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-0002877
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Bernadette Shevlin
Lead inspector:	Julie Pryce
Support inspector(s):	Gary Kiernan;
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
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:	To:
26 February 2015 12:00	26 February 2015 20:30

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

As part of this inspection, the inspectors met with the person in charge, staff and residents. The inspectors observed practice and reviewed documentation such as personal care plans, healthcare plans, accident and incident records, risk assessments, medication records, meeting minutes, policies, procedures and protocols, governance and management documentation, staff training records and staff files.

Six residents resided in this designated centre which comprised two adjacent bungalows in a rural setting. Overall inspectors found that residents had a good quality of life, and that their health and social care needs were met.

Some improvements were required for example, in the assessment and management of risk, and in the upkeep of the premises. These are further discussed in the body of the report and in the action plan at the end.

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

Outcome 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:
There was a personal plan available for each resident of the designated centre. Each plan began with essential and emergency information about the resident, which was followed by more generic information, including the likes and dislikes of the resident and a communication plan. There was evidence that residents had been involved in these, and those who could sign their plans had done so. A 'personal passport' for each resident was in the form of a small laminated booklet, and included accessible information, for example, in relation to the person's schedule or their ways of communicating.

However, the personal plans were not based on a thorough multidisciplinary assessment of needs as required by the regulations, and not all aspects of care were included in the plans. This had already been identified by the person in charge, and a new system of personal planning was being introduced.

In addition, there were elements in the plans with no dates or signatures, so that it was not clear as to whether the information was valid or current, and many aspects of plans included vague guidance, such as 'please support me in...' without any indication of what kind of support was required. Some goals had been identified for people, but these were inappropriate or out of date, for example, a goal for one person referred to a healthcare issue which had been resolved. Whilst there was an emphasis in the designated centre's statement of purpose on skill teaching, there was very little evidence of this in the personal plans. There was only evidence of one resident currently learning a new skill.

Inspectors were also concerned that the implementation of personal plans was not

recorded on a structured basis, as further discussed under Outcome 11, so that it was not clear how the effectiveness of plans could be assessed. In addition the plans had not been reviewed within the 12 months as required by the regulations, or indeed within the timeframe indicated on the plans.

Judgment:
Non Compliant - Moderate

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 designated centre comprised two bungalows within close proximity, each of which accommodates three of the six residents. There were plans in place to extend one of the bungalows to achieve more spacious accommodation for residents. Each resident had their own bedroom and there were adequate communal and private areas within the bungalows.

Inspectors were concerned that some aspects of the premises were not appropriate to meet the needs of residents. For example, there was extensive damp in one of the bathrooms, and although the person in charge reported that a request had gone to the maintenance department to have this repaired it had not yet been addressed.

In addition, the outside area of the premises required considerable improvement. A large fence that had blown down several months ago was still lying in the driveway, and other areas of the garden were unkempt and obstructed.

Judgment:
Non Compliant - Moderate

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:
The inspectors found that systems were in place for the prevention and detection of fire. The training records examined showed that there was regular fire safety training for the staff and that fire drills were conducted. The inspectors found that staff were knowledgeable in relation to fire evacuation procedures. There was a personal evacuation plan in place for each resident and all fire safety equipment had been tested regularly, and although the certificates were not available on the day of the inspection, they were submitted immediately afterward.

The inspectors found that while steps had been taken to promote the health and safety of the residents, staff and visitors, a number of improvements were required with regard to risk management.

There were some risk assessments in place, for example, mobility risk assessments and risk assessments around the safe use of facilities, but these risk assessments were not all reviewed regularly. Not all identified risks had been assessed, for example, external doors were locked at certain times to ensure the safety of some of the residents, but no risk assessment was in place and so there was no evidence of all alternatives having been attempted or considered and ruled out, as further discussed under Outcome 8.

Where risk assessments had been conducted they had not all been implemented, for example, a risk assessment had identified the need for staff training in relevant healthcare issues, but this had not been provided.

Systems were in place in relation to infection control, hand hygiene training had been made available to staff, facilities were readily available, cleaning equipment was appropriately stored and the designated centre was visibly clean.

Judgment:
Non Compliant - Moderate

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

Findings:
The provider had put in place systems to promote the safeguarding of residents and to protect them from the risk of abuse. The inspectors found that staff were knowledgeable in relation to types of abuse, recognising signs of abuse and their role in the safeguarding of residents.

There was a financial management plan in place for each resident in relation to the management of their spending money, however some of these were not dated so that it was unclear as to whether they were contemporary documents. Any purchases were recorded with a receipt and a signature. All balances checked by the inspector, including personal money and household finances were correct.

