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-0002936
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:	Louise Renwick
Support inspector(s):	Conor Brady;Conor Dennehy;
Type of inspection	Unannounced
Number of residents on the date of inspection:	26
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 3 day(s).

The inspection took place over the following dates and times

From:	To:
23 March 2015 09:30	23 March 2015 17:30
24 March 2015 09:00	24 March 2015 16:30
15 April 2015 14:30	15 April 2015 17:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was an unannounced inspection of a designated centre operated and run by St. John of God Community Services Limited. As part of this inspection, inspectors met with residents, the person in charge, clinical nurse managers, nursing staff, social care leaders, social care workers, care assistants and agency staff. Inspectors also spoke with members of the social work team. Inspectors observed practices and reviewed documentation such as care plans, person centred plans, behaviour support plans, accident and incident records, staff files and policies and procedures.

This centre catered for 26 full time residents with complex needs. The centre comprised of a large single storey dwelling divided into four pods, and was based on a campus setting. The inspectors found that the centre was a highly restrictive environment.

Inspectors identified non-compliances with the Health Act 2007 (Care and Support of residents in designated centres for persons (children and adults) with disabilities) Regulations 2013 across all the outcomes inspected. Overall, inspectors had concerns that the institutional setting and the resources available were having a negative impact on residents' safety and quality of life. For example inspectors were concerned that there was an inappropriate mix of residents with highly complex

needs living within a congregated setting. Inspectors were also concerned that the staffing numbers available were not ensuring residents had consistent access to meaningful days or were adequately supported to meet their social care needs.

Inspectors found that the person in charge had been appointed on 16 March 2015, a week prior to this inspection. The person in charge was supported in her role by two clinical nurse managers who worked within the centre. Inspectors found that the clinical nurse managers were involved in parts of the oversight of care delivered in the centre, and had an understanding of the current needs of all residents. Inspectors were concerned however, that the provider and persons participating in the management of the centre were not meeting their obligations within the Regulations. As a result of the ineffective governance and management systems there were direct negative outcomes for residents and high levels of non-compliances observed across all outcomes inspected.

Inspectors noted a staff team who spoke with dignity and interest about the complexities of the residents they supported. However, inspectors found the limitations within the environment, the inappropriate mix of residents and the staffing numbers available were restricting the teams ability to effectively meet all residents needs, and fully promote their safety at all times.

Inspectors visited the designated centre on a third day to follow up the areas of high risk identified during the previous two days of inspection.

Findings will be further discussed in the body of the report, and failings identified within the action plan.

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:
Inspectors were not satisfied that each residents' personal and social care needs were fully assessed and met in the designated centre.

While there was a goal setting tool in place in relation to capturing residents' social needs and wishes, inspectors were concerned that a number of these goals were not meaningful, based on residents' interests and wishes, or improving social outcomes for residents. For example, inspectors found some residents had a goal to have a comprehensive needs assessment completed. On discussion with the clinical nurse managers (CNM), inspectors found that this goal had been identified as necessary in order to determine the supports some residents would need if they were to transition to living in the community. Inspectors were concerned that the provider was failing to ensure assessments as required were carried out. As a result meaningful goals had not been achieved and that the goal setting system for social care needs was only being used as an attempt to ensure basic needs were met.

Inspectors found that a high number of the social goals described in residents' personal plans had not been achieved, with the reasons cited for this as not enough staff, or due to a lack of staffing resources. For example, one resident had a goal to start swimming in the campus based pool in 2014, this had not happened for the resident over the year due to limited staffing resources.

Inspectors found that while a review system was in place to ensure that residents had written care and support plans, there was a lack of review of how effectively the plans worked in achieving what they set out to, as required by the Regulations. For example,

one resident had a goal to improve communication, however no review had taken place to determine if or how the plan had improved this residents ability to communicate more effectively.

Plans reviewed by inspectors were not in an accessible format for residents, and the person in charge was not ensuring reviews were conducted in a manner suitable to the resident to promote maximum participation. For example, residents who were using some photographs to assist with communication did not have plans in pictorial format to assist them to understand their content.

On speaking with staff, inspectors found that some efforts were being made by the staff team to promote residents to be more social, and to engage in the community more. For example, one resident was supported to go to the local petrol station each week to buy some cans of beer, and there was a system in place to ensure some residents went to the local grocery store to buy personal products. However, the provider was failing to ensure suitable arrangements were in place such as adequate staffing to effectively meet residents social needs as planned.

