<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0003013</td>
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<td><strong>Centre county:</strong></td>
<td>Louth</td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>St John of God Community Services Limited</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Bernadette Shevlin</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Ciara McShane</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Siobhan Kennedy</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>12</td>
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<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>0</td>
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</tbody>
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**About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 18 September 2014 10:00
To: 18 September 2014 18:45

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection

The inspection of the designated centre was announced and took place over one day with two inspectors. It had previously been inspected; however the designated centre has since been reconfigured.

The designated centre consisted of two units providing care to 12 male residents with severe intellectual disabilities. It was on a large campus in close proximity to a nearby town.

The Authority received information which triggered this focused inspection. The inspection looked at activation levels, food and nutrition, staffing levels and restrictive practices. The inspectors reviewed documentation such as behaviour support plans, spoke with staff and where possible interacted with the residents.

In general the inspectors saw that staff were responsive on the day and residents appeared to be well cared for. There were mixed levels of activity, in one unit the majority of residents were out involved in activities while in another unit activation levels were lower. This required review to ensure that all residents had access to activities of their preference and choosing.

The inspectors reviewed behavioural support plans and associated documentation and saw that each resident who required a behavioural support plan had one which was recently reviewed. Improvements were required in this area to ensure that plans were up to date in totality, evaluated and effective in meeting the assessed needs of
the residents.

Staff spoken with on the day of inspection interacted positively with residents. Staffing levels were low at times and required a review. A small number of staff required training in therapeutic management of aggression and violence, while other staff required improvement regarding their knowledge of resident’s behaviour support plans and the food and nutrition policy.

The inspectors found that residents had a varied and nutritious diet in addition to choice around mealtimes. Food and beverages were accessible and available to residents. For the most part residents had timely access to dieticians and speech and language therapy.

These findings will be further outline in the body of the report and in the action plan at the end.
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):

Findings:
Inspectors found that activation levels were mixed across the two units. Inspectors saw that some residents had opportunities to partake in activation within the centre. Activation in the centre including going for walks around the campus, visiting the coffee shop which had extended their opening hours to facilitate residents, attend a gardening club once a week, attend the cinema club and arts and crafts. The activation options were focused on activities within the organisation's campus and there was no engagement with the local community regarding activation.

There was a notice board in the living room with pictures of the activation options available to residents for that day. Cinema club was available to residents in the afternoon; the inspector asked a staff member form each unit what the film was that day. One staff member could confirm the film that residents could watch. For those residents that lived in the unit were staff were unaware of the film being played residents could not make an informed choice. Attending a coffee shop, building blocks, watch television and go for a walk were the other options available to residents for that day.

During the morning of inspection in one unit, where five residents lived, one resident partook in no activation for the duration of the morning that the inspectors were present. Another resident went to arts and crafts and returned to the centre a half hour later while a staff member took another resident out for a walk around who also promptly returned. One resident was out on the bus for a spin to a local park that had been organised by an agency activation staff member and the fifth resident played with some building blocks for the morning. There was three staff on in this unit in addition to an agency activation person.
In the afternoon, the inspectors visited the second unit within the designated centre. Seven residents lived in the centre and were supported by four staff on the day of inspection. The activity levels in this unit were high. One resident was at a day service, two residents attended the cinema of; the staff were familiar with the film, two residents were on the bus, another resident was at a shopping centre in a nearby town and the seventh resident was out for a walk to the coffee shop.

Residents had an activation record in their file which logged their level of activity for a particular day. The inspectors saw that these were not always completed with numerous entries left blank and for one resident there were multiple entries of refusals but no reason identified as to why they may not have wished to partake. The inspector saw that a resident had a trip to a nearby city as an activation trip. The inspector asked a staff member where he went in the city; the staff member confirmed that they had attended a hospital appointment. The inspector was of the view that a hospital appointment was not a form of activation and should not be recorded as so. Resident’s files also contained information about their preferences regarding activation. One file stated that the resident had enjoyed water and that swimming was an activity they would enjoy. The staff told inspectors they currently did not take them swimming as they had to source appropriate swimwear. Another file stated that a resident enjoyed bus trips by themselves. The staff told inspectors to date this had not happened due to limited availability of the bus they required.

Improvements were required to ensure that meaningful options were available to all residents, to ensure that staff were aware of their preferred options and endeavoured to ensure these were facilitated. The staffing levels, in particular in one unit, required a review to ensure there was sufficient staff to meet the activation needs of all residents so that residents could experience a fulfilled, purposeful and meaningful day. This will be further outlined in Outcome 17.

Subsequent to the inspection the person in charge confirmed that the appropriate swimwear for the resident, to enable them swim, had been ordered.

