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

## Centre ID:
OSV-0002947

## Centre county:
Kildare

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

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

## Provider Nominee:
Sharon Balmaine

## Lead inspector:
Conor Brady

## Support inspector(s):
Conor Dennehy; Louise Renwick

## Type of inspection
Unannounced

## Number of residents on the date of inspection:
13

## 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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 05 March 2015 14:30  To: 05 March 2015 21:00

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

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Summary of findings from this inspection
The provider is St. John of God Community Services Limited (hereafter called the provider), a company registered as a charity. As part of this inspection, the inspectors met with the person in charge, nursing staff, care assistants, residents and a resident's family member who was visiting the centre at the time of the inspection. The inspectors observed practice and reviewed documentation such as personal care plans, health plans, medical/clinical information, accident and incident records, risk assessments, medication records, meeting minutes, policies, procedures and protocols, governance and management documentation, staff training records and staff files. Thirteen residents resided in this designated centre which was an old premises located on a campus based setting. The building comprised of two adjoining long narrow bungalow buildings with an attached pre-fab extension.

Overall, the inspectors were not satisfied that the centre was being run in compliance with the requirements of the Regulations or Standards. The inspectors found that this centre was operated in a manner that was resource led and this was evidenced in a number of negative outcomes for residents living in the centre. The inspectors found that residents' opportunities to express meaningful choice, wishes and preferences were very limited. In addition, the inspectors found that residents rights, dignity and consultation needs were not being met. The inspectors observed
institutionalised practices taking place that were having a direct negative impact on resident's opportunities to enjoy a good quality of life. Other areas whereby significant failings were clearly evident were:

- Safe and Suitable Premises
- Governance and Management
- Social Care Need's
- Safeguarding and Safety
- Health and Safety and Risk Management
- Workforce, Staffing, Staff Training and Development

All of these areas are discussed in more detail in the main body of the report and in the action plan outlining the specific failings identified that did not meet the requirements of the Regulations and Standards.
**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

This was the centre’s first inspection by the Authority.

**Findings:**

The inspectors did not find that resident's dignity and consultation needs were being appropriately met in accordance with the Regulations and Standards. While inspectors observed staff speaking to residents in a respectful manner, it was very clear that resident's rights were not being upheld across a number of areas.

Choice, Control and Consultation:
Inspectors found that residents' ability to determine and make choices regarding the care they received were very limited. For example, resident's choice regarding the food they received and the time they received it was pre-scheduled by the campus canteen. Residents did not have the option to cook or prepare any food in the centre with the last meal (sandwiches) observed arriving in the designated centre at approx. 3:45pm (which residents ate on their return from day services). The issues pertaining to food and nutrition are further discussed later in Outcome 11.

Inspectors noted that residents who required higher levels of support for transferring/personal care (two persons required to use hoist) were being put into bed early every evening to accommodate the designated centre's staffing roster. The inspectors clearly observed residents being put to bed from 7pm so that they were in bed before the night staff shift change at 9pm. In discussing this matter with staff members, the clinical nurse manager and reviewing all documentation available, it was clear that this was a resource led practice and there was no evidence of choice or consultation by residents.

Inspectors found that resident's choice and preference to partake in activities, clubs,
social events and activation outside of the designated centre to be very limited. From observations, discussions with staff and residents there was a very clear routine in the designated centre. This routine appeared to primarily focus on meeting individual's basic needs of ensuring they were provided with food and supported to go to bed following their return from day services. On the evening of inspection (when the weather was mild and reasonably good) no residents were observed partaking in any activities, e.g. going for a walk, shopping, leaving the designated centre. The only activity observed on this inspection was one resident colouring a colouring book for a number of hours. Most residents were simply observed walking around the designated centre seeking engagement from staff and the inspectors at times.

Privacy, Rights and Dignity
As there were thirteen residents residing in this designated centre, some with considerable support needs, this centre was a busy environment with a lot of movement. However, the environment was not found to be conducive to meeting residents privacy needs. The inspectors found considerable issues with the suitability of the premises which is discussed in detail in Outcome 6. There was very limited space for residents to have privacy or receive visitors. Inspectors found that resident's privacy and dignity rights were not upheld at all times. For example, one resident who was returned from hospital by ambulance came into the designated centre on a stretcher and a discussion was held by staff with paramedics in the middle of the living room/hall about this resident's medical needs. The inspectors observed this discussion took place in front of a room full of people. On another occasion the inspector observed a resident using the toilet with the door wide open in clear view of all passers by.

Personal Possessions
The inspectors noted that resident's rooms were very small and residents had very limited space for storage. For example, rooms could not accommodate a double bed due to the small size and rooms were found to be basic in terms of design and residents personal possessions.

Complaints
Inspectors found a complaints procedure in place and log of complaints and compliments. A family member who visited the centre regularly, informed the inspectors she was aware of the complaints protocols. The inspectors noted that there was a low number of complaints and although information on independent advocacy was available in the centre it had never been used regarding any of the residents in this designated centre. The inspectors found signs outlining how to make a complaint were on the walls of the designated centre however given the profile of residents within the designated centre staff/family/independent advocacy would be required to support/facilitate residents to make complaints.

