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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003004
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Siobhan Kennedy
Support inspector(s):	Jillian Connolly (Day 1) Philip Daughen (Day 3)
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
12 February 2015 19:30	13 February 2015 01:00
13 February 2015 11:00	13 February 2015 19:00
16 February 2015 10:00	16 February 2015 13:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Following an unannounced inspection of this designated centre in November 2014 the Authority found that the services, being operated were not in accordance with the provisions of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013. Primarily these related to staffing and residents' general welfare and development.

Regulatory Enforcement Proceedings (warning letter, regulatory meetings, immediate action and notice of improvement) were initiated by the Authority to bring about immediate and sustained improvements in the operation of the designated centre.

In response the Authority received written correspondence from the management of the designated centre, outlining the action to be taken to address the contraventions of the legislation. The Authority requested a weekly report identifying staffing levels and information regarding significant events in residents' lives in order to monitor the designated centre's compliance with the regulations.

The purpose of the inspection was to assess the progress made by management in

addressing the matters arising from the previous inspection and the breaches of the regulations/standards which were outlined in the Notice of Improvement as follows:
• The number, qualifications and skill mix of staff was not appropriate to the number and assessed needs of the residents, the statement of purpose, and the size and layout of the designated centre.
• Residents did not receive continuity of care and support, particularly in circumstances where staff were employed on a less than full-time basis.
• Staff were not appropriately supervised.
• Residents did not have opportunities to participate in activities in accordance with their interests, capacities and developmental needs.
• Arrangements were not in place to meet the assessed health care needs of two residents.
• Residents were not protected from a risk of a health care associated infection by the adoption of procedures consistent with the standards for the prevention and control of health care associated infection.

The staff roster provided to the inspectors were consistent with those forwarded to the Authority since November 2014 and reflected the staff on duty in numbers and by designation, including staff employed on a less than full-time basis (agency staff). The agency staff were regularly working in the designated centre and were familiar with the residents' needs.

There were adequate staff on duty to provide care and supervision of the residents with the exception of a period in the late evening when residents required the assistance of two staff leaving the remaining residents unsupervised. During the post inspection feedback meeting management agreed to have an additional staff member work in the centre during these hours.

Staff rosters received by the Authority for the period 23 February 2015 to 1 March 2015 identified an additional staff member on duty in the evenings with the exception of 28 February 2015.

Staff had participated in training in respect of positive behaviour support and behavioural assessments had been carried out so that staff knew the triggers which pre-empted certain behaviours and were able to control/minimise these. The numbers of incidents in which behaviours are challenging had decreased and there was less reliance on restraint measures.

The organisational structure have been revised and now includes a designated person in charge who has qualifications and many years experience relevant to the resident group.

Inspectors saw that residents had a variety of opportunities to participate in activities and staff were keen and enthusiastic to assist residents to have meaningful life styles.

Inspectors observed that there were good practices regarding infection prevention and control and the communal facilities and residents' private space were clean. The training records showed that staff had completed training relevant to this aspect of

service provision, including hand hygiene.

Although progress had been made to address the non-compliances identified in the Notice of Improvement inspectors found further areas of major non-compliance (in respect of workforce, medication management, and health and safety and risk management). These are outlined in the action plan of this 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 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
In the main, inspectors saw that residents had opportunities to participate in activities which provided meaning and purpose for them and suited their needs/capacities and interests.

A review of residents' individual programme plan had been carried out and staff had written in the plan residents' preferences and choices and support required to provide appropriate and meaningful day activities.
A notice board detailed all of the events/ activities which residents could attend. However, this was located in the office area and was not in a format and medium that was appropriate/suitable to the resident group.

There were adequate staff on duty during the day to carry out general routines, provide personal care and assist and facilitate residents to participate in social and recreational activities.

Inspectors saw that residents had gone on outings which entailed dining experiences, participation in yoga sessions, attendance at celebratory parties including New Year's eve, reflexology, having movie nights, jamboree sessions, aromatherapy and time to relax. Inspectors observed a staff member assisting a resident to acquire the skill to make a cup in order to further the resident's independence.
Since the last inspection communal space which had not been utilised by residents had been refurbished to create a homely environment for residents. This provided a quiet area for residents.

Residents had freedom to exercise choice and control in their daily lives for example

some residents chose not to go to the Valentine disco and another resident communicated with a staff member that he wished to return to the designated centre half way through an activity. However, inspectors observed that a resident was prevented from going into the kitchen as the door was locked.

