### Centre name:
A designated centre for people with disabilities operated by St John of God Community Services Limited

### Centre ID:
OSV-0003932

### Centre county:
Dublin 24

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
St John of God Community Services Limited

### Provider Nominee:
Bernadette Shevlin

### Lead inspector:
Linda Moore

### Support inspector(s):
Valerie McLoughlin

### Type of inspection
Announced

### Number of residents on the date of inspection:
33

### Number of vacancies on the date of inspection:
13
About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From: 03 March 2015 11:00
To: 03 March 2015 19:30
From: 04 March 2015 08:45
To: 04 March 2015 18:40

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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</thead>
<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
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<tr>
<td>Outcome 12. Medication Management</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection
This was an announced inspection to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. Inspectors met with the regional manager and person in charge to review the type of care delivered. Discussions took place as to whether the service or aspects of it were a designated centre, the regional manager was reviewing this issue further and agreed to continue to liase with the Authority.

Inspectors visited the designated centre which consisted of three locations where residents resided. This included a number of separate apartments in one location, one apartment in another location and a house where three residents resided. They met with residents and staff in these locations.

One unit consisted of 27 apartments and was staffed from a resource centre where the residents accessed the supports as needed. The service was described as independent living. Staff supported residents with medication management, finances, tenancy arrangements and meals. They also responded to disputes between residents and ongoing issues relating to mental health and alcohol dependency issues. However, the support provided was not linked to residents support plans and appeared reactive in the approach to care delivery. This was concurred with by management and they discussed the plans to review the service and ensure that it
met the assessed needs of residents. Inspectors visited four of these apartments where residents received additional support than other residents in the complex and one other apartment where a resident requested to meet with inspectors. All residents had a tenancy agreement with St John of God Housing Association. Staff do not enter any of the apartments without the residents consent with the exception of an agreed protocol with concerns over the resident.

Another location was visited where one resident lived in a five bedroom apartment with support from one staff member. There were four vacancies in the apartment and a five bedroomed apartment which was also vacant.

Inspectors also visited another location, which was a house in a housing estate where three residents resided. All residents in this location had an intellectual disability and presented with behaviour that was challenging. Inspectors were informed that two of these residents who live together were not happy living together and the residents confirmed this.

All residents except one had signed a support agreement.

Inspectors observed practice and reviewed documentation such as personal plans, medical records, accident and incident records, minutes of meetings, policies and procedures, staff training records and staff files.

Overall, inspectors found that residents' healthcare needs were met. Staff supported and encouraged them to participate in the running of the centre and to make choices about their lives. Residents generally chose how they wanted to spend their day and who they invited into their home. They knew who to talk to if they had a concern and staff made themselves available to residents.

Residents were supported to develop and maintain personal relationships and links with the wider community. There were regular meetings for residents, and residents’ communication needs were supported. Relatives were involved in the development of the support needs for residents.

While evidence of good practice was found, areas of non compliance with the Regulations were identified.

The management of behaviours that challenge in one area was not effective and did not protect other residents.

Other areas for improvement included risk management practices, fire safety and the documentation available to support practices. These non compliances are discussed in the body of the report and included in the action plan at the end of the report.
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 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:
Each resident had a personal plan and inspectors reviewed seven of the plans. There was not a consistent approach to the development of the plans. The current model of personal plans did not support the development of current needs and choices of residents. The personal plans were not available in an accessible format.

Residents had a support agreement and this was signed by the resident and staff, it outlined the current support needs of residents. There was some evidence of residents being involved in their plans and other residents had documented that they decided not to partake in the setting of goals. There was some evidence of regular review and participation of residents in the development of their plans, these were reviewed at the weekly team meeting. However, the assessment did not have multidisciplinary input and did not inform the personal plans.

The director of the service and person in charge explained that they were in the process of reviewing the care needs of all residents and the type of service they delivered to meet the needs. Inspectors found that some residents goals were set in 2013, the same in 2014 and there was little evidence to show if the goals set were realised.

The personal plans contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents’ interests. While there were individualised risk assessments completed for some residents to ensure continued safety of residents, these were not consistently completed for all residents and did not detail the actual risk and additional control measures required to minimise the risk of future occurrences.
There was evidence of community involvement. Many of the residents were supported to participate in meaningful community activities and the residents said that this was the case. One resident spoke of the support by staff to do shopping. Staff had accessed computer applications and provided skills training for some residents to maximise their access to and independence in the community.