Judgment:
Non Compliant - Major

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

**Theme:**
Effective Services

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

**Findings:**
Overall the inspectors did not find that residents' had meaningful opportunities to partake in activities appropriate to their assessed needs, interests or preferences. While inspectors found that residents had individualised assessments in place these did not adequately reflect residents' social care needs. Inspectors found that consultation with residents' regarding planning was minimal and that residents' personal plans were not available in accessible formats for residents.

The inspectors found that resident's personal plans required further improvement to meet the assessed needs of residents. The inspectors found variance in the standard of personal plans with resident's goals, ambitions and preferences not consistently recorded or reviewed. For example, of personal plans reviewed there was insufficient evidence of adequate review of the effectiveness of same. Inspectors found a lack of appropriate oversight in terms of the effective monitoring of resident's goals and the implementation of same. In addition, inspectors found that some resident's goals were primarily basic and task orientated as opposed to outcome focussed for the resident. For example, one resident's stated goal was that he would like to use a train. This was facilitated in the residents day service as a one off experience as opposed to part of the residents overall personal plan and skill development. The inspectors also found evidence where residents did not achieve objectives citing insufficient staffing levels as the reason plans were not achieved.

From discussions with staff, residents and on reviewing residents' care plans, progress notes and personal outcome measures it was evident to the inspectors that the meeting of residents social care needs was resource led. While inspectors found some residents had opportunities to attend the cinema or to go shopping occasionally, opportunities to engage in such activities were not common in the centre. Staff highlighted that although transport was available, it was difficult for staff to conduct activities external to the campus and that this took a lot of planning. There were set activities in the centre on certain nights but these were only availed of by certain residents. For example, a local recreation club. The inspectors found an 'activities room' in the designated centre. This is in the pre-fab extension and was very cold as experienced by the inspectors. There was a pool table in this room but as the room was so cold staff stated residents tended not to use it. Inspectors found this room to be full of boxes of files and was clearly been used by the provider as a storage area for records and documentation.
The inspectors found that residents had very limited opportunities to engage in social activities outside of their day service and external to the provider's campus. The inspectors were informed of an instance whereby a resident left the designated centre (without the knowledge of staff) and was found on the provider's campus where local community bingo is played. The inspectors found that this instance was not considered by the provider as this resident possibly trying to communicate a need, wish or preference. When the inspectors asked could this resident not be brought to bingo to play, staff cited that there would not be enough staff on duty to facilitate this for the resident.

Overall the inspectors found that residents' personal plans in this designated centre were inconsistent in terms of their content, design and implementation. In addition, the governance and management oversight regarding the monitoring and review of effectiveness of residents' plans needed significant improvement.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The inspectors found that the design and layout of this centre was not suitable for its stated purpose and did not meet the resident's assessed individual and collective needs in a comfortable or homely way.

The inspectors found that there was not:

- Adequate private and communal accommodation for residents, including adequate social, recreational, dining and private accommodation.
- Rooms of a suitable size and layout suitable for the needs of residents
- Adequate space and suitable storage facilities, insofar as is reasonably practicable, for the personal use of residents
- Communal space for residents suitable for social, cultural and religious activities appropriate to the circumstances of residents
- Suitable storage
- Ventilation and heating suitable for residents in all parts of the designated centre which are used by residents
- A separate kitchen area with suitable and sufficient cooking facilities, kitchen equipment and tableware
- Baths, showers and toilets of a sufficient number and standard suitable to meet the needs of residents

The inspectors found that space was very much limited in the designated centre. Resident's space was spanned over two adjoined narrow houses with one living/dining/kitchen area in each house. Hallways were narrow in each house (3ft approx.). As stated earlier the premises were adjoined by a 'recreation room' which was a pre-fab extension that was found to be very cold and was used for storage of documents due to lack of appropriate storage space. Staff stated while some residents used the room on occasion, due to the difficulty in heating the pre-fab it was often too cold.

Resident's rooms were small and the inspector found that while some efforts were made to personalise rooms they were very basic and institutionalised in design. Storage was limited due to the small size of rooms. For example, each room consisted of a single hospital style metal framed bed, some rooms had a chair, wardrobe and some had a television.

The inspectors found ventilation was poor in the designated centre. For example a resident used the toilet and the odour was evident throughout the centre for a period of time. This issue was due in no small part to the proximity of the toilet to rooms, the narrow corridors and lack of appropriate ventilation (windows/extractor fan).

Inspectors were very concerned that the premises did not meet the needs of residents. For example, one resident was observed seeking to use the toilet but could not do so independently as his wheelchair could not fit into the bathroom because a hoist was stored in the bathroom. This resident had to call for help so staff could remove the hoist from the toilet in order that this resident could use the bathroom. Furthermore, inspectors were very concerned regarding the unsafe manual handling practices of staff that put residents at risk of injury. Inspectors observed resident's been subject to unsafe manual handling practices (See Outcome 7). It was clear to the inspectors that hoisting equipment and chairs would not all fit and could not be appropriately manoeuvred due to the design and layout (and narrow spaces) in the designated centre. For example, residents being transported in hoists.