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 health and safety of residents was promoted and protected at all times.

Inspectors reviewed a fire audit conducted by an external company in June 2014, which had outlined that:
- there was no documentary evidence to show that emergency lighting was routinely checked/ serviced,
- staff were not carrying out daily and weekly checks on fire exits,
- training given did not include safe evacuation.

Inspectors were concerned that these issues had not been addressed and were found to still be an issue in the designated centre at the time of inspection. Some staff had received training in "Fire extinguisher training" which did not include the full fire safety training as required by the Regulations. Inspectors also found five staff had no record of completing any type of fire training.

There was documentary evidence that fire alarm system was routinely serviced by a fire professional. Inspectors found residents had fire evacuation plans on their files which outlined the supports required to evacuate the building. There was also evidence of fire drills taking place over the previous months.

Inspectors found a risk management policy in place along with a risk register which was meeting the requirements of the Regulations. The risks as required by the Regulations were included in the risk register. Inspectors had concerns that in practice, the provider was failing to ensure the measures and actions in relation to the risk of aggression and violence were adequately reducing this risk for residents. This will be further discussed under outcome 8 Safeguarding and Safety.

Inspectors found that there was a system in place to record any accident, incident or near miss in the centre. Inspectors found an open culture of reporting and recording all adverse events. For example, injuries to staff, physical assault and falls. Inspectors were concerned to find a high level of reported accidents, incidents and near misses in this centre. On review of the adverse incident book since January 2015, there had been 77 entries relating to incidents involving residents. Inspectors were concerned that the provider was failing to put in place adequate control measures to prevent adverse events from re-occuring.

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:
Inspectors were not satisfied that effective measures were in place to protect all residents from being harmed or suffering abuse in the designated centre.

Inspectors found there to be a suitable policy in place dated 2013 which dealt with guidance to staff on how to safeguard residents and deal with allegations, detection and response to abuse in the designated centre. Inspectors found that staff could

demonstrate an understanding of the different types of abuse, and were aware of the reporting mechanisms to deal with any allegation, suspicion or disclosure. There was an open culture of reporting in the designated centre. However, inspectors were concerned with the high number of allegations / suspicions of abuse that had been reported to the designated liaison person (DLP) in relation to this centre. Inspectors were concerned with the provider's inability to protect all residents from ongoing harm or abuse. For example, inspectors found there to have been 102 safeguarding issues reported to the DLP in 2014 alone. With the majority of these being categorised as peer to peer physical abuse, or unexplained injuries. While inspectors found a system of investigation was in place, there was a lack of appropriate and timely safeguards implemented by the provider to reduce the likelihood of ongoing issues, and to protect residents from harm.

On review of the staff files and through speaking with staff, inspectors determined that not all staff had received training in safeguarding and protection of vulnerable adults. For those with records showing training had been planned, there was no system in place to show that this training had been delivered as planned, or that staff attended same. Permanent staff had records of training in the Therapeutic Management of Violence as scheduled, however inspectors were not provided with evidence that this training had been attended. A number of other staff had not received training in this area, or their training was now out of date. Inspectors had requested further evidence of attendance such as training certs, or sign in sheets, however this was not made available on the days of inspection.

Residents in this centre required support with their behaviour. All residents had a behaviour support plan in place, and a small number of residents also had a full comprehensive functional anaylsis and plan carried out. Inspectors found that these behaviour support plans, offered guidance on the proactive and reactive/ restrictive strategies for staff in dealing with behaviours. Inspectors found that these plans did not always involve attempts to investigating the underlying causes of behaviours as is required by the Regulations.

Inspectors found that physical, chemical and environmental restraints were in place in this centre. Residents who had restraints in use, had a written restrictive protocol on their file to guide staff in their usage. When these restraints had been used, inspectors found that there wasn't always clear evidence of alternatives tried prior to their use. Inspectors also noted a seclusion room in this centre. Staff informed inspectors that they could decide to use the seclusion room for residents in the case of an emergency situation. On review of records, inspectors found the seclusion room had been recorded as used only once in 2014. On review of the rationale for its use, inspectors were very concerned to note documentation citing "staffing levels" as part of the reason for its use. Therefore it had not been demonstrated that this form of restraint had been used in line with best practice.