Inspectors saw that residents' privacy and dignity was respected by staff knocking on the doors to residents' personal space before entering, discussing residents' personal information in private, ensuring that intimate and personal care was carried out in private and entering the residential home by the front door. However, some aspects of residents' privacy and dignity had not been respected for example:
• The length of fabric attached to a resident's privacy screen was insufficient to provide the resident with appropriate privacy.
• On an occasion staff did not ensure that a resident's clothing was appropriately , fitting, leaving the resident's private space.
• Residents do not have their own bed linen and towels.
• The general laundry was being sorted in residents' private space.
• Some residents' personal garments were not sufficiently ironed/ pressed.
• A bed throw was not clean.
• There was no signage on the shower room door.

The inspectors heard that quality advisers have been supporting the staff team to develop services including appropriate meaningful day activities. Residents had opportunities for new experiences and social participation out side the designated centre in that some residents attended a panto and other residents go to the local library. Other opportunities off-site have also been obtained for some of the residents and they are availing of these five days a week, managed by the programme manager of day services.

Inspectors identified areas, whereby the designated centre was not operated in a manner that respected residents' age/adult hood and disability. For example,
• Reference was made to continence products as "nappies"
• Residents with a disability were referred to as "mentally handicapped"
• The programme on television in the late evening was not appropriate/suitable for the 2 residents who were in the communal sitting room where the television was located.
• The posture of a staff member was inappropriate (standing looking down) while a resident sitting on the floor was in the progress of changing underclothing.
• The radio security systems held by staff as they carried out their duties were loud when being tested and interrupted the quiet relaxed atmosphere of the late evening.

The person in charge informed the inspector that she is planning to have a forum for residents and relatives so that residents can be consulted/ supported to make decisions about the services and that their views are taken in decision making.

The inspectors were given an example whereby a staff member was advocating on behalf of a resident at a multidisciplinary team. The staff member had prepared a report and attended the meeting with the resident. The inspectors met with the resident who is currently involved with an advocacy group.

The person in charge is responsible for investigating complaints. Inspectors reviewed a

complaint which came to the attention of the Authority in November 2014 in relation to inadequate staffing levels. There was evidence that the matter was investigated and substantiated. Management had invited the complainant and advocate to a meeting to outline the findings of the investigation and the action to be taken by management to prevent any further re-occurrences.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
The inspectors saw that residents' communication needs were identified in the residents' personal care plan.

Staff (core and agency) were familiar with the residents' communication modes and were able to interpret non-verbal signs and this was demonstrated regarding residents' lunchtime meal choices.

Currently staff are working on providing pictorial aids to assist residents in understanding the care planning process.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The designated centre accommodates 9 residents. All of the resident have an intellectual disability and were primarily assessed as having a high to maximum dependency. For example, 5 residents have epilepsy.

Matters arising from the previous inspection were in the main satisfactorily actioned in that staff had knowledge of residents' care and condition in relation to epilepsy. However, it was identified that all staff did not have the same interpretation regarding the written procedure and the associated protocol to be followed in the event of a resident having an epileptic seizure, particularly in relation to the administration of medicines (timeline for administering and use of covert methods) and restraint.

The inspectors found that the staff were up to date in their knowledge of the residents' needs and care requirements. Each resident had an Individual Personal Plan (IPP). These were developed in respect of each resident's care and addressed key aspects of the social, emotional, psychological and health care needs of the residents.

Staff in consultation with residents had identified personal goals and staff are aiming to have these developed in a format/medium relevant to each individual resident and placed in their own personal space so that they are accessible.

Documentation showed that there were regular reviews of residents' care plans in consultation with residents and or their next of kin/families. A multidisciplinary review for a resident was arranged during the period of the inspection. The person in charge informed the inspectors that all staff will be provided with further training in the care planning process.

A key worker system has been set up which has identified staff members who are responsible and coordinate the care to a number of residents. The inspectors heard that the first question posed by the person in charge at staff/key worker meetings is "describe the residents that you have responsibility for as a key worker".

Judgment:
Substantially Compliant

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Matters arising from the previous inspection, whereby residents were not protected from a risk of a health care associated infection by the adoption of procedures consistent with the standards for the prevention and control of health care associated infection had been satisfactorily addressed with the exception of a resident's wheelchair lap belt which was not clean as there was ingrained food stains.