One resident was observed returning from hospital via ambulance having suffered a fall in the designated centre and a fractured leg. The inspectors observed paramedics being unable to transport this resident from the ambulance to their room due to the narrow design of the designated centre. Following a number of failed attempts, this resident had to be removed from the stretcher to get them into the bedroom to convalesce. This clearly highlighted that the premises was not meeting the needs of the residents and was unsuitable for its stated purpose and function.
Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors were not satisfied that the systems in place regarding health, safety and risk management were appropriate.

Inspectors found that while risk management policies existed and staff had completed risk assessments in certain areas there were concerns regarding certain risks within the centre. For example, epilepsy management, manual handling practices, review of incidents and accidents, implementing corrective action plans and learning from serious incidents. The inspectors found deficits in all of these areas over the course of this inspection.

- Epilepsy Management: The inspectors found that ten out of the thirteen residents in this designated centre had a diagnosis of epilepsy. A number of residents were experiencing seizures on a frequent basis. One resident was observed going into a seizure while speaking with an inspector and another resident (who was also at the table) became quite distressed and began shouting for support for the resident who was in seizure. This resident informed the inspectors this happened regularly and that he found it upsetting. In reviewing the resident’s epilepsy care plan and documentation it was clear these seizures were a frequent occurrence. In reviewing incidents and accidents the inspector noted injuries to residents occurring while unsupervised. For example, at night time when staffing levels drop to two staff (1 nurse) to 13 residents, one resident was moved from his room to another room due to his unsupervised seizure activities leading to injuries. The inspectors were concerned having reviewed a number of resident’s care plans who had regular seizure activity that staff (particularly at night time) were appropriately equipped to deal with this issue safely. Residents highlighted as requiring supervision at all times (due to seizure activity) were also walking to/from day services unsupervised.

- Manual Handling: The inspectors were concerned that inappropriate and unsafe use of hoisting was on-going in this centre. While there were limitations with regards to the premises as outlined in Outcome 6, inspectors were concerned that staff were not adhering to safe practices when transferring residents. Inspectors were informed by staff that residents were being transported and moved in hoists as opposed to their wheelchairs as space and premises layout made it too difficult to transport individuals in accordance with best manual handling practices. The inspectors observed that the hoist
and wheelchairs would not fit in rooms and bathrooms at the same time. This led to
staff engaging in the transportation of residents in hoists over distances that were
unsafe and not in line with manual handling/moving residents best practices. For
example, the inspectors found that residents were not being transported in a hoist for
the shortest distance in line with safe manual handling practices. In addition, it was not
apparent from records reviewed that all staff working in the designated centre had
undergone up to date training in this area.

- Incidents/Accidents Review and Corrective Actions/Learning: The inspectors were very
concerned that incident and accident were not managed appropriately and learning and
corrective actions put in place. A clear and robust system whereby all incidents and
accidents were reviewed and corrective actions were implemented based on learning
was absent. For example, one resident previously fell from his bed in an incident and
landed beside the bed blocking the ability to open the door, occurred in this designated
centre. This same resident was observed on inspection calling for staff from his room.
The resident was on the floor blocking the door so staff could not enter the room as had
previously occurred. The inspectors observed the staff going outside to try and look in
the resident's window. This resident was lying across the floor and staff could not access
him. The inspectors were very concerned that resident's safety was comprised to such
an extent in terms of staff's inability to access resident's in emergency situations. This
issue had clearly been known to staff and management, however, no appropriate
corrective action or control measure had been implemented for this resident which put
the resident at risk.

- Fire Safety: The inspectors observed a fire folder in place and staff were aware of the
location of fire safety equipment and the fire assembly point. The inspectors found
evidence of drills/evacuations occurring in the designated centre however inspectors
were given contradictory information regarding deep sleep/night time evacuations. For
example, one staff said they were completed and other staff said they were not
completed. Inspectors were looking at this area in terms of the lower night time
compliment of staffing 2:13 and the ability of staff to safely evacuate all residents. There
was not clear evidence of this found on inspection and inspectors were not satisfied that
all residents could be safely evacuated from the designated centre at night time.

While staff members could highlight risks in this designated centre to inspectors, such
as, epilepsy care, seizure management and falls, the inspectors were concerned about
the approach to risk management that existed in this designated centre. For example,
risk assessments completed that lacked actual and appropriate control measures and
consistent risk management plan implementation.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Inspectors were not satisfied that the measures in place to ensure residents were adequately protected from being harmed or suffering abuse were adequate.

The inspectors found a policy and local protocol regarding safeguarding vulnerable adults was in place but found staff’s knowledge of this protocol to be limited. For example, all staff were not fully aware of the reporting mechanisms to be used and the protocols surrounding the reporting of allegations, disclosures or suspected abuse. Staff interviewed stated they had never been involved in reporting abuse and were not aware of any reports made in the designated centre. However, inspectors found clear evidence of a referral of an allegation of abuse had been made and queried this with staff who did not know anything about this report. Further information was sought regarding this matter from the person in charge following inspection. In addition, the inspectors found that staff had not received appropriate education or training in relation to safeguarding residents and the prevention, detection and response to abuse which is a requirement of the Regulations.