**Judgment:**
Non Compliant - Moderate

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**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:**
Inspectors generally found that the provider had put risk management measures in place; however, they needed to be improved. For example, risks associated with fire safety and behaviours that challenge. The systems for the identification, assessment and management of risk required improvement and measures put in place following adverse incidents to prevent them recurring required improvement. Inspectors found that there was no Health and Safety Statement for each location. While staff had started to populate a local risk register, it did not include all risks associated with the premises.

Staff were not knowledgeable in the development of the register, for example, the control measures recorded were not adequate to mitigate the risk. All risks were also not included, such as smoking and skill mix, for example. The person in charge and regional director said they were actively addressing this. There was no date confirmed for this training.

There was a risk management policy in place. This had been recently developed and was in the process of being rolled out. However, it was not being used to guide practice, for example in the area of self harm.

The person in charge undertook a review of all incidents and accidents and the findings of this review were discussed with staff at the weekly management meetings by the team leaders and discussed at the quality and safety meetings. Inspectors reviewed the reports and noted that the information was not being fully analysed to improve the service and this was a missed opportunity to share any learning for the period.

Inspectors found that a number of the incident reports were incomplete, they did not
fully include the incident which occurred and the outcome to the resident. This was similar for reporting of and learning from medication errors. Staff were provided with a report spreadsheet of the incidents, which they said did not provide meaningful information and they said that they did not have access to the necessary information following an incident to effect change. Investigations were not always robust and did not ensure that the learning had taken place and improvements implemented as a result.

Inspectors found that there were centre specific emergency plans in place and staff were familiar with them.

Fire safety
Overall while fire safety was well managed, there were areas for improvement. Inspectors viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as defined by the Regulations. However, the fire training did not include the use of fire fighting equipment, inspectors were informed that this was planned to be included in the next training.

The records of fire drills were detailed and included learning outcomes. However, there was no plan to address the areas identified.
While there was some evidence that fire equipment was serviced regularly, this was not consistent in one of the locations visited. There was evidence that the fire extinguishers were serviced but the records showed that fire alarms and emergency lighting was last serviced in 2013. Inspectors found that all fire exits were unobstructed on the day of inspection.

While personal evacuation plans were in place for residents, these did not include the supports required for residents who required night sedation and may need additional supports to evacuate at night time.

**Judgment:**
Non Compliant - Moderate

<table>
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<tr>
<th><strong>Outcome 08: Safeguarding and Safety</strong></th>
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<tr>
<td>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.</td>
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| **Theme:** |
| Safe Services |
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However these needed to be strengthened in the areas of behaviour that is challenging. Inspectors found that not all residents had been kept safe when other residents presented with behaviour that was challenging and this was having an adverse effect on one resident’s health.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. All staff had received training on safeguarding vulnerable adults.

The policy on safeguarding residents from abuse contained guidelines on how any allegations of abuse would be managed. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had. Residents were knowledgeable of who they could talk to if the need arises.

There was evidence that incidents of all allegations of abuse were appropriately investigated and managed in accordance with the centres policy.

Residents personal finances were well managed, a small amount of money was held for the residents and the balances checked were correct.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. Staff maintained resident’s privacy during the delivery of intimate care.

Overall residents confirmed that they felt safe and described the staff as being very kind and supportive. However, this was not consistent for all residents.

There was a policy on the management of behaviours that challenged, but this was not being used to guide the care delivered. Staff told inspectors that they did not feel they had the skills to manage these episodes and to keep other residents safe as one resident’s behaviour was impacting on another resident in one location. This had resulted in one resident engaging in self injurious behaviour due to the stress of the living arrangement. Residents discussed this at length with inspectors.

Training had been provided in this area but staff said they would welcome more training in the development and implementation of behaviour support plans and the management of a small number of residents with mental health issues.

Overall restrictive practices were used infrequently in the centre. However, not all staff had received training in restrictive practices. Staff had identified that they were using one type of restrictive practice in the centre. A clinical nurse specialist in behaviour was
available to staff and residents and improvements were noted in some residents behaviour as a result. Residents had access to psychology and psychiatry services as required, and management told inspectors that they were in the process of accessing private psychiatry services for one resident. However there was no date for appointment agreed at the time of the inspection.

Inspectors found that the processes needed to be improved in line with the Regulations. Residents were reviewed at the positive behaviour supports committee; however this was not consistent for all residents as the incidents of the use of the restraint were not all recorded.

There was no documentary evidence to demonstrate who initiated all restrictive practice. There were no risk assessments in place to include the alternatives that were tried prior to its use.

There was no record maintained of the frequency of its use in all instances. The regional director said that they were in the process of developing a rights committee to review any restraint in place. While residents had positive intervention support plans, some resident’s plans did not guide the staff and there was no multi element behaviour support plans in place for all residents with behaviour that challenges and the use of restrictive practices as per the policy.

