence the process of review and assessment of each resident to inform the person centred process.

**Proposed Timescale:** 20/11/2015

**Theme:** Effective Services

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

Many of the assessments reviewed did not have multi-disciplinary input.

**26. Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
The appropriate members of multi disciplinary team based, on the individual's need will be involved with the assessment and review of each resident's plan.

**Proposed Timescale:** 12/02/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans did not fully reflect residents' individual needs, choices and aspirations.

**27. Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

**Please state the actions you have taken or are planning to take:**
•Personal plans to be reviewed and amended to include sections to reflect the individual's needs, choices and aspirations, including links to the community, family participation and developing and maintaining friendships.
•Integration of the care plan into the person centred plan to ensure holistic view of the individual's needs and choices.

**Proposed Timescale:** 13/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans did not outline supports required for residents to maximise their capabilities.

**28. Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

•Personal plans will be reviewed and amended ensuring the supports whether staff / family, specialised equipment, transport or other are identified and recorded in order to maximise the individual residents' capabilities.

**Proposed Timescale:** 13/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not supported to participate in the development of their personal plans.

**29. Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

**Please state the actions you have taken or are planning to take:**
•Residents will be provided with appropriate support to participate in the development and review of their personal plan.

**Proposed Timescale:** 13/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were not available in accessible format.

**30. Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

**Please state the actions you have taken or are planning to take:**
•Personal plans to be made available in an easy read accessible format to each resident.

**Proposed Timescale:** 13/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were not updated in line with residents' changing needs or circumstances.

**31. 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:**
•Personal plans to be updated following any change in need. This to be outlined in the protocol for developing and reviewing personal plans for all staff.

**Proposed Timescale:** 21/08/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Annual reviews were not multidisciplinary.

**32. Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
•Annual review to include appropriate members of the multidisciplinary team based on the individual's assessed needs and or change in needs since previous review.

**Proposed Timescale:** 21/08/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were reviewed without the involvement of residents.

**33. Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
•Each resident to attend reviews of their personal plan with appropriate staff support.

**Proposed Timescale:** 13/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
One resident's placement had been completed without any transition plan for the resident and without adequate supports in place.

**34. Action Required:**
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

**Please state the actions you have taken or are planning to take:**
•Transfer and transition policy to be developed and implemented and reviewed as required to ensure protocols are in place to support residents during transition or transfer in or out of the service.
•This policy to be inclusive of the development of admissions, transfer and transition team to ensure that appropriate, realistic, person centred plans are developed and agreed with the resident and the family prior to movement.
•Staff to receive training on policy documentation.

**Proposed Timescale:** 04/09/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Hospital transfer forms were not completed in advance of transfer or contained inaccurate information.

**35. Action Required:**
Under Regulation 25 (1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.

**Please state the actions you have taken or are planning to take:**
•Hospital transfer forms (Grab Sheets) with up to date accurate information to be completed for each resident.
•Hospital transfer forms (Grab Sheets) to be amended following any change for each resident to ensure information provided is accurate at all times.
•Protocol to be developed outlining the procedure for amending and updating same.

**Proposed Timescale:** 07/08/2015

**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 centre had not been well maintained. For example the flooring throughout was substantially damaged and had not been repaired.

**36. 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:**
Premises Overall Action Plan
It is acknowledged that there are numerous non-compliance around the areas of;

•Fire Safety of premises
•Condition and Safety of Buildings Mechanical & Electrical Services
•External Structural / Maintenance Issues
•Internal Structural & Maintenance issues
•Finishes and Decoration
•Furniture and Equipment
The long term plan is to replace the current accommodation with modern fit-for purpose houses in line with Moving Away from Congregated Settings Policy. This plan will take some time to implement and therefore in the meantime the existing premises will be upgraded to address the deficits identified.

This relates to each of the premises within Our Lady's Unit.

Due to funding and operational constraints a phased and prioritised plan has been developed to address the premises issues.

HSE estates will provide an update on schedule of works and timelines by Friday 31July 2015.

Additional staff to reduce fire safety risk will be maintained until fireworks are completed.