The following measures have been put in place:
• A refresher training in hand hygiene was provided on 25 November 2014 by the clinical nurse specialist in health promotion. The refresher training included all staff working in the designated centre.
• Training in infection-control took place during December 2014
• Cleaning schedules were in place and the centre was found to be cleaned.
• Staff had an opportunity to read the centre's operating procedures in respect of infection control.
• Infection-control audit was carried out 3 December 2014 by the clinical nurse specialist in health promotion. An action plan was agreed, prioritised and implemented by management of the centre.

Inspectors found that the health and safety of residents was promoted and protected with the exception of fire prevention and safety.

The centre was provided with fire alarm, fire extinguishers and emergency lighting coverage throughout.

There were two fire alarm panels located within the centre. One panel covered half of the centre and a neighbouring centre. The other panel covered the other half of the centre as well as another neighbouring centre. The fire panel locations seem to reflect an older centre layout that was annotated on drawings on the walls where the boundaries of the centres within the building were different to what currently is the case. The situation as it currently exists represents a possible delay in the raising of the alarm as staff in the centre would possibly have to check both panels in the event of an activation to deduce the location of the fire. The current situation also means that in the

event of fire alarm activation in the neighbouring centre, staff from there would have to leave their centre through a link corridor and go to the designated centre in order to check the panel.

From information received from staff, inspectors could not determine if staff were able to read the panel correctly in order to find the location of the activation in a timely fashion. The lack of clarity from staff as to the procedure to follow indicated that there was training required in this regard.

While it was self evident to inspectors from observation that the centre was compartmented from neighbouring centres with fire resistant construction, it was unclear to inspectors if there was a policy of total or phased evacuation within the designated centre. There were no adequate procedures displayed on the walls in the centre. There were drawings annotating the layout of the centre on the walls but they required updating as they did not reflect current arrangements at the centre.

The records relating to past fire drills were inadequate and of variable frequency. Therefore inspectors were not assured that the evacuation procedures were fit for purpose and that there was a sufficient number of staff at all times to ensure a timely evacuation in the event of fire. See outcome 18 for action plan.

There was a personal emergency evacuation plan provided for each of the residents. The plans contained good detail in relation to the residents' reaction to a fire alarm activation but inspectors found that in some instances, more detail was required to explain the individual support needs and the use of any evacuation aids for evacuation of residents in the event of activation.

The physical support needs of residents were explained to inspectors by a member of staff. Of the nine residents, it was explained that six would require physical assistance from staff in order to get them out of bed at night time for evacuation by wheelchair or by sheet. The remaining three residents required staff supervision to guide them out but required no physical assistance. It was explained to inspectors that the typical night time staff level was two staff with the possibility of summoning more staff from neighbouring centres by radio in the event of an emergency. Inspectors could not determine if the staffing level was sufficient to ensure a timely evacuation in the event of an emergency at night. Furthermore inspectors were unable to locate any fire drill records to demonstrate the adequacy or otherwise of the night time staff levels.

As the centre is a single storey building, all escape routes were horizontal out of the building. Inspectors found that the centre was provided with an adequate number of escape routes. The escape routes were adequately distributed around the building. There was clear signage indicating these escape routes.

Many of the fire doors were not provided with self closers and in some instances, the fire closers had been found to be disabled or removed. The bedroom doors appeared to be fire doors but had no self closers or cold smoke seal provided around the door. Many of the doors, both internal and final exit doors, on the primary escape routes were equipped with key locks. These doors had a key provided in a break glass unit located adjacent to the door. There were also internal doors equipped with key locks with no

key provided but these doors were primarily located along circulation route and did not appear to be locked in normal practice.

Fire escape routes were obstructed as follows in such a way that would impede residents, staff and visitors from moving freely away from the building as follows:
One escape route was found to be partially obstructed with furniture in a manner that would impede resident evacuation in the event of fire, a final exit from the building had a step down outside the door, the external area adjacent to this exit was obstructed with planting and a ramp outside another exit .

Inspectors found that while emergency lighting, fire alarm and fire extinguishers all appeared to be in good order.

The maintenance records were incomplete as recorded in the maintenance log book. There were incomplete records relating to daily and weekly fire safety checks carried out by staff. See outcome 18 for action plan.