**Judgment:**
Non Compliant - Major

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**Outcome 11. Healthcare Needs**

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

**Theme:**
Health and Development

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

**Findings:**
Inspectors found that there were appropriate arrangements in place to support residents’ health care issues as they arose. However, the inspectors found that there was a lack of care plans in place to guide staff in the care of residents with diabetes, for example. While some residents were identified as requiring specialist healthcare, they were on waiting lists and there was no evidence as to when this care would be delivered. There was evidence of poor outcomes for some residents as a result.

Inspectors reviewed the personal plans and medical folders for five residents and found that they had access to a general practitioner (GP), including an out of hour’s service. There was evidence that residents accessed other health professionals such as
chiropodists, opticians and dentist. Health assessments were up to date for all residents and provided valuable information for staff in the care of residents. However the health action plans were not specific to guide the care. For example, one residents health assessment stated that routine blood samples were taken but there was no follow up when a resident had high cholesterol. Another resident was due for an appointment in a general hospital, but there was insufficient records that this appointment had taken place. Another resident required assistive equipment to enable independence with eating, but there was no plan as to when this would be received or if the resident was seen by the occupational therapist. This delay was having poor outcomes for the resident.

Inspectors found that residents were supported to be independent at meal times. There was a focus on supporting residents to be independent with meal choices and preferences. Residents had their evening meal when they returned to their apartments. Residents decided what they wanted for their evening meal and if any resident changed their mind, this was facilitated. Inspectors found that there was an ample supply of fresh food and fruit. Staff followed the recommendations by the dietician for one resident who had specific healthcare needs but there was no care plan to guide this care.

Judgment:
Non Compliant - Moderate

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:
Inspectors found staff were knowledgeable about medication management and administered medications safely. Staff had received training in this area.

There was a comprehensive medication management policy in place which gave guidance to staff on areas such as ordering, prescribing, administration of medicines ‘as required’ (PRN) medication, refusal and withholding medications. Written evidence was available that medications were regularly reviewed by the doctor. There was no medications that required strict controls in place, but staff outlined the procedure they would follow. Inspectors noted that many of the residents were supported to be independent with self medications and the policy guided this practice.
Judgment:  
Compliant

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

Theme:  
Leadership, Governance and Management

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

Findings:  
The provider had undertaken a number of audits and reviews of the safety and quality of the service. The provider had established a management structure, and the roles of managers and staff were clearly set out and understood.

Overall there was a management system in place on the day of the inspection which supported and promoted the delivery of quality services. The role of the person in charge was under review at the time of the inspection. A new residential coordinator was employed on the week of the inspection and was being developed in the role. The regional director and person in charge discussed the plans to review the type of service being delivered and the support needs of the residents.

The person in charge was appropriately qualified and had continued his professional development. However, due to the size and layout of the service and his current role, the provider did not ensure that the management systems were in place to ensure the service provided is safe and appropriate to the residents needs. For example in the development and review of the residents personal plans, access to and follow up on healthcare issues, allied health services, and positive behaviour support.

The provider had established monthly regional management meetings, quality and safety committee, residential quality improvement and the supervisors forum meetings where the managers of services could meet to discuss common areas of interest and share their learning. There was no current formal system for team leaders to meet the person in charge to discuss resident’s needs.

The person in charge and staff had arranged regular meetings for residents in the centre as a way of supporting residents to communicate their views. Residents told inspectors that they used the meetings to make decisions what activities they wanted to engage in and the supports required.
Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
Staff were observed to be very caring and passionate about the care they provided.

While there appeared to be sufficient staff on duty in the apartments, the skill mix was not sufficient to meet the needs of residents with mental health issues in one location. Inspectors found that the staffing levels were based on historical data and not on the current support needs of residents. The management acknowledged this and said they were actively reviewing this as part of the service review.

Inspectors found that there was an inconsistency in the numbers of staff hours allocated in one location when agency staff were on duty. A resident who was vulnerable in one location and the agency staff were not familiar with whom the resident could contact in the absence of being staff in the house for two hours during the day. While the principle social worker was available to the resident, this arrangement was not formalised.

Staff files were reviewed and they met the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Staff meetings took place regularly however; there was no formalised supervision of staff in place. Inspectors were informed that the individual performance reviews had not taken place since 2012 and the records were not available for review.