In the interim, a full review of the staffing and skill mix required is on going.

Phase 1.
Life Safety / Fire Issues will be dealt with as first priority. To include;
•Installation of L1 automatic Fire Detection and Alarm system
•installation of new Emergency Exit Doors to bedroom corridors
•sub-division of each house into 2 or 3 Main Fire Compartments
All as per the Fire consultants recommendations
Phase 2.
Internal Structural Works to include;
•Widening of doorways to give easier and safer Access and Egress to Bedrooms

•fire Sub compartmentation by installation of fire rated doors to bedrooms and upgrade of ceilings.
external Structural works to include;
•repairs to roofs
•repairs / Replacement of Windows
•repairs / upgrade of footpaths etc
Upgrade of premises Mechanical and Electrical Services, including;
•Replace Electrical distribution Boards
•upgrade / replace Wiring and outlets as necessary
•installation of Low surface temperature Radiators / Radiator covers
•upgrade of Domestic Hot Water system

Phase 3.
Internal Works to include;
•Repair / Replace damaged Floors, Walls, Doors
finishes & Decoration Upgrade include;
•new floor coverings
•painting & Decoration of Walls, Doors, Windows
replacement of furniture & equipment.

Proposed Timescale:
Phase 1 – Q3 2015;
Phase 2 – Q4 2015
Phase 3 – Q1 2016

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Paintwork was peeling from the wooden windows and doors externally.

**37. 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:**
See Phase 3 Works above

Proposed Timescale: Q1 2016

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**
Paintwork was damaged on walls and wardrobes inside the bungalows.

**38. 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:**
See Phase 3 works above.

Proposed Timescale: Q1 2016

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Parts of the centre were visibly unclean.

**39. 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:**
•Additional household staff to be recruited.
•daily cleaning schedules to be put in place and monitored by the person In charge.

**Proposed Timescale:** 20/11/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Most of the soft furniture and chairs for residents throughout the first area was damaged and held together with duct tape.

**40. Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
Replace damaged furniture and fittings. See Phase3 above

Proposed Timescale: Q 1 2016

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Flooring through this first area was also damaged and held together with duct tape.

**41. Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
Floors will be repaired as necessary. Floor coverings will be replaced as necessary.
See Phase 3 above.

Proposed Timescale: Q1 2016

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The heating cannot be turned off in sides 1,2 and 3 as it was used to provide hot water.

**42. Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
Heating System will be upgraded. See Phase 2 works above.

Proposed Timescale: Q4 2015

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**
One of the bungalows was home to five residents, nearly all of whom had a visual impairment. This bungalow had not been equipped with any appliances or aids to help people to move independently around their home.

**43. Action Required:**
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

**Please state the actions you have taken or are planning to take:**
•National Council Of The Blind, Ireland (NCBI) engaged to assess required needs of visually impaired residents, outlining in their report the individual needs in relation to environment, suitable equipment and appliances/aids to assist resident to move independently in their home.
•Recommendations of report to be implemented.
•NCBI to provide staff training.

**Proposed Timescale:** 20/11/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The pathway leading to the entrance of one bungalow was extremely uneven.

**44. Action Required:**
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

**Please state the actions you have taken or are planning to take:**
Footpaths will be repaired / replaced as necessary. See Phase 2 above

Proposed Timescale: Q4 2015

**Proposed Timescale:** 31/12/2015

**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:**
The process for hazard identification and assessment of risk throughout the designated centre was not understood by staff.

**45. Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
Risk Assessment Policy to be reviewed and amended to include hazard identification.
•staff training to be provided in the use of risk management systems.

**Proposed Timescale:** 17/09/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The process for incident identifying and recording of incidents was not understood by staff.

**46. Action Required:**
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
•Incident and accident systems to be reviewed and corrective measures taken to ensure effective recording and reporting of all incidents, accidents.
•staff training to be provided to ensure all staff and management have a clear understanding of the process.

**Proposed Timescale:** 01/10/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Procedures, in line with the standards for the prevention and control of healthcare associated infection published by the Authority, were not consistently implemented in relation to invasive medical devices.