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

Findings:
The matter arising from the previous inspection was satisfactory addressed as inspectors found that staff were knowledgeable in protecting residents from all forms of abuse. In discussions with the inspectors staff described the various types of abuses and their duties and responsibilities in relation to any incident, allegation or suspicion of abuse.

In addition, staff had received training to respond to the behaviours displayed by residents that were challenging in consultation with the broader managerial team have found ways to support residents to manage these behaviours.

Inspectors noted that this had reduced the incidence of behaviours and the restraint measures previously in place. For example a stress ball was used as opposed to arm

gaiters.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Inspectors observed the serving of the evening supper and lunchtime meal.

The supper meal was not a social occasion for residents and there was a limited choice of food which did not reflect each resident's individual dietary needs and preferences.

The supper meal was served to residents at different times and it was a rushed event due primarily to having only two staff members on duty.

In contrast the lunchtime meal looked wholesome and nutritional offering residents a variety of choices and there were sufficient staff on duty to assist residents with their meals in an appropriate manner.

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):
No actions were required from the previous inspection.

Findings:
There were written operational policies relating to the ordering, prescribing, storing and

administration of medicines to residents.

The medication trolley was left unlocked on 2 occasions.

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

Findings:
Since the last inspection the management structure of the designated centre has been reviewed and changes made. The inspectors saw that there was a clearly defined management structure that identified the lines of authority and accountability, specific roles and details of responsibilities for all areas of service provision.

From November 2014 and for an interim period an experienced person in charge was in an acting position and provided improved leadership for management and staff of the designated centre. She is a qualified intellectual disability nurse with approximately 15 years experience in the area of intellectual disability and registration with the professional body is up-to-date.

Recruitment for the position of director of care and support has taken place and an appointment made to this position. The staff member was working during the inspection.

Quality advisers have been supporting management and the staff team on a weekly basis to develop services including appropriate meaningful day activities.

The person in charge is supported by the director of care and support, regional director of services and quality advisers in addition to weekly attendance at a forum where matters can be discussed and decisions taken.

The designated manager of the centre has been given protective time on a weekly basis to carry out managerial responsibilities.

Although inspectors found that progress had been made to bring the centre into compliance with the legislation, the cumulative findings of this inspection (which includes major non-compliance in respect of workforce, medication management, and health and safety and risk management) has evidenced that management systems in place have not ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Since the last inspection inspectors saw that management had introduced a number of measures in order to achieve compliance with the breaches of the legislation identified in the Notice of Improvement in relation to staffing. For example: –
• The appointment of an experienced person in charge (on an interim basis) who is in the designated centre on a daily basis, assessing the staffing levels necessary to meet the residents' needs and liaising and communicating with the "allocations team" to ensure that only regular staff who are familiar with the residents' needs work in the designated centre.
• The clinical nurse manager has been given protective time on a weekly basis to perform managerial duties including the supervision of staff. However, inspectors noted that staff were not appropriately supervised and this is outstanding from the previous inspection.
• All staff members who are employed on a less than a full-time basis, are now inducted prior to working with the residents. This includes reading the "Critical Information of the IPP" and "Behavioural Support Plan"
• Documentation has been set up to support the induction process.
• A staff member is identified in the absence of the clinical nurse manager to coordinate the day to day operations of the centre.
• Systems have been set up to monitor/audit practices with in the centre regarding the health and safety of residents and the implementation of a meaningful day for residents.

• Each residential home within the designated centre has a specific staff roster.
• A housekeeper has been employed to work in the centre on a daily basis.

Inspectors reviewed a complaint which came to the attention of the Authority in November 2014 in relation to inadequate staffing levels. There was evidence of the matter was investigated and substantiated. See outcome 1 for details.

Inspector saw that the meal at supper time was served at different times and it was a rushed event due primarily to having only two staff members on duty. See outcome 11 details.

The person in charge is responsible for investigating complaints. Inspectors reviewed a complaint which came to the attention of the Authority in November 2014 in relation to inadequate staffing levels. There was evidence that the matter was investigated and substantiated. Management had invited the complainant and advocate to a meeting to outline the findings of the investigation and the action to be taken by management to prevent any further re-occurrences.

Inspectors found that there were adequate staff on duty to provide care and supervision of the residents with the exception of a period in the late evening when residents required the assistance of two staff leaving the remaining residents unsupervised. Staff identified that there were "four or maybe five residents" who require the assistance of two staff members to prepare for bed.