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):
**Findings:**
The inspectors found that residents, where required, had for the most part relevant and appropriate behavioural support plans. The inspectors found that six mechanical restraints were prescribed across two units in addition to chemical restraints. Those residents that had restraints also had a behavioural support plan. Behavioural support plans were developed locally with input from the clinical nurse specialist. For residents that had restrictive practices in place a referral, along with a risk assessment and up to date behavioural support plan, was forward to a locally formed committee for authorisation of the use of the restrictive practice. Inspectors were told the committee reviewed all relevant documentation and applied authorisation with conditions. The inspectors saw that a mechanical restraint for one resident had a condition that stipulated it could only be applied at night time when the resident was in bed. The inspectors saw the entries made in the restraint log reflected this. The restraint log was found to be up to date and recorded all necessary information including the duration the restraint was used for.

The inspector reviewed a sample of behavioural support plans and found that they had recently been reviewed and information within some of the plan had been updated to reflect changes in circumstances. However, the inspectors saw one behavioural support plan that had been identified as being reviewed but were not fully update to reflect changes. One resident had finished attending a class however this had not been reflected in the plan that had been signed and dated as reviewed. The inspectors also found that not all behavioural support plans had been signed by all staff as instructed. The behavioural support plans were detailed and outlined what the behaviour was, the antecedents, triggers in addition to proactive and reactive strategies and guidelines for staff. Improvements were required as the inspectors found that a number of the behavioural support plans were repetitive and had unnecessary information which may pose a risk to staff when reading the information. A review of these behavioural support plans was necessary ensuring that all information documented in the plan was relevant and necessary in guiding staff to support the resident. This will be outlined in Outcome 18.

The guidance outlined in behavioural support plan were not also adhered to by staff. The behavioural support plan for one resident outlined instructions for staff to record instances of when the behaviour occurred. The number and type of instances were recorded, however no further information was recorded which would benefit the care team in developing future guidance and strategies. In addition the staff did not record the days where there were no instances nor was the reasons why there were no instances documented. Such information would be pivotal in reviewing and evaluating the effectiveness of the behavioural support plans. In addition another behaviour support plan offered clear guidance for staff on their interactions with a non verbal resident throughout the day and the requirement to use prompts. Inspectors were present in the unit for three hours where at least two prompts for this resident should have occurred. No staff prompted the resident as per the guidance in the behavioural support plan. Also the same prompts were being used for two different activities which would confuse the resident. Further instruction for staff to implement the guidance was necessary in addition to a review of the use of prompts.
A mechanical restraint was in place for one resident; the guidance in their behavioural support plan stipulated this should be removed during safe periods such as the resident seated for lunch. The inspectors observed the staff only removing the mechanical restraint when the resident was half way through their meal. This practice required review to ensure that the mechanical restraint was only used where necessary so the resident could be alleviated.

The inspectors reviewed a behavioural support plan that referenced a reduction in self injurious behaviour and therefore a reduction in the use of the restrictive practice. It was not documented and it was unclear as to why the self injurious behaviour and the use of the mechanical restraint was reduced. In addition a trial period of six weeks was carried out for this resident without the mechanical restraint. The inspectors were told by staff and found that no incidents occurred during the six week trial therefore reflecting a lower risk. However, the use of the restraint was reinstated as the committee thought the risk was too high. This required a further review. Although each resident had a behavioural support plan in place, evaluation and review of the documentation and practice was necessary to ensure the approach applied by staff was consistent and supported the residents.

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):

Findings:
The inspectors found that residents had sufficient food available to them that was varied, nutritious and wholesome. Inspectors saw that residents had choice and were satisfied that access to food and drink was plentiful.

Inspectors saw that residents were offered three main meals a day in addition to snacks throughout the day and supper in the late evening. Residents were supported to make choice at all meal times by staff. Staff completed a menu selection for residents for blocks of four days based on their knowledge of resident’s preferences. The inspectors saw a choice of breakfast cereals in the presses in addition to eggs and bread which residents could also have. Inspectors observed staff assisting residents with hot and cold beverages which were made in accordance to their assessed dietary requirements. Inspectors also saw that the lunch which was served from the main kitchen and delivered by bain-marie to each unit was hot, attractively served and was served appropriate to residents assessed dietary requirements such as mince moist and soft pureed. Additional food was also sent up with the main lunch meal including salads,
additional meat and soup in the instance that a resident refused their main meal. The inspectors also saw some pureed fruit that was served with custard for residents desert after lunch or later in the afternoon if residents so wished.

The inspectors reviewed a sample of resident’s files and saw that residents had access to speech and language therapy in addition to a dietician. For the most parts access was timely, however a general practitioner requested a dietician referral five days previous which the staff nurse had not yet done. The person in charge subsequent to inspection confirmed the referral was made once he was made aware of the deficit at feedback. The inspectors were satisfied that where staff had concerns regarding residents weight their BMI and MUST score was calculated in addition to a fluid and food chart being commenced. The inspectors seen these completed for a resident who had lost weight. Weekly weight checks were also in place for this resident. Inspectors also saw that residents had been prescribed additional supplements were there was a requirement.