Training records were held centrally which outlined the actual training for all staff. Actual training provided in 2014 and 2015 included areas such as, policy training, medication management, fire safety and safeguarding. Staff had not received training to care for residents with specific needs such as diabetes, restrictive practices, mental health issues, and infection control.
Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

| Centre name: | A designated centre for people with disabilities operated by St John of God Community Services Limited |
| Centre ID:   | OSV-0003932                                                                                   |
| Date of Inspection: | 03 and 04 March 2015                                                        |
| Date of response: | 25 March 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 05: Social Care Needs

Theme: Effective Services

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

Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
(1) The Social care Leader will review all personal plans to ensure a consistent approach to meeting the needs and choices of residents

(2) A committee is meeting to discuss the personal plans and decide which information needs to be kept in the persons file and which can be kept electronically. The first meeting was held on February 16th and service users will be involved in the review.

(3) The Person in Charge will ensure all residents personal plans are reviewed to identify and agree accessible formats and develop and implementation plan.

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

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not reflect the assessed needs of residents.

**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:
(1) The support agreement for all residents will be reviewed in conjunction with the resident / their representative and their circle of support to reflect the support needs of each resident and identify all supports that the person is receiving and needs to receive. These assessments will be completed and reflected in the residents file.

(2) Using Your Environment – An environmental assessment will be completed for each resident, where applicable, to promote independence
(3) The findings from the “using your environment assessment” will be incorporated into the residents personal plans.
(4) The Person in Charge will meet with social care Leader on a monthly basis for regular review and update.
(5) A new template for weekly staff meetings will be reviewed to ensure changing needs/circumstances are identified.

**Proposed Timescale:**
1. September 30th 2015
2. April 30th 2015
3. August 31st 2015
4. March 31st 2015
5. April 30th 2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessment did not have multidisciplinary input and did not assess the effectiveness of the plan.

Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
(1) The support agreement for all residents will be reviewed in conjunction with the resident / their representative and their circle of support to reflect the support needs of each resident and identify all supports that the person is receiving and needs to receive.
(2) All future assessments and reviews will include relevant multidisciplinary input and will be evidenced on the Personal Plan.

Proposed Timescale: 30/10/2015

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 risk management policy did not guide practice in relation to residents at risk of self-harm.

Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
(1) All residents at risk of self-harm will be reviewed at a multidisciplinary meeting and appropriate supports will be identified to ensure all control measures are adequate to promote the health and wellbeing of the resident.

(2) The Person in charge will review the risk management policy to identify and target the risks in relation to self-harm.

(3) Risk assessments for these areas will be put in place that will identify, assess and establish adequate and clear control measures for the risks identified.

(4) Person in Charge will meet with social care Leader on a monthly basis for regular review and update.

(5) A local Risk Management Policy will be reviewed to include the necessary
precautions to be taken for residents who smoke

(6) Residents who smoke will be supported through the completion of a risk assessment with their involvement.

(7) Residents who smoke will be supported to be aware of the dangers associated with smoking by 30th March 2015

(8) All staff will be inducted to the risk management policy at team meeting

(9) All risk assessments will be reviewed at the team meeting as specified on the risk assessment form

**Proposed Timescale:**
1. April 8th 2015
2. 29th May 2015
3. 29th May 2015
4. 31st March 2015
5. 29th May 2015
6. 29th May 2015
7. 30th March 2015
8. June 30th 2015
9. As specified on individual risk assessments.

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not guide practice.

**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:**
(1) The Person in charge will review the risk management policy to identify and target the risks in relation to fire safety, smoking, behaviours that challenge and self-harm.
(2) Risk assessments for these areas will be put in place that will identify, assess and establish adequate and clear control measures for the risks identified.
(3) The risk management policy will be refreshed with all staff
(4) A review of the adverse incident system will be undertaken to identify an agreed method of shared learning and set a date for implementation of same.

**Proposed Timescale:**
1. 29th May 2015
2. 29th May 2015
3. 30th June 2015
4. 29th May 2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff had not received training in the use of fire extinguishers.

**Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

**Please state the actions you have taken or are planning to take:**
(1) The person in Charge will liaise with the HR department and the Orders fire officer regarding training in the use of fire extinguishers.

**Proposed Timescale:** 30/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All fire equipment was not regularly serviced.

**Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
(1) The person in charge will liaise with SHARP security to ensure the fire equipment is serviced on a quarterly basis. This documentation will be kept in the fire register

**Proposed Timescale:** 30/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no plan to address the learning identified from the fire drills.

**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:**
(1) The Social Care Leader with support from the person in charge will review all fire
drills completed over the last 18 months to ensure that all issues of concern have been addressed

(2) The person in charge will continue to ensure that quarterly fire evacuation drills are carried out and reports forwarded to the Health & Safety committee.