In addition, there was insufficient evidence to confirm that there were adequate staff on duty in the event of an emergency, whereby residents would need to be evacuate. See Outcome 7 for details.

Staff in their communications with the inspectors demonstrated that they were knowledgeable of residents' needs, capabilities, life histories, family support circles and behaviour management plans where appropriate.

Staff confirmed that the new leadership arrangements had a positive impact in bringing about better outcomes for residents and improving staff morale.

Inspectors were informed that staff meetings had taken place on a weekly basis.

Staff had participated in training relevant to their role and responsibility for example positive behaviour support, moving and handling, safeguarding and the role of the key worker.

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):

No actions were required from the previous inspection.

Findings:

The fire safety records in relation to the centre were examined and it was found that the records relating to previous fire drills were insufficiently detailed and of variable frequency.

The fire safety maintenance records and daily, weekly fire safety checks carried out by staff were incomplete as recorded in the maintenance log. See outcome 7.

The records to be kept in the centre in respect of each resident regarding medication management were not fully maintained as follows:

- The prescription sheet in relation to the administration of medicines had not been fully signed by the prescribing practitioner.
- Some medicines on the prescription sheet had been crossed out.
- In some instances, residents' reviews had not been signed.

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:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003004
Date of Inspection:	12 February 2015
Date of response:	07 May 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:
A notice board detailing information in relation to residents' events/ activities was located in the office area and was not in a format and medium that was appropriate/suitable to the resident group.

Action Required:

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

Under Regulation 09 (2) (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:
1. On the day of inspection notice boards were available in the dining area, detailing the activities scheduled for the particular day, however the Person in Charge is going to explore the format/medium further, by ensuring each resident in the Designated Centre has a notice board in their bedroom, which will include pictures of the activities the resident is participating in for the day, and the members of staff which are supporting them on a daily basis in the Designated Centre.

2. The key worker also ensures they communicate to residents regularly providing them with the details of activities/events which are scheduled for the day.

Proposed Timescale: 29/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident was prevented from going into the kitchen as the door was locked.

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:
1. Following the inspection an additional member of staff has been rostered from 20.00 to 23.00. Staff accompanies the resident into the kitchen, and supports the resident to make a cup of tea. Details of how to support the resident whilst making a cup of tea has been defined in the residents individual personal plan (IPP).
2. All incidents relating to access for resident's throughout the Designated Centre are risk assessed on an individual basis to maximise resident's access.

Proposed Timescale: 30/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' privacy and dignity had not been respected as follows:
• The length of fabric attached to a resident's privacy screen was insufficient to provide the resident with appropriate privacy.
• On an occasion staff did not ensure that a resident's clothing was appropriately, fitting, leaving the resident's private bedroom space to join others in the communal

sitting room.
• Residents do not have their own bed linen and towels.
• The general laundry was being sorted in residents' private bedroom space.
• Some residents' personal garments were not sufficiently ironed/ pressed.
• A bed throw was not clean.
• There was no signage on the shower room door.

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:
1. To ensure the residents privacy and dignity is respected the Person in Charge has contacted a supplier to adjust the length of the fabric on the privacy screen

2. The Person in Charge has communicated with all staff at the team meeting, and discussed the importance of respecting the resident's privacy and dignity, especially in regards to ensuring residents clothing is appropriate and fits appropriately. The Person in Charge has also met with the individual member of staff to go through the SJOG value in practice policy. The staff member now understands the importance of respecting the privacy and dignity of residents and the experience for the residents.

3. New towels have been ordered for each individual resident. The resident's bed linen is removed as required and sent to the contracted cleaners and replaced with fresh linen.

4. To ensure general laundry is not sorted in resident's bedrooms, the Person in Charge has identified an specific area within the Designated Centre for the sorting of laundry. This specific area has been identified as it is being used by the residents and this has been communicated to all staff.

5. To ensure resident's personal garments are ironed/pressed the Person in Charge has purchased an iron and ironing board and this will be available to staff at all times, within the Designated Centre.

6. The cleaning of bed throws has now been included onto the cleaning rota, and the Person in Charge has communicated this to staff.