**47. 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:**
•Infection Control nurse has been engaged to review and assess the requirements of

individual residents in relation to invasive medical devices.
•recommendations of report will be implemented as directed.

**Proposed Timescale:** 24/07/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Procedures, in line with the standards for the prevention and control of healthcare associated infection published by the Authority, were not consistently implemented in relation to the prevention, management and control of the spread of healthcare associated infections.

**48. 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:**
• Infection Control nurse has been engaged to review and assess the requirements in relation to prevention and control of healthcare associated infections.
• Interim measures have been taken i.e. staff carrying toggle hand sanitizers and spirogel replaced by Ecolab.
• Hand wash basins will be installed as part of the work being undertaken in the unit by contractors in communal areas.
• Recommendations of report will be implemented as directed.

**Proposed Timescale:** 18/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
None of the recommendations from a consulting engineer on fire safety had been implemented to date.

**49. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
All of the recommendations of the Fire consulting Engineer have been included in the Phased program of Works outlined above. We have consulted with the Fire Engineer in prioritising the schedule of works.

Proposed Timescale: Q3 2015 and Q4 2015

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no fire policy document outlining St Patrick's service commitment to ensuring fire safety in the premises.

**50. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
Documented fire safety management system is currently being put in place.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not satisfied that fire extinguishers were readily available to staff/residents.

**51. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
Sufficient fire extinguishers will be provided and located correctly.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Throughout the premises there were key pad locked final exit doors which did not open automatically in the event of fire.

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

**Please state the actions you have taken or are planning to take:**
Final exit doors will have magnetic locks. These will release normally by use of electronic fob / card. They will release automatically on activation of the fire evacuation alarm.
See Phase1 Works

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that all houses were not fitted with an automatic fire detection and alarm system.

**53. Action Required:**
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
Full L1 automatic fire detection and alarm system will be installed as top priority.
See Phase 1 Works above.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Personal emergency evacuation plans required review as they were not adequate to respond to a fire situation.

**54. Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
Evacuation plans are included in the fire safety management system currently being finalised and implemented

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**
Fire drills were not being completed as required by needs of residents.

**55. Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
Fire drills have been brought up to date. Schedule and record of fire drills will be included in fire safety management system.

**Proposed Timescale:** 14/07/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Fire procedure notices not on display.

**56. Action Required:**
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

**Please state the actions you have taken or are planning to take:**
This is included in fire safety management system. All required notices will be on display.

**Proposed Timescale:** 30/09/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Interventions were not reviewed within the timelines specified in residents' plans.

**57. Action Required:**
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**
1.Medication management procedures relating to the administration of PRN medication to be reviewed to ensure protocols are in place ensuring all medications are recorded in

line with best practice and clinical standards.
2.Studio 111 clinical psychology team to liaise with the behaviour specialist and clinical team to schedule reviews as outlined in each resident's personal plan.

Proposed Timescale: 1. 28/08/15 2. 08/01/16

**Proposed Timescale:** 08/01/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Many forms of environmental restraint were not recognised and placed undue restrictions on residents..

**58. Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
•A complete review of all restrictive practices will immediately be carried in conjunction with Studio 111 and the behaviour specialist. This review will be person centred to ensure that if there is a need for any restrictive practices, that these will be individually assessed from a behaviour, risk management and human rights perspective.
•Studio 3 on site 10 August 2015
•All unnecessary restrictions will be removed as part of this assessment.
•Review of all PRN medications currently being undertaken by Behaviour Support Specialist, Consultant Psychiatrist, CNM2 to ensure administration of same is consistent and all other means of redirecting and reducing the individuals anxieties are applied prior to using PRN chemical restraint. 23 July 2015
•No restrictive practice will be implemented or applied to any individual or location without prior approval from the multi disciplinary team.

**Proposed Timescale:** 27/11/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Restrictive procedures outlined were deemed to be disproportionate.

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

**Please state the actions you have taken or are planning to take:**
A detailed review of each individual care and behaviour support plans will be carried out immediately by the behaviour specialist in consultation with Studio 111. These review plans will focus on positive interventions and where restrictive strategies are needed, they will be approved by the multidisciplinary team in accordance with current best practice.