Inspectors found the environment to be highly restrictive, while this was deemed necessary for some residents' safety, other residents were being unduly restricted access to areas of their home. For example, inspectors reviewed documentation outlining the rights restrictions on certain residents in accessing the kitchen, due to the safety needs of some of their peers. Inspectors were not satisfied that a restraint free environment was being promoted in this centre at all times, or that all restraints were

always used in line with best practice.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
On review of a sample of residents' files and from speaking with staff, inspectors found that there was access to a range of allied health care professionals for the residents living in this centre. For example, the organisation provided speech and language support, occupational therapy, physiotherapy and hydrotherapy. Residents were also supported to avail of dentistry, psychology, psychiatry, dietetic services as required. This was in line with the requirements of the Regulations in relation to the provision of health care. Inspectors found care plans in place for residents with an identified health need or health risk, for example, falls management or epilepsy.

While there was access to a range of allied health care professionals, inspectors identified gaps in relation to the provision of food and meal options and the management of residents nutritional and dietary needs. Inspectors found that residents in the centre were provided with a varied diet, and there was a system in place to record the nutritional and dietary needs of residents. For example, each resident had a folder in the kitchen which outlined recommendations from the SALT and dietician. Weights were recorded monthly. There was also a record sheet to record the food and fluid intake of each resident. Inspectors found that the recording of residents' intake required improving. For example, one resident who was recommended an intake of 2.5lts of fluid a day to prevent constipation did not have this clearly recorded. Inspectors could not determine if this resident was receiving the recommended amount of fluids each day. Similarly, inspectors noted the advice of a dietician to replace a resident's usual breakfast cereal with an alternative had not been facilitated. On review of the food records since the dietician's assessment the previous month, inspectors noted this resident had not been facilitated to try the alternative advised by the dietitian, and also noted this resident had breakfast cereal for supper every evening the previous month also. Inspectors also found this resident had only two records of snacks offered between meals in the month. This was also not in-line with the advice of the dietician to incorporate high fibre snacks between meals.

Inspectors had concerns regarding residents' access to food and access to suitable

kitchen facilities. Inspectors found that residents were not supported to buy, prepare or cook their own meals due to a lack of appropriate facilities and a lack of staff training in food safety. Inspectors were informed, and observed that the campus canteen provided all meals which were transported to the designated centre in a heat box. Residents were offered the two choices for lunch and dinner the day previous. Apart from these set meals, inspectors found that there were inadequate facilities to prepare nutritious meals or snacks in the centre outside of these set meal times. For example, residents who wished to have cooked eggs, or a fry for breakfast were not facilitated to have this. Inspectors found that choices around supper meals were limited, with most residents having breakfast cereal or toast as their evening meal. Inspectors observed the meal time experience, and found it to be not fully promoting a positive mealtime experience for residents. For example, inspectors observed some residents' were given their meals through a hatch. Inspectors did note in some units of the centre, a more person centred approach to meal times, with photographic table settings to assist residents to set the table, and skills teaching for some residents to be more independent at meal times. However, inspectors found that the provision of food in this centre was not wholly provided in a person centred manner and was restrictive in nature. For example, residents having to go to a different unit in the centre to drink tea and coffee at breakfast time due to one resident's behaviour.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Inspectors were satisfied that the practices in relation to medication management, for the most part, protected residents. However, improvements were required in relation to documentation.

Inspectors found that the prescription forms were formatted in such a way that there was not enough space under certain sections to clearly write medication prescribed. For example, the prescription records were difficult to read, with unclear writing, and discontinued medication scribbled out. This could pose a potential risk of medication error. Inspectors also noted that not all medication was individually prescribed by the General Practitioner with some prescription forms only having one signature for all medications listed.

Inspectors reviewed the administration records and noted that the spaces allocated for staff to record times of administration had been predetermined and with the prescription records not clearly demonstrating the time to be administered, inspectors could not determine that residents were receiving medication as prescribed. While inspectors saw evidence of a medication management audit completed in July 2014, there was a lack of oversight in relation to medication management practices to ensure continuous review of practices. For example, to determine if medication was routinely administered at the time prescribed, and the review of medication errors.

On observation of medications being administered, inspectors found some good practice in this regard. For example, medication was only signed as administered after they had been taken.

Judgment:
Non Compliant - Moderate

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 health care 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. Inspectors were not satisfied that this designated centre was being managed appropriately in accordance with the requirements of the Regulations and Standards.