As outlined in Outcome 7, the inspectors were particularly concerned at the safeguarding arrangements regarding staff member’s inability to access residents in difficulty/emergency situations, as observed by inspectors and evidenced in documentation reviewed. This did not promote the safety of residents from harm at all times from a safeguarding perspective and inspectors were not assured staff could keep residents safe in these circumstances.

Regarding the management of behaviours that challenge, inspectors found that some residents did have a behavioural support plan in place however inspectors found that not all staff had been provided with training in this area.

**Judgment:**
Non Compliant - Major

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

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

Findings:
The inspectors found some evidence where residents were supported to enjoy good health in some areas, however further improvement was required to meet the requirements of the Regulations.

The inspector noted some access for residents to appropriate health care and allied health professionals. For example, General Practitioner (GP) and Occupational Therapy. The inspectors reviewed a sample of care plans regarding the provision of epilepsy care, tissue viability and skin integrity care planning and the provision of assessment led assistive technology/supports for some residents. From the information available in care plans reviewed the inspectors could see that these residents did appear to have access to health professionals.

The inspectors also found instances where appropriate access to services was not provided and or recorded. For example residents on modified diets had aspirated while eating and required intensive support as a result of same. However there was no evidence of appropriate follow up (post incident) review and re-assessment with speech and language therapy (SALT) or appropriate risk assessment and management completed and/or implemented. Furthermore, inspectors found instances where residents who were assessed as requiring specified diets had no recording regarding food and fluid intake. This contradicted the personal plans for these residents which required food and fluid intake to be recorded. In addition, inspectors noted instances whereby a resident had hit his head during ‘drop seizures’ and there was no corresponding records in the nursing notes and no record as to post incident follow up or whether neurological observations were taken.

Inspectors were very concerned regarding food and nutrition. As highlighted in earlier outcomes there was very limited choice for residents when it came to the food they received. The campus canteen provided two options on a daily basis and this was transported to the designated centre. Inspectors observed sandwiches followed by fruit cocktail for the evening meal in the designated centre on the inspection date. When queried with staff inspectors were informed that residents ate their dinner in their day service. Inspectors were informed that this meal was resident's final meal of the day. Inspectors were informed that hot drinks were provided before bed. The inspectors found that the provision of food in this centre was provided in manner that was institutionalised. The inspectors found that there was nothing about the dining experience observed that was homely, person centred or choice based. In discussing this matter with staff, the inspectors were informed that staff were not trained in food safety and therefore no meals were cooked or prepared in the designated centre.

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:
The inspectors found that there were some systems to ensure each resident was protected by the designated centres’ policies and procedures for medication management.

Inspectors found that there were medication protocols in place regarding the prescription, administration and management of medication. Inspectors observed medication administered in a manner that was respectful to residents. Inspectors found a system whereby medication administration was recorded clearly and in line with the prescription sheet. The inspectors found that medication stock was admitted to the centre monthly in blister packs that were clearly labelled and there was a checking, counting and recording system in place involving two staff. The inspectors found nurses to be knowledgeable regarding resident’s medication. The storage of medication was found to be appropriate in terms of secure medication presses, medication refrigerator and medication trolley.

The inspectors found some issues regarding the management of medication documentation in that prescription documentation was not presented in a manner whereby sufficient space was afforded to the medication. For example, some prescription documents were unclear and medication was written under incorrect headings, e.g., PRN (as required) medication section. In addition, in examining medication errors it was not clear that procedure was followed in terms of the reporting, response and corrective actions taken regarding medication errors. For example, there was no evidence to suggest root cause analysis of the incidents and whether further staff training/re-training was required.

Judgment:
Substantially Compliant

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Inspectors were very concerned at the lack of governance and oversight by the provider and persons participating in the management of this centre as evidence by the high number of non compliances. This lack of compliance does not demonstrate that the provider has engaged in the regulatory process since commencement. Inspectors found deficits in the provision of safe care, quality of life and healthcare for residents. The failure of the provider to review and engage in oversight of the service provided to residents has resulted in negative outcomes for these residents.

It became apparent at the early stages of this inspection that the person in charge was not adequately involved in the effective governance, operational management and administration of the designated centre. The person in charge held a Director of Nursing position based on the campus and was nominated person in charge for 8 designated centres overseeing the care of 147 residents across all of these centres. The nominated person in charge informed the inspectors at the outset of inspection that this decision was currently being reviewed by the provider and restructuring was planned.

The inspectors found that the person in charge did not work in the designated centre, did not regularly visit the designated centre and did not attend staff meetings in the designated centre. The person in charge was not highlighted by the residents, staff or families as the person they would go to regarding this designated centre. The inspectors found that the person in charge was not a presence in the designated centre and managed the centre through monthly meetings with the clinical nurse manager. Ultimately, inspectors found that the person in charge was not adequately involved in governance, management and oversight in the designated centre and met inspectors briefly at the outset of inspection and then attended inspection feedback. While the person in charge was employed in a full-time post as Director of Nursing, her responsibilities regarding this designated centre were not being met in terms of ensuring the centre was in compliance with the Regulations and Standards.