Improvements were identified regarding the documentation of a resident’s prescription sheet, which was last updated in 2012. It stated that the resident was one stone heavier than their actual weight. This resident was being treated for weight loss, receiving nutritional supplements and was on multiple medications. Staff spoken with by the inspectors were not familiar with the recently introduced nutrition and food policy. Inspectors saw communication of from senior management the staff notice-board instructing all staff to familiarise themselves with the new policy. The staff member spoke with was also a keyworker for a resident who was experiencing weight loss. Staff were unable to tell inspectors what the meals were for that day and therefore residents did not know what to expect for their meal in turn. This is outlined in Outcome 18.

Supervision at mealtimes also required review. On the day of inspection a resident was hospitalised due to a resident taking food from another residents plate and subsequently received a facial injury that required attending by the local hospital.

**Judgment:**
Non Compliant - Moderate

**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):**

**Findings:**
Improvements regarding the level of staffing and staff training was required.
The designated centre had the potential of multiple activities in one of the units during the night. With one staff member on night duty it posed a risk to residents and staff should there be a number of incidents occurring at once.

Not all staff were trained in therapeutic management of aggression and violence which was stated in as a requirement in multiple documents reviewed by the inspectors such as risk assessments for residents that had behaviours that challenge.

Care staff who were working in isolation with residents, although familiar with their needs, had not been inducted with regards to their positive behavioural support plans. All staff did not receive training in Therapeutic Management of Aggression and Violence.

Agency staff were employed to assist with activation. However the staff members assisting residents were not consistent therefore there was insufficient continuity of care and familiarity for the residents.

The rosters required a review as they were not reflective of the actual staffing arrangements across the designated centre. Staff worked in both units at various intervals during the day but this was detailed or apparent looking at the rosters.

Increased staff supervision was necessary to ensure that all staff were familiar and up to date with policies and procedures in addition to adhering to resident's guidelines as outlined in their care plans. On the day of inspection, the inspectors saw a management note for all staff to familiarise themselves with the new food and nutrition policy. All staff members spoken with on the day of inspection were found not to be familiar with the policy and they had yet to review it. Staff members were also not adhering to the guidelines as outlined in residents care plans such as guidelines regarding a resident's behavioural support plan and the need to provide prompts at regular intervals throughout the day.

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):**
Findings:
As outlined in Outcome 11, a staff spoken with by the inspectors were not familiar with the recently introduced nutrition and food policy. Inspectors saw communication of from senior management on the staff notice-board instructing all staff to familiarise themselves with the new policy.

Judgment:
Non Compliant - Minor

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:

Ciara McShane
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Centre name: A designated centre for people with disabilities operated by St John of God Community Services Limited

Centre ID: OSV-0003013

Date of Inspection: 18 September 2014

Date of response: 31 October 2014

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:
Although residents have access to some facilities for recreation they are limited in choice and are dependent on staffing levels.

Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
1. A social assessment will be completed with each resident in determining a greater choice of recreational activities.
2. Post assessment each resident will have comprehensive social goals reflecting their choice of recreational goals. These goals include the staffing supports required by the resident and be clearly time-lined to ensure achievement.

**Proposed Timescale:** 30/11/2014

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents who had identified activities of interest were not supported to participate in them.

**Action Required:**
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
1. A review of all residents’ activities will occur by each key worker.
2. These activities will be timetabled to ensure residents have the opportunity and supports required to participate in them.
3. Outcomes of the activities will be documented by staff in the daily record book.
4. A monthly audit will be coordinated by the person in charge to ensure that residents are being supported to participate in their activities of interest.

**Proposed Timescale:** 30/11/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff working at the designated centre were not trained in Therapeutic Management of Aggression and Violence.

All staff had not been inducted regarding the behavioural support plans for all residents.

Guidelines instructed staff to use prompts for a residents, the same prompt was being used for two different activities. Staff were also not implementing the guidelines.

**Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
1. A review of the TMAV training records shall be undertaken to identify any training gaps for staff and ensure a training calendar to address TMAV training needs. This will include refresher training.
2. Ensure all staff members have read and signed behaviour support plans present in the designated centre.
3. Ensure all new staff members as part of their induction are familiar with the content of all behaviour support plans. This will be documented as part of the induction checklist for new staff members.
4. Ensure clear guidelines are in place for all staff members to follow when using objects of reference as a communication tool with residents.

**Proposed Timescale:** 30/11/2014

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A trial which was established for a resident proved to be successful and without incident. However, the mechanical restraint was reinstated.

Staff failed to remove the mechanical restraint used for one resident at periods when it was safe to do so.