**Proposed Timescale:** 16/09/2015
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
It was not documented that alternative interventions were considered prior to the use of restrictive procedures.

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

**Please state the actions you have taken or are planning to take:**
•The behaviour specialist will review all current behaviour support plans. The behaviour specialist will draw up a schedule for developing a new behaviour support plan for each resident that the multidisciplinary team has identified.

•These behaviour support plans will be modelled on current best practice i.e., Studio 3, MEBS (Multi element Behavioural Support LaVigna, Donnelan et al), and PENT (Positive Environments Network of Trainers)

•Reviews commenced on 21 September 2015

**Proposed Timescale:** 27/11/2016
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Records that did not demonstrate that episodes of restrictive practices were considered only if there was potential benefit from use of a restrictive procedure to the resident and the risk involved if the procedure was not used, outweighs the possible negative effects on the resident subject to the procedure

**61. Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are

considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
• The Behaviour Specialist will immediately review the behaviour recording process
• Each resident's behaviour support plan will outline all the positive strategies to be implemented for the resident.
• Only in the event of these positive interventions being unsuccessful, will the use of restrictive practices be permitted
• The process will be regularly monitored and reviewed by the behaviour specialist

**Proposed Timescale:** 08/01/2016

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A full assessment of the resident prior to each episode restrictive procedure, monitoring of each residents during any episode, adverse events resulting from the restrictive procedure and a detailed record of each episode were not documented.

**62. Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
•While reviewing and updating the behaviour support plans for all residents, the behaviour specialist will ensure that all restrictive strategies are in accordance with current good practice and national policies.
•All appropriate recording and monitoring documentation will be implemented as part of the behaviour support programme being developed in conjunction with Studio 111 the behaviour support specialists and multi disciplinary team.
•Appropriate training will be provided to all staff as part of the process.

**Proposed Timescale:** 08/01/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Positive behaviour support plans were not sufficient to guide staff to support residents and many did not have multidisciplinary input. Clear strategies were not outlined to support residents to manage behaviour that challenges that focussed on a proactive and positive approach

**63. Action Required:**

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

**Please state the actions you have taken or are planning to take:**
•Each resident's behaviour support plan will outline all the positive strategies to be implemented for the resident.
•only in the event of these positive interventions being unsuccessful, will the use of restrictive practices be permitted
•the process will be regularly monitored and reviewed by the behaviour specialist.

**Proposed Timescale:** 23/09/2015

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy in relation to the prevention, detection and response to abuse was not implemented which had resulted in residents not being appropriately safeguarded.

**64. 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:**
•Policy on the prevention, detection and response to abuse to be reviewed, and amended as required in line with the HSE Safeguarding Vulnerable Adults from Abuse to Policy.
•policy to be implemented.
•all staff / management to receive appropriate training as required by policy.

**Proposed Timescale:** 14/08/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Allegations of neglect were not always identified and followed up in a timely way

**65. 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:**
•Social worker currently reinvestigating the alleged allegation of neglect.
•full report will be available on completion of investigation by social worker and the

designated team.

**Proposed Timescale:** 31/07/2015

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Measures that had been recommended by the multidisciplinary team, such as alternative accommodation, had not been put in place to protect residents.

**66. 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:**
•Alternative accommodation currently being sourced in consultation with families.
•transfer and transition plan currently being developed with management and multi disciplinary team.

**Proposed Timescale:** 20/03/2016

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Authority did not receive all necessary notifications including an alleged allegation of misconduct within the designated timeframe as stipulated in the Regulations.

**67. Action Required:**
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

**Please state the actions you have taken or are planning to take:**
•All necessary notifications required to be reported to the Health Information and Quality Authority within the designated timeframe stipulated within Regulations.

**Proposed Timescale:** 15/07/2015

**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:**
It was unclear from reviewing resident's personal plans if their wishes and aspirations regarding training, education were known or that this was assessed or explored on behalf of the residents as there was no supporting documentation available.