7. Following the Inspection a permanent sign has been placed on the shower room door.

Proposed Timescale: 30/04/2015

Theme: Individualised Supports and Care

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

the following respect:
The designated centre was not operated in a manner that respected residents' age/adult hood and disability. For example,
• Reference was made to continence products as "nappies"
• Residents with a disability and were referred to as "mentally handicapped"
• The programme on television in the late evening was not appropriate/suitable for the 2 residents who were in the communal sitting room were the television was located.
• The posture of a staff member was inappropriate (standing looking down) while a resident sitting on the floor was in the progress of changing underclothing.
• The radio security systems held by staff as they carried out their duties were loud when being tested and interrupted the quiet relaxed atmosphere of the late evening.

Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
1. The Person in Charge has met with the individual staff member on a 1-1 basis and all staff at staff team meeting, to discuss the importance of using appropriate person centred language on the 14th February 2015.

2. As per the Corporate Policy all staff are being supported by the Person in Charge through the performance development programme in regards to privacy, dignity and appropriate language

3. As part of the role and responsibility of the Manager/Shift Leader in each house it is their duty to ensure all staff are using appropriate language when speaking to individual residents and to ensure staff are corrected where necessary

4. A template is in place to support the role of Manger/ Shift Leader on a daily basis. This encompasses a wide set of requirements including the need to promote an appropriate homely environment and ensure staff are using appropriate language.

5. The Person in Charge met with staff to communicate and discuss the importance of resident's experiences and this includes ensuring the TV is switched off when not in use and that it is supervised to ensure resident's access to appropriate programmes.

6. The staff radio system is essential as a form of communication for all staff/supervisors who are on call and in the eventuality of a emergency, therefore staff have been communicated with to ensure the radios are turned down to the minimum audiable sound to ensure the privacy and dignity of residents is respected.

Proposed Timescale: 30/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangement had not been put in place to ensure that all staff were fully aware of the specific procedures to be followed in the event of residents having an epileptic seizure.

Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
1. All residents who present with epilepsy have epilepsy care plan in place, which are currently being reviewed and stored in the residents' Individual Programme Plan. The epilepsy care plans will be discussed at the team meetings to ensure all staff have a full understanding of the resident's needs and what to do in the event of a resident having an epileptic seizure.

2. A signing sheet has been developed for epilepsy care plans. All staff have to read and sign these plans to confirm that they understand them. This is supported by the shift leader.

3. Staff have also been reminded to ensure they have read each residents Critical Information Sheet, which is also stored in the Individual Personal Plans.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' individual personal plans were not available, in an accessible format, to the resident and, where appropriate, his or her representative.

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:
1. The Person in Charge has commenced work on four residents Individual Personal Plans to ensure they are in an accessible format for the resident and, where appropriate their representatives. Once these four plans have been completed, the Person in Charge will evaluate its effectiveness and explore alternative mediums where deemed necessary.

Proposed Timescale: 30/07/2015

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:
A resident's wheelchair lap belt was not clean as there was ingrained food stains.

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:
1. Prior to the inspection the Person in Charge had referred the matter of cleaning the wheelchair lap belt to the Infection Prevention and Control Committee. Products were sourced following the committee's recommendations; however they have not been effective. As a result the Person in Charge has secured two new lap belts for the wheel chair.

2. The cleaning of wheelchair lap belts is included onto the cleaning schedule for night staff.

Proposed Timescale: 07/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective, fire safety management systems were not in place due to the location of fire alarm panels.

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:
1. The management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.

2. The service is in the process of installing two repeater fire panels which address the location of fire alarm panels for this Designated Centre.

3. All staff have completed fire training and additional site specific training including

safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April.

4. An Emergency Evacuation Plan has been reviewed and updated for this Designated Centre and it's contained within the Fire Safety Register and located beside the Fire Panel.

5. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre. .

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not sufficiently knowledgeable with regard to reading the fire panel in order to find the location of the activation panel in the event of an emergency.

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 met with staff at the team meeting immediately after the inspection to discuss and ensure staff understood how to read the fire panel, in order to find the location of the activation panel in the event of an emergency.

2. All staff have completed fire training and additional site specific training including safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April 2015.

3. An Emergency Evacuation Plan has been reviewed and updated for this Designated Centre and it's contained within the Fire Safety Register.

4. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre.

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

the following respect:
The fire policy/procedure was unclear with regard to total or phased evacuation within the designated centre.
The procedure was not displayed on the walls in the centre.
There were drawings annotating the layout of the centre on the walls but they did not reflect the current arrangements at the centre.
The physical support needs of residents and use of evacuation aids were not detailed sufficiently in residents' individual evacuation plans.