Aside from the person in charge the inspectors found the centre was managed by a Clinical Nurse Manager (CNM) II (not available on inspection date) and was supported by a CNM, staff nurses and care assistants. While this offered some defined management structure the inspectors did not find clear lines of authority and accountability. For example, as evidenced in the findings of outcomes 1, 5, 6, 7, 8, 11, 17, the inspectors were not satisfied that this designated centre was being managed appropriately in accordance with the requirements of the Regulations and Standards.

Inspectors found a lack of oversight in terms of the effective monitoring, auditing and
management systems to ensure the quality and safety of care in the centre was meeting regulatory requirements. Of the auditing that was reviewed on this inspection, the standard was found to be poor, with the provider highlighting themselves 'compliant' in most areas of self assessment. For example, a provider audit reviewed by inspectors highlighted that the centre was fully resourced to meet the assessed needs of all residents. As outlined in this report, inspectors did not find evidence that this centre was effectively managed in the key areas of risk, health and safety, safeguarding, resourcing and staffing. However inspectors were also concerned that there was a clear deficit in terms of the managerial oversight regarding the actual implementation of personal plans for residents focusing on improving resident's quality of life. Staff members spoken to as part of this inspection openly highlighted resourcing issues, staffing numbers, and facilities as areas they felt needed to be significantly improved. However inspectors did not see these issues being managed effectively in terms of facilitating staff to highlight and address these concerns as is required by the Regulations.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
The inspectors were not satisfied that there were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. The inspectors found all staff did not have up-to-date mandatory training and access to appropriate education and training to meet the needs of residents.

Inspectors found a staff roster in place which highlighted the staffing levels in the designated centre. The staff compliment was made up of nursing and care assistant staff with the use of agency staff also used. Inspectors saw that staffing levels varied in the centre from 5 staff to 2 staff to provide care for 13 residents. The inspectors found staffing levels insufficient to meet all residents assessed needs. The inspector found this resulted in negative outcomes for residents as outlined in previous outcomes.

For example:
- Inspectors found that a resident had to 'purchase' staffing when his day services were
closed so as his social care needs could be met as the compliment of staffing in the designated centre could not meet this need.
- Inspectors found residents were being put to bed from 7pm to accommodate the staffing roster and lower staffing levels at evening/night time.
- Inspectors found residents opportunities to leave the designated centre and partake in community activities were limited by inadequate staffing levels.
- Inspectors found individuals personal outcome measures highlighted staffing resources as a reason why resident's goals/objectives were not met.

In addition, inspectors found that all staff working in this designated centre did not have up to date mandatory and/or relevant training. For example, in reviewing training documentation the inspectors found gaps in staff training in the areas of epilepsy, safeguarding vulnerable adults, and manual handling. The inspectors found that of the staff files reviewed there was Schedule 2 documentation in place regarding staff files. The inspector was informed there was 'annual appraisals' held regarding all staff but saw no documentary evidence of same on inspection.

**Judgment:**
Non Compliant - Major

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002947</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>05 March 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>21 April 2015</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have the freedom to exercise choice or control over their daily lives.

Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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. A review of the mealtime options will be undertaken by the Person in Charge, Clinical Nurse Manager 2 and catering department manager to enhance participation and choice at mealtimes.

2. Staff training records regarding food safety and hygiene training will be reviewed to ensure that all staff have the required training.

3. The Clinical Nurse Manager 2 will coordinate the systematic review all Personal Outcomes Measures (POMS) to ensure they are adequate & to ensure identified social goals of each resident are adequately met.

4. The evening activity schedule will be reviewed and updated with keyworkers and individual personalised activity timetables will be developed.

**Proposed Timescale:**
1. 22th May 2015
2. 22th May 2015
3. 31st July 2015
4. 30th April 2015

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

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of consultation with residents regarding decision making was very limited.

**Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Weekly individual resident meetings with keyworker with an agreed defined agenda will commence. A record of these meetings will be maintained in each resident’s personal plan and daily record book. The outcomes of these meetings will inform the activity schedule for the house.

2. The Speak Up meetings will continue to take place.

3. All complaints will be managed and investigated in line with Saint John of God Complaints policy SJOGCS17 Management of Consumer Feedback to include Comments, Compliments & Complaints
4. All staff members will be re-inducted to the complaints policy by the person in charge to ensure they understand the process to be followed in the event of a complaint being made.

5. An information session will be organised for staff to educate them on advocating for residents positively. This talk will be facilitated by the Chairperson of the Speak up Council.

6. An information session will be organised for the staff team, residents and families to educate on accessing advocacy services for residents & information regarding residents’ rights. This information session will be facilitated by the national advocacy services.

Proposed Timescale:
1. 30th April 2015
2. 22nd April 2015
3. 22nd April 2015
4. 22nd April 2015
5. 30th June 2015
6. 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident’s privacy and dignity needs were not being met.

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. A local operational procedure (LOP) on privacy and dignity will be developed. All staff will be inducted to this LOP. An accessible version will be devised for residents.