**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:**
1. A review of this resident’s mechanical restraint will occur to ensure the least restrictive strategy is in place for the resident.
2. A staff meeting will occur to ensure any restraint is used as per any authorisation.

**Proposed Timescale:** 24/10/2014

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Records were not appropriately maintained or evaluate to assist in the identification and alleviation the cause of the resident's behaviour.

**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:
1. The Person in Charge will compile guidelines for staff in the designated centre to
ensure documentation relating to behaviours of concern are comprehensively recorded
to support the identification and alleviation of such behaviours. 30/11/2014
2. A staff meeting will be coordinated by the Person in Charge in conjunction with the
staff team in the designated centre to ensure the implementation of the guidelines -
Completed
3. The Person in Charge will conduct a monthly audit of documentation relating to
behaviours of concern to ensure accurate recording. 31/12/2014

Proposed Timescale: 31/12/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
Access to allied health professionals was not always timely. A referral to a dietician, as
recommended, by the general practitioner five days previous had not been made.

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:
1. The referral to the dietician was made on the day of the inspection following
feedback by the inspector.
2. The Nutritional Status and Management Standard Operating Procedure has been
developed and circulated to all of the homes in the designated Centre. The SOP clearly
outlines the process, when a member of staff has concerns about a resident in regards
to Nutrition. The Person in Charge shall ensure all staff have signed to confirm staff
have read and understood the Standard Operating Procedure.
3. The Person in Charge will coordinate a meeting with the staff team in the designated
centre to ensure accurate implementation of the nutritional status and management
policy.

Proposed Timescale: Completed

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
The inspectors found that in one unit there were insufficient staff to assist all residents
with their meal resulting in an injury to another resident.

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:**
1. A review of staff breaks during mealtimes of residents has taken place to ensure there are sufficient staff members present to assist all residents with their mealtimes experience.

**Proposed Timescale:** 14/10/2014

### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Although there was a roster in place it was not reflective of the actual staff that worked across the two units.

**Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
1. Carry out a roster review to ensure all rosters are reflective of staff working in the two areas of the designated centre.
2. Ensure that appropriate codes are used to indicate when staff are rostered to work but participating in training - completed

**Proposed Timescale:** 31/10/2014

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Agency staff were employed to assist with activation. However the staff members assisting residents were not consistent therefore there was insufficient continuity of care and familiarity for the residents.

**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:**
1. A review of agency staff that support residents with activation to ensure as far as is possible that there is consistency in staff members that support residents to ensure continuity of supports.
2. The service has commenced a recruitment process in May 2014 to engage competent professionals to increase the availability of staff on the relief/bank panel, who have
received the required mandatory training. Alongside this, in September 2014 the service commenced the recruitment to engage in competent professionals to back fill the long term vacancies.

3. A roster review steering committee has been established, which will review staffing numbers and skill mix, per designated centre.

**Proposed Timescale:** 31/12/2014  
**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The low staffing levels on nights required review as the lone working with residents who had behaviours that challenged posed as a risk.

**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:**  
1. The Person in Charge will compile a protocol with night staff in the designated centre to ensure comprehensive use of the float night staff at night when behaviours of concern or support needs of residents require additional assistance.
2. The Person in Charge in conjunction with senior night staff will conduct a full review of staffing at night within the designated centre to ensure there are adequate supports to meet the assessed needs of residents at night.

**Proposed Timescale:** 31/10/2014  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
All staff were not trained in Therapeutic Management of Aggression and Violence.

**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:**  
1. A review of the TMAV training records shall be undertaken to identify any training gaps for staff and ensure a training calendar to address TMAV training needs. This will include refresher training.
2. Ensure all staff members have read and signed behaviour support plans present in the designated centre.
3. Ensure all new staff members as part of their induction are familiar with the content of all behaviour support plans. This will be documented as part of the induction checklist for new staff members.
Proposed Timescale: 14/11/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff members were unfamiliar with the food and nutrition policy.

Staff members were not adhering to guidance as stipulated in residents care plans.

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

Please state the actions you have taken or are planning to take:
1. The Person in Charge shall coordinate a meeting with the staff team in the designated centre to review the food and nutrition policy to ensure all staff members are familiar with the content.
2. Food and Nutrition plans of each resident will be reviewed as part of the meeting to ensure clarity re: their implementation and review and updates shall be reflected in their individual personal plan. An initial meeting has taken place to agree dates for these reviews however it was clarified at the meeting that there are no concerns identified in the area of food and nutrition for these residents

Proposed Timescale: 14/11/2014

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff members were familiar with the food and nutrition policy.

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:
1. Co-ordinate a meeting with the staff team in the designated centre to review the food and nutrition policy to ensure all staff members are familiar with the content.
2. Staff will be required to sign to confirm they have read and understood the standard operating procedure. It has been confirmed all staff have been inducted into the policy and have signed to indicate this.

Proposed Timescale: 24/10/2014