Inspectors found that the person in charge had been appointed on 16 March 2015, a week prior to this inspection. The person in charge held the role of Clinical Nurse Manager 3 (CNM) and was responsible for 3 designated centres in all. The person in charge was supported in her role by two CNMs who were based within the centre and were part of the staffing compliment giving direct care to residents. Inspectors found

that the clinical nurse managers were involved in parts of the oversight of care delivered in the centre on a daily basis. This offered some structure in relation to the lines of authority and accountability with staff reporting directly to clinical nurse managers, who reported to the person in charge.

The new person in charge had the required experience and qualifications for the role. Prior to her appointment as person in charge she had on-gong involvement in meetings regarding the running of the centre in her capacity as CNM. This involvement was planed to continue as part of her new role as person in charge. Inspectors found her to be involved in the governance, management and oversight of the care needs of residents in this designated centre.

While there was some oversight in place by the clinical nurse managers based in the centre, Inspectors determined a lack of effective systems in place to ensure all aspects of care and support were being monitored and reviewed on a consistent basis. For example, on review of a folder of audits inspectors found audits completed in 2013 in relation to residents finances, 2014 for medication management and a pharmacy audit in 2013. Inspectors found an unannounced provider inspection had been carried out in October 2014, but this focused solely on 4 particular Regulations with the focus being on risk management, fire safety and Statement of Purpose.

It was not evident that these audits were being used to drive the safety and quality of care. For example, a fire safety audit had been carried out in June 2014 by an external company which identified issues with the checking of emergency lighting and the appropriateness of the training delivered. Changes had not been made to address these issues in response to these audit findings. Inspectors also read a review carried out by an internal team between May and August 2014 which looked at the suitability of the centre in meeting the needs of the residents who lived there. This review detailed plans for some residents to move out within 9 months pending a needs assessment. At the time of inspection, these needs assessments had still not been conducted and all residents remained living in the designated centre.

While inspectors saw evidence of some audits and provider inspections in 2013 and 2014, there was a lack of systems to ensure the service that residents were receiving was of a good quality, was meeting their needs and that residents had a good quality of life. The provider was failing to take appropriate action in response to any audits or reviews that had taken place. Likewise inspectors were concerned at the provider's inability to respond and act upon repeated incidents of peer to peer assault and ensure that residents were protected from harm, and felt safe in the designated centre.

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:
Inspectors were not satisfied that the staff numbers on duty were adequate to meet the assessed needs of all residents on a consistent basis.

Some residents were assessed as requiring one to one support, with a high number of residents presenting with behaviours that were challenging to the service, such as physical aggression and self injurious behaviour. Inspectors were concerned to find documentary evidence of staffing levels having a direct negative impact on the lives of residents. For example, one resident had been placed in the seclusion room in 2014 with the review of the incident citing staffing levels as a factor in the decision to use this intervention. Inspectors were concerned that staffing levels had also been documented as the reason why a high number of residents personal goals had not been achieved over the course of the previous year. Inspectors were also informed of a high level of staff sick leave on an ongoing basis in this centre. This was confirmed with documentary evidence of absenteeism for the centre provided to inspectors on the third day of inspection.

Inspectors found that person in charge needed to rely on the use of relief or agency staff in the centre. Inspectors reviewed documentation that outlined residents difficulties in being supported by unfamiliar staff members, and the risks that this posed. During the course of the inspection, inspectors met agency staff who were not often in the centre and were not familiar with the contents of the care plans and documentation to guide residents' care. Inspectors were informed by staff members and the clinical nurse managers, that sick leave was an issue in the centre. If a staff member was off sick, the provider was not covering this absence. Inspectors were concerned that the provider was not ensuring continuity of care and support for residents.

While inspectors found a selection of education and training was available to staff working in the centre, this was not consistently delivered to all staff. Documentary evidence was lacking to assure inspectors that any scheduled training had been delivered. For example, training records listed scheduled dates for mandatory training, but there was no documentation available to inspectors to determine that this had been delivered and attended in line with the plan. As mentioned in previous outcomes, not all staff had received training in safeguarding and protection and fire safety. Inspectors also found staff had not been provided with training in the area of autism awareness, this was concerning given that 19 of the 26 residents were on the autism spectrum and had needs in relation to this. While staff were committed to supporting residents and their needs, the provider had failed to ensure they were adequately skilled to meet the needs of the residents in relation to their autism. This an issue that had been identified

as part of the provider's unannounced inspection of the centre and subsequent action plan, but to date training in this area had not been arranged or scheduled.