2. The clinical nurse manager 2 will coordinate the review of all residents intimate care plans to ensure they comprehensively meet the needs of residents.

3. Ensure all staff are aware of, read and sign they have read and understand the Intimate Care Policy.

4. There is a room available for residents to receive visitors. An improvement plan will be devised to improve this area.
<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>29/05/2015</th>
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</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
<td>Individualised Supports and Care</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td></td>
</tr>
<tr>
<td>Resident's rooms did not have adequate space for storage.</td>
<td></td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td></td>
</tr>
<tr>
<td>Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.</td>
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</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Storage options will be reviewed for each resident by the clinical nurse manager 2 in conjunction with key workers. This review will identify any gaps relating storage and personal property of residents.</td>
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</tr>
<tr>
<td>2. A committee is being established to identify and plan suitable alternative accommodation for residents in the designated centre.</td>
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<tr>
<td>Proposed Timescale:</td>
<td></td>
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<tr>
<td>1. 29th May 2015</td>
<td></td>
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<td>2. 30th September 2015</td>
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<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>30/09/2015</th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
<td>Individualised Supports and Care</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td></td>
</tr>
<tr>
<td>Residents did not have appropriate access to facilities for occupation and recreation.</td>
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<tr>
<td><strong>Action Required:</strong></td>
<td></td>
</tr>
<tr>
<td>Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.</td>
<td></td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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</tbody>
</table>
1. The activities room in the house will be reviewed with a view to enhancing the environment for the residents.

2. Weekly individual resident meetings with keyworker with an agreed defined agenda will commence. A record of these meetings will be maintained in each resident’s personal plan and daily record book. The outcomes of these meetings will inform the activity schedule for the house.

3. The Clinical Nurse Manager 2 will coordinate the systematic review of all Personal Outcomes Measures (POMS) and ensure they are up to date to ensure identified social goals of each resident adequately met.

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident's opportunities to participate in activities in accordance with their interests, capacities and developmental needs were very limited.

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

Please state the actions you have taken or are planning to take:
1. The activities room in the house will be reviewed with a view to enhancing the environment for the residents.

2. Weekly individual resident meetings with keyworker with an agreed defined agenda will be introduced. A record of the meeting will be maintained in each resident’s personal plan and daily record book. The outcomes of these meetings will inform the activity schedule for the house.

3. The Clinical Nurse Manager 2 will coordinate the systematic review of all Personal Outcomes Measures (POMS) and ensure they are up to date to ensure identified social goals of each resident adequately met.

4. The person in charge will review the activities to ensure residents are receiving positive outcomes from these activities

Proposed Timescale:
1. 30th September 2015
2. 30th April 2015
3. 30th June 2015
4. 11th May 2015
**Proposed Timescale:** 30/09/2015

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The assessed needs of all residents were not met.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.</td>
</tr>
</tbody>
</table>
| **Please state the actions you have taken or are planning to take:**
| 1. A committee was established to review the content of ‘My Personal Plan’ (MPP). A revised personal planning template has been agreed. |
| 2. All personal plans will now be reviewed by the person in charge in conjunction with the resident / their representative and their circle of support to ensure their assessed needs are met in a timely manner. |
| 3. Following the reviews the personal plans will be updated by the residents’ key workers to ensure personal plans meet their assessed needs. |
| 4. The Person in Charge will meet with Clinical Nurse Manager and the team on a monthly basis for regular reviews and updates on progress relating to personal plans. |
| **Proposed Timescale:**
| 1. 22nd April 2015 |
| 2. 30th September 2015 |
| 3. 30th September 2015 |
| 4. 30th September 2015 |

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

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
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<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong> Personal plans were not available in an accessible format for residents and families.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are</td>
</tr>
</tbody>
</table>
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. A committee was established to review the content of ‘My Personal Plan’ (MPP).
2. A revised personal planning template will be agreed in an accessible version for implementation for all residents.

Proposed Timescale:
1. 22nd April 2015
2. 30th November 2015

**Proposed Timescale: 30/11/2015**

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not evidence of maximum participation of residents in personal plans.

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

**Please state the actions you have taken or are planning to take:**
1. Personal plans for all residents will be reviewed in conjunction with the resident, their representative and their circle of support to ensure their assessed needs are met in a timely manner.

**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 effectiveness was not being appropriately reviewed.

**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. All personal plans will now be reviewed in conjunction with the resident, their representative and their circle of support to ensure their assessed needs are met in a timely manner with their maximum participation.

2. The Person in Charge will meet with the Clinical Nurse Manager to review the effectiveness of plans on a regular base, to ensure the consistency, effectiveness and implementation of plans.

3. Changes in circumstances and new developments will be reflected in each resident’s personal plan. The changing needs and circumstances is now included in the agenda of staff weekly meetings

Proposed Timescale:
1. 30th September 2015
2. 30th July 2015
3. 22nd April 2015

Proposed Timescale: 30/09/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises was not meeting the assessed needs of all residents.

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
1. The development committee will commence on the 22/04/2015. This committee will identify fit for purpose accommodation required for residents.