**68. 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:**
•Through the key worker system residents wishes and aspirations will be assessed and explored as part of the person centred planning process.
•each resident will have an individual timetable outlining meaningful activities that they choose to engage in
•evidence of this will be recorded in the resident's personal plan.

**Proposed Timescale:** 08/11/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Unsuitable environment and inappropriate placement of residents negatively impacted on the provision of healthcare that met the needs of residents

**69. Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**
1.Behaviour support specialist to review and develop an appropriate response to the residents whose activities of daily living are placing their peers at risk.
2.Review of residents placed inappropriately to be undertaken with a view to relocation to more suitable environments.

Proposed Timescale: 1. 30/07/15 2. 18/03/16

**Proposed Timescale:** 18/03/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Evidence based assessment tools were not used to proactively refer residents to allied health care services

**70. Action Required:**
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**
•Tissue Viability Nurse currently assessing the needs of residents
•dietician engaged to review nutritional needs of residents
•recommendations from clinical reports will be implemented and reviewed as required.
•recruitment of a Social Worker and Occupational therapist to commence August 2015.
•recruitment process to include attaining all relevant documentation required under the Health Act for each person.

All appropriate training to be provided prior to commencement of post

**Proposed Timescale:** 16/11/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Allied health care services did not reflect the diverse needs of the residents

**71. Action Required:**
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**
Allied health care services currently being engaged to assess and provide services to residents as identified, reflecting residents' diverse and complex needs, these include SLT, OT, dietician, NCBI, Psychology, Infection Control, and Tissue Viability

**Proposed Timescale:** 12/08/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Accessible healthcare information was not available for residents

**72. Action Required:**
Under Regulation 06 (2) (e) you are required to: Support residents to access appropriate health information both within the residential service and as available within the wider community.

**Please state the actions you have taken or are planning to take:**
Easy read documentation to be developed on an individual basis in conjunction with CATTS as required for each individual resident, explaining their healthcare needs in a format appropriate to their understanding.

**Proposed Timescale:** 18/11/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
End of life wishes had not been made and decisions had not been made to ensure that each resident receives care in line with their best interests

**73. Action Required:**
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

**Please state the actions you have taken or are planning to take:**
•Consultations with residents and families must take place in relation to their end of life care.
•These should ascertain what actions to be taken such as transfer to hospital, administration of intravenous medicines, artificial hydration and nutrition, admission to critical care environment, ventilation or resuscitation.
•This will be recorded in their person centred plan.

**Proposed Timescale:** 12/11/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Food of a modified consistency was mixed together rather than served separately

**74. Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

Food will be mixed individually

**Proposed Timescale:** 15/07/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some residents did not have free access to the refrigerator.

**75. Action Required:**
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

**Please state the actions you have taken or are planning to take:**
Behaviour support specialist to review and develop an appropriate response to the residents' whose activities of daily living are placing restrictions on their peers.

**Proposed Timescale:** 19/08/2015

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personalised medicines management plans contained inaccurate information that would impact of the effectiveness of medicines prescribed.

**76. Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
All medication management plans to be reviewed and subject to ongoing audit

**Proposed Timescale:** 30/09/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Ambiguous prescriptions were not clarified prior to administration.

**77. Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
All prescriptions for regular medications are reviewed on a four weekly basis and any ambiguities noted are clarified. We are changing our practice to review the PRN and stat medications forthwith.

**Proposed Timescale:** 30/08/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medicines to be administered were not equivalent to those prescribed.

**78. Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
Audit of medications undertaken to ensure compliance.

Pharmacy and Medical Staff to agree protocol to ensure ongoing compliance

**Proposed Timescale:** 30/08/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medicines to be crushed were not individually prescribed.

**79. Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
Only medications individually prescribed suitable for crushing are being crushed.

**Proposed Timescale:** 24/07/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medicines to be administered were not equivalent to those prescribed

**80. Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
Audit of medications undertaken on a daily basis to ensure compliance.
The Person In Charge and Medical Staff to agree protocol to ensure ongoing compliance

**Proposed Timescale:** 30/08/2015

**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 statement of purpose didn't contain all the information set out in Schedule 1 of the regulations.