Inspectors found that visual supervision of staff was provided by the clinical nurse managers, who also worked directly with residents on a daily basis. There was a plan in place by the clinical nurse manager to performance manage all staff. At the time of inspection not all staff had taken part in a formal performance review for 2014/2015.

A sample of staff files were reviewed as part of this inspection, and found to be mostly in compliance with Schedule 2 of the Regulations. There was a system in place to seek Garda Vetting for staff, written references and proof of identity.

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:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

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-0002936
Date of Inspection:	23 March 2015
Date of response:	21 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 in accessible format for residents.

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

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

made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
1. An accessible template of 'My Personal Plan' will be developed.

2. A schedule of introduction of the rollout of the accessible version, with all residents, will be developed.

3. All key workers will prepare an accessible 'My Personal Plan' for each resident with the involvement of residents and or their representatives.

Proposed Timescale:
1. 30/07/2015
2. 30/08/2015
3. 30/10/2015

Proposed Timescale: 30/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure the reviews of plans were conducted in a manner that ensured the maximum participation of residents.

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. All reviews of plans will be carried out with the residents and or their representatives.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews did not assess the effectiveness of plans in place for residents.

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. Template for reviews will be amended to incorporate the effectiveness of the plans.

2. Revised template will be communicated to all staff for use in all future reviews.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements were not put in place to meet residents' needs as per their social care plans.

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

Please state the actions you have taken or are planning to take:
1. A review of all available data will be undertaken to ensure all residents accessed needs are identified.

2. A review of staff skill mix and numbers will take place in order to identify gaps in meeting residents social care needs

3. Staff rosters to be reviewed to ensure that staffing numbers and skill mix meet the assessed social care needs of residents.

Proposed Timescale:
1. 31/08/2015
2. 31/10/2015
3. 31/10/2015

Proposed Timescale: 31/10/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure adequate control measures were in place to reduce the risk of harm from aggression and violence.

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. A review of the environment will take place in order to maximise areas that can be used as alternative living and or recreational options.

2. Person In Charge will source sensory arrangements to support residents with their behaviours of concern.

3. Staff rosters to be reviewed to ensure that staffing numbers and skill mix meet the assessed needs.

4. The local Risk Management Policy will be reviewed to identify control measures are in place to reduce the likelihood or impact of adverse incidents from re-occurring.

5. A review of staff training records will be undertaken to identify gaps in Risk Management, Safeguarding, Crises Management and Positive Behaviour Support.

6. A draft Policy re: Behaviours of Concern will be referenced to guide staff practice in the management of behaviours.

7. Outcomes of screening of safeguarding incidents will be advised to the Person in Charge.

8. Where necessary, following MDT review a referral will be sent to the Psychology Department for a functional assessment.

9. All NIMS reports will be reviewed at staff team meetings.

10. All data and analysis from Incidents, including near misses, and or behavioural incidents will continue to be reviewed through the Quality and Safety Committee.

11. A development committee has been established which will identify alternative and appropriate living environments for each resident.

Proposed Timescale:
1.31/08/2015
2. 31/08/2015
3 31/10/2015
4. 31/07/2015
5. 31/06/2015
6. 31/07/2015
7. 31/06/2015
8. 31/05/2015

9.31/06/2015
10. 31/05/2015
11. 31/10/2015

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure that all staff received appropriate training in all aspects of fire safety.

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

Please state the actions you have taken or are planning to take:
1. A review of Fire Training records will be commissioned in order to ensure that all staff has received appropriate training.

2. A training schedule will be developed for identified gaps

Proposed Timescale:

1. 15/06/2015

2. 30/06/2015

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the emergency lighting had been routinely checked or serviced.

Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
1. All records of routine checks of Emergency Lighting will be entered into the Local Fire

Register.

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no system in place for the routine checking of escape routes and exits.

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

Please state the actions you have taken or are planning to take:
1. All escape routes are checked twice daily.

2. All staff will continue to complete daily fire register, as in place.

Proposed Timescale: 19/05/2015

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:
The person in charge had failed to identify underlying causes of residents' behaviour, alternative measures were not tried prior to restraints being applied and the least restrictive procedures had not always been applied.

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

Please state the actions you have taken or are planning to take:
1. A draft Policy ,re: Behaviours of Concern will be referenced to guide staff practice in the management of behaviours.