Inspectors were concerned about the arrangements for the management of the finances of one of the residents, and there was currently no plan in place to address these concerns. The regional manager undertook to furnish the inspectors with a structured plan of action within two weeks of the inspection, and this plan was submitted to the Authority as requested.
Some improvements were required in the management of restrictive interventions. For example, there was no evidence of alternatives to the locking of doors having been considered. In addition, a protective helmet was in use for one of the residents, and staff reported that this was always used when the resident was out in the community, but not when they were in the house. There was no evidence of a clear rationale for this decision, nor evidence that consideration had been given to the socially restrictive nature of the intervention.

A behaviour support team was in place, and where this team was involved in the care of a resident, there was clear evidence of their communication and support. However, inspectors were concerned that not all residents who required behaviour support had a behaviour support plan in place.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The inspector found that residents healthcare needs were met for the most part. Residents had access to a General Practitioner and there was input from other healthcare professionals, for example, speech and language therapists, physiotherapist, dentist, where required.

However, whilst staff demonstrated detailed knowledge of residents' healthcare needs, plans were not in place for all these needs, and where they were in place they were not always current. In addition, implementation of care plans was not recorded so that it was unclear as to how the effectiveness could be assessed, as discussed under outcome 5.

The inspector was satisfied that residents' nutritional needs were met to an acceptable standard. Meals were planned in advance with the residents at a weekly meeting, and pictures of various meals were available to assist communication. The kitchen was well stocked, and snacks and drinks were readily available.

Judgment:
Compliant

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:
While there was evidence of structures and processes in place in relation to the management of medications, some improvements were required.

There was a medication management policy in place and staff were aware of its content, however, a recent medication error examined by the inspectors had not been managed in accordance with this policy, as discussed under Outcome 8.

Documentation relating to the management of medications for residents was in place for the most part, prescriptions included the required information and administration was recorded appropriately. However, there was no guidance for staff as to when 'as required' (PRN) medications should be administered.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The Statement of Purpose included all the requirements of the regulations and adequately described the service provided in the centre.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspectors were satisfied that there was an appropriate management structure in place which supported the delivery of safe care and services.

The inspectors found that the person in charge of the centre was suitably qualified and experienced. She was knowledgeable regarding the requirements of the Regulations and the National Standards for Residential Services for Children and Adults with Disabilities. She was present in the centre on a regular basis and it was clear that she was well known to the residents. She had a very good knowledge of the health and support needs of the residents. She was clear about her roles and responsibilities and about the management and the reporting structure in place in the organisation.

Regular team meetings were held, and discussions took place at these meetings in relation to individual residents, and to the organisation of the centre. Healthcare professionals involved in the care and support of residents, for example, members of the behaviour support were involved in these meetings as required. Meetings were also held between line managers and supervisors, these meetings were recorded and actions were identified.

There was evidence of an unannounced visit having been conducted by the provider, as required by the regulations, and also of various audits having been conducted in the centre.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
The inspectors found that staff were knowledgeable about the individual needs of the residents, including a resident who had not been in the centre for long, and about the organisation of the centre and of their responsibilities under the regulations. All interactions between staff and residents observed by inspectors were caring and respectful, and appropriate to the assessed needs of the individual residents.

Inspectors reviewed the staff rosters and observed the daily activities and found that staffing arrangements were not always based on the assessed needs of the residents. For example, there was a significant reduction in the number of staff on duty from 20.00hrs, so that any evening activities could not continue beyond 19.30hrs. The person in charge had identified this and outlined a plan to restructure the numbers of staff in the evenings.

There was safe recruitment systems in place to ensure that staff employed in the centre were suitable to work with vulnerable adults. Staff files were reviewed and it was found that they contained the required documents as outlined in Schedule 2 of the Regulations.
Records were maintained of staff training. These records showed that not all staff had received up to date mandatory training, and that training had not yet been provided to all staff in relation to some of the needs of residents, for example, in the management of epilepsy.

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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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-0002877
Date of Inspection:	26 February 2015
Date of response:	27 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Plans were not based on a comprehensive assessment.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
A New Keyworker has been identified for each resident.
A comprehensive Assessment "All About Me" which identifies support needs and priority goals has been completed for two Residents. The assessments for the remaining four residents will be completed by Sept 1st 2015.