**81. Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
•All information required under Schedule 1 to be included in the Statement of Purpose and Function.
•Amended Statement to be forwarded to HIQA.

**Proposed Timescale:** 14/08/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that the document had been reviewed at intervals of not less than one year as it did not contain an implementation and/or review date.

**82. 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:**
The Statement of Purpose and Function will be reviewed as per The Health Act 2007.

**Proposed Timescale:** 14/08/2015

**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:**
Failing to ensure that concerns raised by the person in charge on numerous occasions in relation to inadequate staffing and skill mix were appropriately responded too.

**83. Action Required:**
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

**Please state the actions you have taken or are planning to take:**
•Staffing levels and skill mix to be agreed at senior management level.
•Staffing numbers to be maintained as agreed and increased, as required by changing needs of residents.
•Human Resources dept to ensure relevant, qualified personnel are deployed and maintained within the designated centre as set out by the staff numbers agreed.
• Recruitment procedure to outline protocols in relation to future planning to ensure staffing levels remain consistent to meet the requirement of service provision.

**Proposed Timescale:** 12/11/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was unclear if this annual report of quality of care had been shared with residents and their families.

**84. Action Required:**
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

**Please state the actions you have taken or are planning to take:**
The annual review of quality & safety of care & support for the designated centre will

be complied following consultation with residents and their representatives. It will also be shared with residents and their representatives

**Proposed Timescale:** 31/12/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While there was an annual review of quality of care it was not effective.

**85. Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**
An annual review of quality of care will be undertaken with appropriate inputs from patients and their representatives.

**Proposed Timescale:** 31/12/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was not effective communication between the provider nominee and the person in charge.

**86. 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:**
•Review of management structure to be undertaken.
•Clear reporting lines to be established.
•Agreed management team meetings to be scheduled and commenced on a monthly basis.
•Agreed Person In Charge and Provider Nominee meeting to be scheduled and commenced on a monthly basis.
•All meetings to be agenda driven and minuted, with action plans recorded, person responsible for actions named and completed dates for these actions recorded

**Proposed Timescale:** 31/07/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that management systems were in place to ensure that the service provided was safe appropriate to residents needs consistent and effectively monitored.

**87. 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:**
Following on from the District Court Hearing on 28 June 2015 the Provider has changed from St Patrick's Centre (Kilkenny) Ltd to the Health Service Executive and a new Provider Nominee is in place.
In addition, significant additional management and clinical supports have been put in place or are being sourced in the context of this action plan to support the provision of good care to the residents Clear reporting and governance lines are being established

**Proposed Timescale:** 31/07/2015

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre was not being well maintained.

**88. 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:**
•Maintenance plan currently being addressed over a phased period.
•Ongoing maintenance being undertaken.

**Proposed Timescale:** 15/07/2015

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff were not being replaced which impacted on governance and also residents needs.

**89. 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:**
•Recruitment process currently being undertaken to ensure optimum staffing levels are present.
•Recruitment of staff nurses, social care workers, recreational support staff, social worker and occupational therapist currently being undertaken.
Recruitment process can take up to five months to ensure all appropriate documentation required under the Health Act is in place, all appropriate training and induction is also in place prior to any staff member commencing employment

**Proposed Timescale:** 20/11/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The skill mix of staff was not appropriate to the number and assessed needs of the residents.

**90. Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
•Skill mix currently under review, appropriate grades to be recruited as part of the recruitment process as noted above.
•The recruitment of social care workers, recreational support staff, community linkers and members of the multi disciplinary team have been identified as required to meet the needs of the residents.

**Proposed Timescale:** 20/11/2015

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inadequate staffing levels had an impact on residents being able to undertake social activities.

**91. Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the

statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
•As an interim measure additional staff have been assigned to ensure residents are able to undertake social and recreational activities 23 July 2015.
•Recreational support staff currently being recruited in order to realise resident's person centred plans and to create opportunities for community involvement and social activities.

**Proposed Timescale:** 20/11/2015

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider failed to demonstrate that staff numbers met the current assessed needs of residents in the centre.