2. Where necessary, following MDT review a referral will be sent to the Psychology Department for a functional assessment.

3. Restrictive Practices Kardex and protocols is under development for any restrictions in place and to ensure due process.

4. The Person In Charge will review all rights restrictions to ensure due process is adhered.

5. The Person In Charge will continue to promote a restraint free environment in the Designated Centre, as far as is possible.

6. A development committee has been established

Proposed Timescale:
1. 31/07/2015
2. 31/05/2015
3. 31/06/2015
4. 31/07/2015
5. 19/05/2015
6. 31/10/2015

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in the management of violence or challenging behaviour. Records for some staff did not show that training had been attended as scheduled.

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. Staff CORE training records will be audited to ensure that they reflect actual staff attendance at scheduled training.

2. Where staffs have not received training in Positive Behaviour Supports and Crises Management, a schedule of training will be developed.

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure all residents were protected from peer to peer abuse.

Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
1. A review of the environment will take place in order to maximise areas that can be used as alternative living and or recreational options.

2. Person in Charge will source sensory arrangements to supports residents with their behaviours of concern.

3. Safeguarding Vulnerable Adults Training; a review of this training will take place.

4. Where staff have not received training in Positive Behaviour Supports and Crises Management, a schedule of training will be developed.

5. Outcomes of screening of safeguarding incidents will be advised to the Person In Charge.

6. Local risk management policy and procedure, section 7, will be reviewed in terms of ensuring listed precautions are in place and are evidenced.

7. Residents and or their representatives will be supported to access the complaints process.

8. A development committee has been established which will identify alternative and appropriate living environments for each resident.

Proposed Timescale:
1 31/08/2015
2 31/08/2015
3 31/06/2015
4. 31/08/2015
5. 31/06/2015
6 31/07/2015
7 19/05/2015
8 19/05/2015

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to take appropriate action in response to residents

suffering harm from their peers.

Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
1. A review of the environment will take place in order to maximise areas that can be used as alternative living and or recreational options.

2. Person In Charge will source sensory arrangements to supports residents with their behaviours of concern.

3. Safeguarding Vulnerable Adults Training; a review of this training will take place.

4. Where staff have not received training in Positive Behaviour Supports and Crises Management, a schedule of training will be developed.

5. Outcomes of screening of safeguarding incidents will be advised to the Person In Charge.

6. Local risk management policy and procedure, section 7, will be reviewed in terms of ensuring listed precautions are in place and are evidenced.

7. Residents and or their representatives will be supported to access the complaints process.

8. A development committee has been established which will identify alternative and appropriate living environments for each resident.

Proposed Timescale:
1. 31/08/2015
2 .31/08/2015
3 .31/06/2015
4. 31/08/2015
5. 31/06/2015
6 . 31/07/2015
7. 19/05/2015
8. 19/05/2015

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure all staff were appropriately trained in the prevention, detection and response to abuse. Training records did not indicate who had attended scheduled training, and some staff had no training on file.

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. All staff will receive training in the prevention, detection and response to abuse.

2. A schedule of training will be developed to address any identified gaps.

3. Staff files will be maintained and updated to reflect actual staff training.

Proposed Timescale: 31/07/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure the advice of allied health care professionals was consistently implemented for residents.

Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
1. Where residents have Dietician assessments these will be reviewed to ensure all recommendations are implemented and communicated to staff team.

2. All staff will read and record recommendations.

3. Food plans will inform agenda at staff team meetings.

4. Where an allied health care professional makes a recommendation in relation to the support / care of any resident this will be documented in the resident personal plan by designated key worker or key team. All new recommendations will be communicated to all staffs and documented accordingly.

5. The Person in Charge will develop an audit tool of compliance in this area.

Proposed Timescale:
1. 30/09/2015
2. 30/07/2015
3. 30/07/2015
4. 30/06/2015
5. 30/09/2015

Proposed Timescale: 30/09/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge was not ensuring residents could buy, prepare and cook their own food if they wished.

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. Residents are consulted to choose and plan their weekly shop

2. An audit of the meal time options will be carried out including access and support to residents in the preparation of snacks and other meals.

3. Residents' additional food preferences will be identified to support purchase, preparation and cooking of their preferred snacks and meals.

4. Where additional training is required, this will be facilitated for staff.

5. A review of storage and facilities in kitchen areas will take place.

Proposed Timescale:
1. 19/05/2015
2. 31/08/2015
3. 30/05/2015
4. 15/06/2015
5. 31/12/2015

Proposed Timescale: 31/08/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
The person in charge was failing to ensure adequate choice available to residents for each meal.

Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
1. Residents are consulted to choose each meal.

2. An audit of the meal time options will be carried out to identify opportunities for further choice at mealtimes.

Proposed Timescale: 31/07/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge was failing to ensure resident had access to appropriate food and snacks outside of the set mealtimes.

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. All residents will be supported to access, at all times, appropriate foods and snacks outside of set mealtimes.
2. A review of kitchen areas will take place in order to support residents access to appropriate meals, refreshments and snacks at all times.
3. An audit of meal time experience will be undertaken.

Proposed Timescale:
1. 30/05/2015
2. 31/12/2015
3. 19/05/2015

Proposed Timescale: 31/12/2015

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:
Documentation was unclear in relation to medications prescribed.

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. Documentation: a review of current kardex system will take place.

2. Medication Management Practices: a schedule of audits will be developed by Person In Charge.

3. Resulting recommendations will be implemented.

Proposed Timescale:
1. 30/06/2015
2. 30/08/2015
3. 30/11/2015

Proposed Timescale: 30/06/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure effective management systems were in place to effectively monitor the care delivered in the centre.

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1. A review of Organisational Governance structures is currently underway.
2. A Quality Enhancement Strategic Committee has been developed and takes place on a weekly basis with the Register Provider.
3. A Person In Charge Implementation Committee has been established and meets weekly.
4. Designated Centre Committee Meetings have been established.
5. All staff will be advised of lines of management, reporting, responsibility and

accountability.
6. The Quality & Safety Committee will review all audits, data and other relevant reports.
7. Multi-Disciplinary reviews will continue to take place as necessary.

Proposed Timescale:
1. 30/04/2015
2. 30/04/2015
3.07/05/2015
4. 31/05/2015
5. 30/06/2015
6.19/05/2015
7. 19/05/2015

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:
The provider had failed to put in place sufficient plans to address identified concerns regarding the standard of care in the centre.

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. Findings from previous audits and action plans will be included in an overarching Designated Centre Quality Enhancement Plan which will be actioned and monitored through the Quality Enhancement Strategic Committee.
2. Quality and Safety Committee will review all data and other relevant reports.

Proposed Timescale:
1. 31/07/2015
2. 20/05/2015

Proposed Timescale: 31/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to carry out an annual review of the quality and safety of care and support delivered to residents in accordance with the Standards.

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 Registered Provider will review the current system of six monthly unannounced visits to the Designated Centre.

2. Awaiting guidance to be issued, in the regulatory notice as previously advised by the Chief Executive Officer of the Health Information and Quality Authority will be issued to Service Providers.

Proposed Timescale: 31/12/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure an adequate number of staff on duty to meet the needs of residents.

Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1. Staff rosters will be reviewed in order to ensure adequate staffing resources are in in place at all times to meet the needs of the residents.

2. Allocations of staffs is being reviewed
3. A schedule of training will be developed to address any identified gaps, which will include, Autism training, crisis management training, safe guarding vulnerable people and mandatory training

Proposed Timescale:
1. 31/10/2015
2. 31/07/2015
3. 31/06/2015

Proposed Timescale: 31/10/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
the provider was failing to ensure that residents recieve continuity of care and support due to ongoing issues with sick leave, and inappropriate cover for these absences.

Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
1. Staff rosters will be reviewed in order to ensure adequate staffing resources are in in place to meet the accessed needs of the residents.

2. An information session for management in absenteeism has taken place.

3. A review of the management of absenteeism will be undertaken to maximise continuity of care and supports to residents.

4. Staffing support arrangements in respect of absences will be reviewed to ensure continuity of care and support.

Proposed Timescale:
1. 31/10/2015
2. 20/05/2015
3. 30/06/2015
4. 30/07/2015

Proposed Timescale: 31/10/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Gaps were identified in the provision of mandatory training and refresher training for all staff. Gaps were also identified in the provision of training in autism which was relevant to the needs of the residents.

Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
1. A schedule of training will be developed to address any identified gaps, which will include, Autism training, crisis management training, safe guarding vulnerable people and mandatory training
2. The Regional Director of Service and or Person In Charge will commission a A review of all staff training records to identify in all areas.
3. A train schedule will be developed to address identified gaps in identified training needs.

Proposed Timescale: 30/06/2015