The Staff Team are being supported by Speech and Language Therapy and Occupational Therapy in putting a Skills Teaching Programme in place for each Resident. The Assessment Tool "Using your Environment – Home and Community Assessment" is being used in conjunction with the multidisciplinary team for each resident. This assessment will provide each resident with realistic goals to enable them to have new skills and a meaningful Day. An assessment of Residents' social care needs will also be included in the above assessment. These assessments will be completed by 1st July, 2015.

Proposed Timescale: 01/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not a personal plan in place for all identified needs.

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

Please state the actions you have taken or are planning to take:
An Audit of each Residents P.C.P. will be carried out by the Supervisor on a Monthly basis until all PCP's are fully up to date. An individual Personal Tracking Form has been put in place for each file by the Supervisor to ensure all elements of the person centred plans are current, appropriate, dated and signed. This audit will then be carried out on an annual basis.

A comprehensive multi-disciplinary assessment has been completed for the resident that moved into the house in January 2015. A person-centred plan has been developed to meet that Resident's assessed needs.

A review will be completed annually of each Residents Person centred plan, dated and signed by the Keyworker, Teamleader and Person-in-Charge. Families will be invited to participate in this review where appropriate.

Comprehensive Care Plans will be developed for individuals where there is a medical concern with input from Nurses on the staff team by the 31/05/2015.

Proposed Timescale: 01/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence of supports required to maximise residents'' development.

Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
The "All About me" Assessment Tool is a thirty page document, which will generate from every section a support/care plan where needed for both medical and social needs. The document is easy to navigate, clear and precise and is flexible to input more information if needed. This document also reflects the resident's choice and interests and skills teaching.

The Supervisor will review the PCP's bimonthly with each keyworker to monitor progress and implementation of the "All About Me" assessment.

The PCP for their key resident will also be reviewed within Staff's Professional Supervision plan and will be included in Staff's yearly P.D.R.

Proposed Timescale: 01/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all aspects of personal plans were reviewed in order to assess the effectiveness of the plan.

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

Please state the actions you have taken or are planning to take:
The person-in-charge will ensure that each resident's personal plan will be reviewed annually.
This review will be multi-disciplinary and will take account of the residents changing

needs.
The resident and their family or representative will be invited to participate in the review.
Any proposed changes will be carried out and reviewed by the Teamleader and Person-in-Charge.

Proposed Timescale: 31/05/2015

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 were not kept in a good state of repair, both internally and externally/

Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
A meeting took place with the Maintenance Dept. on the 13th April and on the 11th May to review the Maintenance List.
A new on-line Maintenance Requisition Log has been set up.
A Deep clean of both premises took place in April facilitated by the household department. All damp was removed from the bathroom. Ventilation was improved and vents unblocked.
The Maintenance department cleared all debris and rubbish from the side of the houses. Gardeners had been already contracted to cut hedges and trees and this was completed on the 25th March 2015.
Heating system has been serviced and updated in both houses.
Patio door was repaired in one house. It was not closing properly and this was causing the door to be locked unnecessarily.
The old fence that had blown down in a storm has been removed from the premises. Work on a new fence, gate and pillars will commence on the 18th May and finish on the 21st May 2015.
Maintenance Review Dates have been set up between the Person-in-Charge with the Supervisor and the Maintenance Manager to review any outstanding Maintenance issues. These meetings will take place bimonthly.

Proposed Timescale: 31/05/2015

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:
Not all risks had been assessed or managed.

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:
Risk Assessments will be reviewed in a comprehensive manner in order to fully guide practice by the 31/05/2015.
Risk Assessments were completed on the external locked doors. A tracking system has been put in place and this has facilitated the door being unlocked until the sleepover staff is going to bed.

Training has been provided to staff in Healthcare Needs identified in Risk Assessments such as:
Epilepsy Management on the 25th March and the 29th April 2015.
Infection Control on the 13th April 2015.
One Day Introduction to Multi-Element Behaviour Support on the 26th March 2015.
Staff are scheduled in for Diabetes Training on the 19th May 2015.

Infection control audits will be scheduled for the designated centre by the 1st June 2015 and resultant findings shall be actioned by the supervisor.

Adverse Incident Forms will be reviewed monthly by the Person-in-Charge and Impact Risk Rating Reviewed.

The Person-In-Charge will continue to provide Bi-Monthly Reports to the Quality and safety Committee to include the following.

Update on Action Plans.
Complaints.
Adverse Incident Reports.
Notifications to Hiqa.
Safeguarding Referrals.
Supervision of Staff.
Mandatory Training.

Proposed Timescale: 01/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all restrictive procedures were applied in accordance with national policy and evidence based practice.

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

Please state the actions you have taken or are planning to take:
The Designated Centre views the wearing of Helmets as a Restriction.