**92. Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
•Three personal assistants have been provided as an interim measure to ensure the care and wellbeing of residents is being met 13 July 2015.

•Based on the assessed needs of each resident and in conjunction with the multi disciplinary team to identify the required staff numbers and skill mix the recruitment process is currently being undertaken to ensure optimum staffing levels are present.

**Proposed Timescale:** 20/11/2015

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that where nursing care was required it was provided at all times.

**93. Action Required:**
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

**Please state the actions you have taken or are planning to take:**
Recruitment of nursing staff currently being undertaken to ensure optimum nursing staff levels are present at all times.

**Proposed Timescale:** 20/11/2015

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Filing to ensure continuity of care and support for residents as in rosters viewed by the inspector for the last quarter there was a shortfall of 3.05 WTE nursing staff.

**94. Action Required:**
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**
•All available nursing staff are being sourced from within the service and neighbouring services to ensure appropriate numbers of nursing staff are present.
•Recruitment of nursing staff currently being undertaken to ensure optimum nursing staff levels are present at all times.

**Proposed Timescale:** 20/11/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have access to other appropriate training such as dementia, end of life, CPR, care of peripheral intravenous catheters.

**95. 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 training audit to identify training gaps completed. 24 July 2015
•Training schedule will be completed by 14 August 2015
•Management of Allegations of Abuse training completed by 30 July 2015
•Fire Evacuation and Safety completed 17 July 2015
•CPI / MAPA training completed 28/ July 2015
•Training schedule as identified above to be developed and appropriate skilled trainers sourced to provide training in dementia, end of life, CPR, care of peripheral intravenous catheters, infection control, hand hygiene, Studio III, communication process and others.

**Proposed Timescale:** 18/03/2016

**Theme:** Responsive Workforce

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

**in the following respect:**
Staff files of the work placement student not in accordance with Regulation 30.

**96. Action Required:**
Under Regulation 30 (c) you are required to: Ensure volunteers working in the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (No. 47 of 2012).

**Please state the actions you have taken or are planning to take:**
Garda vetting to be completed on all volunteer/students prior to placement

**Proposed Timescale:** 15/07/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of support and supervision available.

**97. Action Required:**
Under Regulation 30 (b) you are required to: Provide supervision and support for volunteers working in the designated centre.

**Please state the actions you have taken or are planning to take:**
•Volunteer policy to be developed and implemented, to include supervision and support procedure.
•Supervision and support to be provided by a named person, at weekly intervals, minuted and held on the person's file.

**Proposed Timescale:** 15/08/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff files of the work placement student not in accordance with Regulation 30.

**98. Action Required:**
Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

**Please state the actions you have taken or are planning to take:**
•Roles and responsibilities of volunteers will be outlined and held on the person's file and they will receive a copy of same.
•Volunteer's contract will be agreed and signed between the service and the volunteer.

**Proposed Timescale:** 17/08/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A number of policies were not implemented including risk management, food and nutrition and safeguarding.

**99. Action Required:**
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
•All policies as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 will be reviewed and implemented in all areas.

**Proposed Timescale:** 29/08/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not meet the requirements of regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

**100. Action Required:**
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
Risk management policy to be reviewed, amended and implemented.

**Proposed Timescale:** 29/08/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The safeguarding policy available to staff did not contain an implementation or review date.

**101. 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:**
Safeguarding policy to be reviewed, amended and implemented.

**Proposed Timescale:** 29/08/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records of food provided for residents did not contain sufficient detail to determine if the diet was satisfactory and if special or modified diets were adhered to

**102. Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

**Please state the actions you have taken or are planning to take:**
Records of food provided, that is menus and specialised diets prepared for residents will be available for inspection in each location.

**Proposed Timescale:** 15/08/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Medication administration sheets were left blank at a number of times where medication was due to be administered.

**103. Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
All medication administration sheets being audited on a daily basis and appropriate training given where required.
Clinical nurse managers to review performance and ensure compliance on an ongoing basis

**Proposed Timescale:** 30/07/2015