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 management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.

2. All staff have completed fire training and additional site specific training including safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April.

3. The Emergency Evacuation Plan has been reviewed and updated for this Designated Centre and it's contained within the Fire Safety Register.

4. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre.

5. Following on from the Inspection the Person in Charge immediately arranged for the fire drawings to be updated to reflect the current arrangements at the Designated Centre.

6. All residents have Individualised Personal Emergency Evacuation Plans in place which reflects the resident's needs in case of an emergency. Key Workers are currently in the process of reviewing these to ensure all key/relevant information is detailed.

7. In the resident's Individual Personal Plans and fire register there is an Individual Personnel Emergency Evacuation Plan , which details, what the resident's individual needs are and the supports required, in the event of an emergency

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

Many of the fire doors were not provided with self closers.
Fire doors in the designated centre with self closers were either disabled or removed.
The bedroom doors (appeared to be fire doors) did not have self closers or cold smoke seal provided around the door.

Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
1. The management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.
2. Fire doors will be provided with self-closers and smoke seals replaced where needed.

3. All staff have completed fire training and additional site specific training including safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April.

4. The Emergency Evacuation Plan has been reviewed and updated for this Designated Centre and it's contained within the Fire Safety Register.

5. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An escape route was found to be partially obstructed with furniture in a manner that would impede resident evacuation in the event of fire.
A final exit from the building had a step down outside the door.
The external area adjacent to an exit was obstructed with planting and a ramp outside another exit which impeded residents, staff and visitors from moving freely away from the building.

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:
1. The furniture, which was partially obstructing an escape route, was immediately removed on the day of the inspection.

2. The external area adjacent to an exit which was obstructed with planting and a ramp outside another exit which impeded residents, staff and visitors from moving freely away from the building is currently being reviewed and prioritised as part of the overall Fire Safety Risk Assessment/Fire Safety Plan for this Designated Centres.

3. The management of the service is currently up-dating their overall fire safety plan in consultation with recognised Fire Safety Expert to prioritise all actions as identified during this Inspection visit.

4. All staff has completed fire training and additional site specific training including safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April.

5. The Emergency Evacuation Plan has been reviewed and updated for this Designated Centre and it's contained within the Fire Safety Register.

6. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre.

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:
The supper meal was served to residents at different times and it was a rushed event due primarily to having only two staff members on duty.

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. Following the inspection an additional member of staff has been rostered from 20.00hours to 23.00hours within the designated centre, which will allow consistency at mealtimes, resulting in it being a more positive experience for the residents.

2. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of mealtime experience for the residents ensuring meals are served at the same time and not be a rushed event.

3. The Person In Charge met with the staff at their team meeting to discuss the importance of ensuring a positive experience for residents during mealtimes.

4. The Person in Charge will carry out observational audits around mealtimes as part of the ongoing development with staff, to ensure where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

5. In the absence of the Person In Charge a template is in place to support the Manager and Shift Leader with regard to promoting positive and person centred meal time experiences.

Proposed Timescale: 30/04/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The supper meal was not a social occasion for residents and there was a limited choice of food which did not reflect each resident's individual dietary needs and preferences.

Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
1. Following the inspection the Person In Charge has secured additional support of a Speech and Language Therapist (SALT), who will be available 1 day a week for the service and to support residents within this Designated Centre as required.

2. On the 9th March 2015, the Chef, Dietician and Senior Speech and Language Therapist met with Director of Care and Support to undertake a review to discuss the resident's preferences, choice available for residents, and ensure all residents' individual dietary needs were communicated.

3. Details of each resident's individual dietary needs are specified on each of the resident's Critical Information Sheet and eating and drinking care plan within the Individual Programme Plan.

4. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of mealtime experience for the residents.

5. In the absence of the Person In Charge a template is in place to support the Manager and Shift Leader with regard to promoting positive and person centred meal time experiences.

Proposed Timescale: 30/04/2015

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:
The practices relating to the prescribing and administration of medicines were not appropriate and suitable as follows:
• The medication trolley was left unlocked on 2 occasions.
• The prescription sheet had not been fully signed by the prescribing practitioner.
• Some medicines on the prescription sheet had been crossed out.
• In some instances, residents' reviews had not been signed.