2. A implementation plan will be developed by this committee

Proposed Timescale:
1. 22th April 2015
2. 31st December 2015

Proposed Timescale: 31/12/2015

Theme: Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The there was not adherence to all requirements outlined in Schedule 6 regarding matters to be provided for regarding the premises.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
1. The development committee will commence on the 22/04/2015. This committee will identify fit for purpose accommodation required for residents.

2. A implementation plan will be developed by this committee

Proposed Timescale:
1. 22th April 2015
2. 31st December 2015

Proposed Timescale: 31/12/2015

Outcome 07: Health and Safety and Risk Management
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems were found to be inadequate in terms of risk management in this designated centre.

Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. The Risk Management Policy for the house will be reviewed in light of concerns relating to manual handling and epilepsy.

2. Risk assessments associated with epilepsy management will be reviewed to ensure documented controls meet the safety needs of residents.

3. All residents Epilepsy Care plans will be reviewed and updated

4. Additional technology control measures will be identified and made available to support staff in responding to residents who have regular seizure activity at night.
5. Reviews of risk assessments will be carried out at house level as per documented review dates.

6. An audit on Manual Handling practices in the house will be conducted.

7. All manual handling assessments will be updated as required following the completion of the audit.

8. The Person in Charge will review all staff training records to ensure all staff have completed appropriate training.

9. Risk assessments will be carried out with all Residents that are at risk of falls due to epilepsy.

10. All Incidents/Accidents will be reviewed at the fortnightly staff meeting and corrective Action/Learning will be communicated to all staff.

11. All data and analysis from Incidents/Accidents will be reviewed by the person in charge and programme manager. This will be reviewed also through the Quality and Safety Committee.

12. The site specific emergency plan will be reviewed and updated.

13. An MDT review has been convened to review the risk assessment and review living and sleeping arrangements of an individual.

Proposed Timescale:
1. 30th June 2015
2. 30th June 2015
3. 30th June 2015
4. 30th June 2015
5. 30th June 2015
6. 30th September 2015
7. 30th September 2015
8. 30th September 2015
9. 30th May 2015
10. 30th May 2015
11. 30th May 2015
12. 29th May 2015
13. 22nd April 2015

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

**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not evidence based protocols and procedures to ensure all residents in the designated centre could be evacuated safely at night time.

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. A deep sleep drill will be conducted.
2. All personal emergency evacuation plans will be reviewed and updated as required.
3. Revise protocol/ procedure to deal with fire emergency in the DC.

Proposed Timescale: 15/05/2015

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:
All staff did not have training regarding the management of behaviours that challenge.

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

Please state the actions you have taken or are planning to take:
1. An audit of staff training in the Management of Actual Potential Physical Aggression (MAPPA) in the designated centre will be undertaken by the Person in Charge.
2. Staff training in the area of MAPPA will be scheduled.

Proposed Timescale:
1. 30th September 2015
2. 21st December 2015

Proposed Timescale: 21/12/2015
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
Staff were not appropriately trained in the safeguarding of residents and the prevention, detection and response to abuse.

Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
1. The Person in Charge will conduct a review of staff training records in safeguarding.

2. Refresher safeguarding training in relation to safeguarding residents and the prevention, detection and response to abuse will be scheduled for all staff.

3. All incidents of a safeguarding nature will be reported to the Designated Person.

4. An MDT review has been convened to review the risk assessment and review living and sleeping arrangements of an individual.

Proposed Timescale: 22/04/2015

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:
Access to allied health professionals was not apparent for all residents reviewed.

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. SALT assessments will be reviewed to ensure all recommendations are in place and implemented.

2. All fluid and food intake by residents on modified diets are recorded as specified in the SALT assessment.

3. The Clinical Nurse Manager has informed all staff that in the event of a resident sustaining injury, any observations and follow on care is to be documented in the residents nursing notes/ daily record books.

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<tr>
<th>Proposed Timescale:</th>
<th>30/05/2015</th>
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<tbody>
<tr>
<td>Theme:</td>
<td>Health and Development</td>
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</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not supported to cook, prepare or buy food.

**Action Required:**
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**
1. A review of mealtime options will be undertaken by Person in Charge and catering department. There are facilities in the house to provide hot snack and meals should the resident choose however cooking facilities are limited and will be reviewed.
2. Staff training records regarding food safety and hygiene training will be reviewed to ensure that all staff have the required training.
3. An audit of the mealtime experience will be undertaken by the catering manager to evaluate the mealtime experience of residents.

Proposed Timescale:
1. 22nd May 2015
2. 22nd May 2015
3. 31st August 2015

<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
<th>31/08/2015</th>
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</thead>
<tbody>
<tr>
<td>Theme:</td>
<td>Health and Development</td>
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</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents did not have appropriate access to food, meals and snacks.

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

**Please state the actions you have taken or are planning to take:**
1. A review of mealtime options will be undertaken by Person in Charge and catering department.
department. There are facilities in the house to provide hot snack and meals should the resident choose however cooking facilities are limited and will be reviewed.

2. Staff training records regarding food safety and hygiene training will be reviewed to ensure that all staff have the required training.