(3) After each fire drill the social care leader will identify with staff any learning that came from the fire drill. A risk assessment identifying learning from each drill will be completed. Each individual’s personal evacuation plan will be updated and communicated to all staff.

(4) The Personal evacuation Plan will be reviewed for residents where night sedation they are currently using affects their ability to evacuate.

(5) The social care leader is to notify the person in charge if there are any issues in relation to the fire drill.

(6) The learning from all fire evacuation drills will be discussed quarterly, after each fire drill, at the team meeting with staff.

Proposed Timescale:
1. 29th May 2015
2. April 30th 2015
3. April 30th 2015
4. April 30th 2015
5. April 30th 2015
6. April 30th 2015

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:
Staff did not have the specialist skills to respond to behaviour that was challenging.

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) Staff in all areas are to be re-inducted into behaviours that challenge policy
(2) Current training on behaviours that challenge and restrictive practices, on offer to specific staff teams will be provided to the staff team in this designated centre.
(3) Staff to be inducted into the guidelines for an individual with mental health issues as provided by the psychology department.
Proposed Timescale:
1. June 30th 2015
2. December 30th 2015
3. April 30th 2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of restraint was not in line with national policy.

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) All occasions where a restriction is implemented will be recorded documented there will be review on a monthly basis by the Positive Behaviour Support Committee

(2) The rights committee is in the process of being developed and all rights restriction will be reviewed by the committee when operational.

(3) A review of all restrictive practices in this designated centre will be undertaken

Proposed Timescale:
1. March 30th 2015
2. September 30th 2015
3. May 28th 2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents had been kept safe when other residents presented with behaviour that was challenging.

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:
(1) Identified residents will be reviewed by psychiatry and psychology in terms of their wellbeing and safety needs

Proposed Timescale: 30/04/2015

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:
There was insufficient evidence that all residents had access to allied health professionals as required.

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 Social Care leader will review residents health action plans this will target what allied health professionals the residents have/need access to and ensure follow-up
(2) All referrals, assessments and follow up information by allied health professionals will be documented on the residents’ personal files.
(3) Outstanding Health Action Plans will be completed
(4) Health Action Plans will be reviewed biannually by the keyworker and reviews recorded on files.

Proposed Timescale: 30/08/2015
Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The health action plans were not specific to guide the care to be delivered.

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) All Outstanding Health Action Plans will be completed.
(2) A proactive action plan projecting the resident care into the future will be identified. An action, person responsible and completion date will be assigned to each action identified.

Proposed Timescale: 31/08/2015

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:
The provider did not ensure that the management systems were in place to ensure the service provided is safe and appropriate to the residents needs.
**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:**
(1) The Person in charge will arrange to meet with the social care leader of the area monthly to discuss any concerns in relation to this designated centre. Residents needs will be discussed as a priority agenda item at these meetings.
(2) The person in charge will target areas of concern (i.e. development and review of personal plans, access to healthcare services, positive behaviour support) through action plans and audits to ensure the actions put in place are effective and efficient.
(3) The regional director will meet with the person in charge and the residential coordinators to review the effectiveness of the person in charge structure currently in place.

**Proposed Timescale:**
1. April 30th 2015
2. April 30th 2015
3. June 30th 2015

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The number of staff was not consistent in one location.

There was an inappropriate skill mix to meet residents needs.

The staffing levels were not based on the assessed needs of residents.

**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) There is a committee currently in place that is reviewing the staffing structure in place in supported living
(2) This new structure will allow the various teams to focus on specific areas of support and target and develop the skills required for these areas.
(3) Assessments will identify the needs of the residents which will enable us to ensure the correct staffing levels are in place and will also enable us to target specific areas of need in this designated centre.
**Proposed Timescale:** 30/10/2015

**Theme:**Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no formalised supervision of staff in place.

**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. A schedule for PDR’s for each individual staff member to be completed by the social care leader. The social care leader to complete performance reviews, as indicated by the schedule, for all frontline staff in this designated centre.
2. The person in charge to complete a performance review with the social care leader.

**Proposed Timescale:**
1. June 30th 2015
2. December 30th 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 training as outlined in outcome 17.

**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) The social care leader, with the support of the person in charge to complete an audit of all mandatory training for staff in this designated centre. Social care Leader to conduct a review of all staff training to ensure all training is up to date
(2) Staff supporting residents in this designated centre will receive appropriate training in the following;

- Diabetes
- Restrictive practices
- Mental health
- Infection control

**Proposed Timescale:**
1. 30th September 2015
2. 30th December 2015