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:
1. The Person in Charge and Clinical Placement Co-ordinator met with the individual member of staff to discuss the importance of the medicines management practice in accordance with the Corporate Person Centred Medication Management Policy. It was agreed the member of staff would be supervised by the Clinical Placement Co-ordinator.

2. Following on from the inspection the member of staff has undertaken the Health Services Executive Land, online medicines management training as part of their on-going professional development.

3. The Person in Charge has met with the staff team to ensure that medication cupboards are kept locked as per the person centre medication policy.

4. The Person in Charge has communicated to all nurses within the designated centre, that they are not to accept a tick on the prescription from the prescribing practitioner and that the prescription sheet has to be fully signed by the prescribing practitioner.

5. The Director of Care and Support has arranged to meet with the consultant who works in the designated centre, to discuss the importance of documentation being completed fully and appropriately.

6. The Person in Charge will conduct a monthly audit to ensure the Medicines Management Policy and Procedure is being adhered to, and ensure any actions are followed up and communicated to staff.

7. The Clinical Placement Coordinator is in the process of arranging a date to carry out training with staff to re-induct them on the Medicines Management Policy and Procedure.

Proposed Timescale: 30/04/2015

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:
Management systems in place have not ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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 Clinical Nurse Manager has twelve hours Protected Time to facilitate the mentorship of individual staff members using a systematic approach. This will ensure all practices within the Designated Centre are effective/ safe and appropriate towards meeting residents assessed needs on a consistent basis.

2. The Director of Care and Support has agreed a schedule, to meet with the Person in Charge on a weekly basis. This regular forum facilitates efficient communication on a 1-1 basis which supporting the role of Person In Charge for the Designated Centre.

3. A Supervision Standard Operating Procedure has been developed and implemented by the Person in Charge for the supervision on staff within the designated centre to ensure consistency and adherence to care practices and processes.

4. A Person In Charge Forum is in place and meets on a weekly basis where priorities are actioned.

5. The Quality Team are conducting regular practice development sessions with staff in the designated centre on an on-going basis, which supports staff to gain a greater understanding of key themes e.g. meaningful day, mealtimes experience, privacy and dignity.

Proposed Timescale: 30/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient staff in the late evening to meet the needs of residents.
There was insufficient evidence to determine that there were adequate staff on duty

during the night to evacuate residents in an emergency.

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 night time evacuation procedure has been reviewed to reflect current processes/practices and is contained within the Fire Safety Register.

2. An additional staff has been allocated to work in the designated centre between 20.00 to 23.00 to ensure the needs of the residents are being met.

3. The management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised Fire Safety Expert to prioritise all actions as identified during this Inspection visit.

4. All staff has completed fire training and additional site specific training including safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April.
5. An Emergency Evacuation Plan has been reviewed for this Designated Centre and is contained within the Fire Safety Register.

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

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 Designated centre continues to work with a Shift Leader in place. A template is in place to support the role of Manger/ Shift Leader on a daily basis. This encompasses a wide set of requirements including ensuring all new staff to the home are inducted using the induction template and staff are supervised appropriately throughout the day

2. A Supervision Standard Operating Procedure has been developed and implemented by the Person in Charge for the supervision on staff within the designated centre to ensure consistency and adherence to care practices and processes.

3. The Person In Charge/Clinical Nurse Manger 1, will continue to provide individual

feedback to staff on a regular basis, and ensure team meetings continue to take place.

4. The Person In Charge who is supernumerary is in place alongside a Clinical Nurse Manger who has protected hours to ensure staff are appropriately supervised. They provide supervision formally and informally.

Proposed Timescale: 30/04/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire safety records were not maintained in accordance with the legislation as the previous fire drills were insufficiently detailed and fire maintenance records and daily and weekly fire safety checks carried out by staff were incomplete.

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:
1. The management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.

2. All staff have completed fire training and additional site specific training including safe evacuation procedures completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th and 9th April.

3. An Emergency Evacuation Plan has been reviewed for this Designated Centre and is contained within the Fire Safety Register.
4. In the absence of the Person In Charge a template is in place to support the Manager and Shift Leader with regard to completing the fire safety records.
5. A schedule of fire drills has been agreed for this Designated Centre and support for its implementation will be facilitated by Fire Experts to ensure compliance with Fire Regulation.

Proposed Timescale: 30/04/2015