**Proposed Timescale:** 22/05/2015

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not adequate arrangements in place regarding the provision of adequate food and drinks in the designated centre.

**Action Required:**
Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

**Please state the actions you have taken or are planning to take:**
1. A review of mealtime options will be undertaken by Person in Charge and catering department. There are facilities in the house to provide hot snack and meals should the resident choose however cooking facilities are limited and will be reviewed.

2. Staff training records regarding food safety and hygiene training will be reviewed to ensure that all staff have the required training.

**Proposed Timescale:** 22/05/2015

**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:
Protocols for the management of medication errors and documentation regarding prescription sheets were not clear.

**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. A review of all medication Kardex(s) will be conducted.
2. Regular medication audits will be conducted in the house.

3. All staff will be re-inducted in medication variances reporting procedures.

Proposed Timescale:
1. 22nd April 2015
2. 31st December 2015
3. 22nd April 2015

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

**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 nominated person in charge was not adequately involved in governance, management and oversight in the designated centre.

**Action Required:**

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

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

1. The role of the Person in Charge has been reviewed.

2. An interim arrangement is now in place for the Designated Centre.

3. A recruitment drive has been undertaken to recruit a permanent Co-ordinator who will assume the role of Person in Charge for this Designated Centre.

4. This Person in Charge will be actively involved in the governance, management and oversight in the Designated Centre.

Proposed Timescale:
1. 22st April 2015
2. 22st April 2015
3. 30th June 2015
4. 30th June 2015

**Proposed Timescale:** 30/06/2015
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not clear lines regarding accountability and authority.

Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
1. A Review will be completed regarding the governance and management in the Designated Centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of Designated Centre.
2. The Statement of Purpose (SOP) will be reviewed in line with new governance management structures.
3. A service organogram will be distributed to all staff highlighting the new structure.

Proposed Timescale:
1. 30th June 2015
2. 28th August 2015
3. 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Reviews completed were inaccurate and ineffective.

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

Please state the actions you have taken or are planning to take:
1. The Quality & Safety committee will review all audits, data and other relevant reports i.e. unannounced visits, to the Designated Centre, ensure action plans are developed and ensure all recommendations on quality and safety is followed up and monitored by the Person in Charge.
2. An annual review of the Quality and Safety of the Designated Centre will be
The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Findings of unannounced visits were not found to be accurate or effective in terms of improving quality of care and support and working towards regulatory compliance.

Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
1. The Quality & Safety committee will review the reports of the unannounced visit and other relevant data from the Designated Centre to develop an action plan to ensure any recommendations on quality and safety is followed up and monitored by the PIC and management team.

2. The registered provider will review the current system of six monthly unannounced visits to the designated centre and we wait guidance in the regulatory notice that we have been advised by the Chief Executive Officer of the Health Information and Quality Authority will be issued to Service Providers.

Proposed Timescale:
1. 25th May 2015
2. 31st December 2015

Proposed Timescale: 31/12/2015
Theme: Leadership, Governance and Management

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

There was not an effective system to facilitate staff concerns regarding safety of care and support of residents.
**Action Required:**
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

**Please state the actions you have taken or are planning to take:**
1. All complaints will be managed and investigated in line with Saint John of God Complaints policy SJOGCS17 Management of Consumer Feedback to include Comments, Compliments & Complaints.

2. All staff members to be re-inducted to the complaints policy by the person in charge to ensure they understand the process to follow in the event of a complaint being made.

3. Staff are encouraged to voice, raise concerns about the quality and safety of the care and support provided to residents at the fortnightly staff meetings and/or as concerns arise.

4. Unresolved concerns will be escalated to Person in Charge regarding safety of care and support of residents.

5. The Person in Charge will review staff supervision in the designated centre, and develop a local operational procedure for staff supervision.

6. Clinical Nurse Managers attend fortnightly meetings with the Person in Charge.

7. The Person in Charge attend fortnightly meetings with the Programme Manager.

**Proposed Timescale:**
1. 21st April 2015
2. 30th May 2015
3. 11th May 2015
4. 30th May 2015
5. 30th June 2015
6. 30th July 2015
7. 30th September 2015

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

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were not appropriate numbers of staff numbers and skill mix to meet the assessed needs of all 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:**
A full review of staffing roster, numbers and skill mix will be undertaken by the Person in Charge.

**Proposed Timescale:** 30/06/2015  
**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Staff training was not up to date in all of the required areas.

**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 Person in Charge will conduct an audit of staff training records and identify training needs for the Designated Centre.
2. A training plan will be developed appropriate to meet staff requirements

**Proposed Timescale:** 21/05/2015  
**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not evidence that all staff were appropriately supervised and performance managed in their role.

**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. Performance Development Review (PDR) will be completed with all staff and evidenced in their Human Resource file.
2. The Person in Charge will review staff supervision in the designated centre, and develop a local operational procedure for staff supervision.

3. Clinical Nurse Manager attend fortnightly meetings with person in Charge

Proposed Timescale:
1. 29th May 2015
2. 11th May 2015
3. 11th May 2015

**Proposed Timescale:** 29/05/2015