The Resident has Epilepsy. He is under the care of a Neurologist who has prescribed in writing that he should wear a protective Helmet at all times. The resident has identified that he would like to wear the helmet less frequently than his Neurologist has prescribed. The Resident has an appointment with his G.P. on the 28th May, to assess the seizure data and refer back to Neurologist to have prescription of helmet wearing reviewed.

The reasons for wearing of this Helmet are historical, uncontrolled epilepsy resulting in falls causing serious head injuries.

A multidisciplinary approach is used in assessing the need for helmet, protocols and procedures and risk assessment for the requirement for a resident to wear a protective helmet.

The service through the Helmet Restraints Committee provides a holistic oversight by ensuring that the Helmet is used in the most appropriate way for the least amount of time ,is the least restrictive, supporting documents are in place i.e. Protocol, tracking, risk assessments.

They ensure that there is a clear rational for wearing the Helmet, tracking and review dates are in place.

He has an Appointment with the Helmet Restraints Committee on the 03/06/2015 to review his need to wear this Helmet, particularly the Protocol for when he needs to wear it and for when the Helmet is not worn.

Currently, improvements in medication has brought about a decrease in the number and severity of seizures, however he still has frequent seizures the last two being on the 30/04/2015 and the 2/05/2015 each lasting two minutes, no injuries suffered as he was sitting in an armchair at the time.

Proposed Timescale: 01/07/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents who required one had a behaviour support plan.

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

Please state the actions you have taken or are planning to take:
All residents who require one now have a behaviour support plan with review dates in place. This was completed in conjunction with the Psychology Department and the Behaviour Support Practitioner.

The behaviour of the newest Resident in the house has significantly decreased due to the implementation of his new Behaviour Support Plan and consistency of staff.

Each Resident's financial Management Plan has been reviewed by their Keyworker. The Supervisor has put a check system in place to ensure all transactions are dated and recorded accurately.

The Person-in-Charge is awaiting legal advice from the Saint John of God Order's solicitors in order to start a process of meetings with one resident's sibling in order for her to access her own finances.

Proposed Timescale: 31/07/2015

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:
There was insufficient guidance relating to PRN medication to ensure that it was administered as prescribed and medication errors were not managed in accordance with best practice.

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:
A local Medication Management protocol including PRN medication has been put in

place for the D.C. since the 30/04/2015.

All P.R.N. medication has been reviewed by the G.P. and the Consultant Psychiatrist and protocols have been put in place, where its use was deemed necessary.

Prescribed P.R.N. medication was removed from the Kardex, where it had not been used. It will be prescribed by the G.P. on a once only basis if necessary.
Midazolam has been removed from the Kardex by the G.P. as it was no longer required for two residents.

A written protocol for P.R.N. Psychotropic medication has been put in place by the Consultant Psychiatrist for one resident.

Where P.R.N. medication has been prescribed for pain, a pain management plan has been put in place plus a protocol for the use of this P.R.N. medication.

A new locked medication cupboard was put in place on the 18th March 2015. All medication is now stored in one secure location.

Relief Staff were trained in Safe Administration of Medication on the 11th and 12th March 2015.

All staff have been re-inducted into the procedure should a medication error occur.

1) Inform the person.
2) Contact the doctor for advice immediately and follow his/her instructions.
3) Record advice in person's file accurately.
4) The line manager/supervisor on call (whichever is available) must be contacted and informed.
5) Inform the person's next of kin/guardian.
6) Complete an adverse incident report form.

The pharmacy used by the residents has been changed to a local pharmacy to ensure better communication and access to a pharmacist when necessary. The pharmacist will complete a medication audit in the designated centre. Date awaited from the pharmacist for this. Expected by the 30/06/2015

Proposed Timescale: 30/06/2015

Outcome 17: Workforce
Theme: Responsive Workforce **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Staffing levels were not based on the assessed needs of the 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:** The shift times for staff were changed on the Rota with staff working till 9pm and where necessary 10pm instead of 8pm. This is to allow residents to have evening activities and they have been enjoying some social activities in the evening. The restructuring of the Rota was postponed due to the Transition of the New Resident. He was having a particular difficulty with his bedtime routine and it was advised by the multidisciplinary team that the same core staff should continue to put his night routine in place. A further restructure is now planned as the new Resident has settled into the house. It is proposed that the staff complement of ten will work between both houses. This will be fully in place by the 31st July 2015 taking into account National agreements on staffing and roster changes to ensure the efficient use of the allocated complement.
Proposed Timescale: 31/07/2015