| Centre name: | A designated centre for people with disabilities operated by St John of God Community Services Limited |
| Centre ID:   | OSV-0003008 |
| Centre county: | Louth |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | St John of God Community Services Limited |
| Provider Nominee: | Sharon Balmaine |
| Lead inspector: | Siobhan Kennedy |
| Support inspector(s): | Paul Pearson; |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 16 |
| 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 2 day(s).

The inspection took place over the following dates and times

From: To:
17 February 2015 10:00 17 February 2015 19:00
18 February 2015 09:30 18 February 2015 18:30

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

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Summary of findings from this inspection

The designated centre was previously inspected as part of a larger centre, but subsequently has been reconfigured and now consists of two houses, accommodating 16 residents (8 in each house). Residents are assessed with a diagnosis of intellectual disability.

Regulatory Enforcement Proceedings (warning letter, 24 October 2014 and regulatory meetings in May, June and November 2014) were initiated by the Authority as it was found that the designated centre was in contravention of the Health Act 2007, as amended, and regulations made there under, as the number, qualifications and skill mix of staff was not appropriate to the number and assessed needs of the residents, the statement of purpose, and the size and layout of the designated centre.

The purpose of the inspection was to determine the appropriateness of the staff numbers and skill mix to meet the assessed needs of residents. However, other matters mainly in respect of the safe delivery of services were observed and
therefore form part of this report.

The organisational structure had been revised since November 2014 and at the time of this inspection included a designated person in charge who has qualifications and many years of experience relevant to the resident group. This person was seconded to the designated centre until 31 March 2015.

Inspectors found that the centre was not resourced to ensure the effective delivery of care and support as the number of staff was not sufficient and this prevented residents from participating in social and recreational activities in accordance with their interests, capacities and developmental needs.

Management systems did not ensure that residents received continuity of care and support.

Staff members had not been given sufficient opportunity to get to know the residents’ life histories, communication modes/mediums, behaviour support plans or to form relationships so that they could assist and support residents in a meaningful way.

Systems were not consistently and effectively monitored as residents were not fully protected from a risk of fire.

The premises of the designated centre did not meet the needs of residents primarily due to the lack of space.

The findings of the inspection have identified major non-compliances in the majority of outcomes inspected. These were shared with the management team, including the person in charge during the post inspection review meeting. A new provider nominee has been appointed but was not at the post inspection meeting.

The action plan of this report identifies the areas to be addressed by the provider nominee and person in charge in order 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 and the National Quality Standards for Residential Services for Children and Adults with Disabilities.

The action plan returned to the Authority was rejected as the actions and timeframes outlined in their responses did not mitigate the risks identified. An amended action plan was subsequently returned to the Authority on the 27 May 2015.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
There were periods when residents were engaged in social and recreational activities. However, in the main, the majority of residents did not have opportunities to participate in activities which provided meaning and purpose for them and suited their needs/capacities and interests.

During the first morning of the inspection a staff nurse (shift leader) on duty informed the inspectors that “residents were not participating in any activities as they were busy on the previous day, and this was a relaxing day at home”.

Inspectors observed the majority of residents seated in the communal sitting room or at the dining table with limited or no interaction from staff and no stimulating engagement. One resident, by choice, was having a lie in. Another resident who was loud and vocal demanded the full attention of the staff nurse. From morning through to midday the television and radio in the communal sitting area were both on. However, residents were asleep and/or were uninterested.

Recordings in a resident’s care notes in relation to the activity opportunities participated in by a resident highlighted nature walks, walking in the grounds of the designated centre, massage, listening to radio, arts and crafts, and going to the cinema. However, a written entry in the resident’s care notes on 10 February 2015 identified that the resident from 10:00 hours to midday was “relaxing on the unit, listening to music”, but a written note made on the side read “staff shortages”. Another written entry signed by a staff member in a resident’s care notes on 14 February 2015 reported “resident walked around the grounds – not enough staff to go to multisensory”.

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In the afternoon three residents from one of the houses went to participate in a multisensory experience leaving four residents in the centre. The centre was quiet, as one resident was sitting at the dining table, having something to eat, another resident was assisted by a staff member to attend to personal care needs, another resident sat on the sofa with a ball and one resident stood in the kitchen.

Inspectors observed staff making and serving pancakes to four residents. One resident was encouraged to participate in the activity.

On the second morning of the inspection staff were supporting and assisting residents to prepare to go to Mass. However, there were insufficient staff to push a resident in a wheelchair and so the resident watched the other residents leave the house while he was left behind, still wearing his outdoor coat. Some time elapsed before the staff member in the house, communicated with the resident that he would not be going out to mass by taking off his outdoor coat.

Staff explained that one of the residents likes to watch television in the communal sitting room. However, other residents continually walked about the room obstructing his vision.

There was strong evidence that residents enjoyed social events. For example two agency care staff members and three residents went to the cinema in the afternoon. Staff communicated to the inspectors that this was an enjoyable experience for the residents and residents were vocal and appeared enthusiastic on returning home. Also the inspectors were informed that a resident had a significant birthday, and this was celebrated in a favourite local restaurant and the resident proudly had his birthday cards on display in the house.

The inspectors were informed that a resident was sociable and enjoyed meeting new people and having a conversation. However, this was difficult due to the noise level in the house which was further compounded by a delivery man sliding a dry goods container across the kitchen floor and the back door closing with a bang. There was no private quiet area. The resident’s own private space is too small to accommodate the resident, mobility equipment and visitors.

Inspectors saw that when staff were interacting with residents they treated the residents with dignity and respect. However, there were some aspects of residents’ privacy which had not been respected, for example:
- Staff intruded upon a resident’s personal space by entering and using a resident’s bedroom to sort the general laundry for all of the residents in the house.
- There was no signage on the shower room door, residents’ bedroom doors and staff facilities.
- The entrance into one of the houses of the designated centre was not clearly identified as there are three doors and one of these leads directly into a resident’s bedroom.

There were notice boards in the two houses. However, on one there were no photographs of the staff working on the day of the inspection and on the other there
were three photos of staff but their names were not identified. In one house the notice board did not detail any events/activities or relevant information in an appropriate format/medium to inform the resident group of anything meaningful to their daily lives. In the other house the notice board was updated in the afternoon to identify a group activity for three residents.

Inspectors identified areas, whereby the designated centre was not operated in a manner that respected residents’ age/adulthood and disability. For example:
- Reference was made to "my fallers".
- The television remained on in the communal sitting room, even though no residents were watching it.
- Both the radio and television were on at the same time in the same communal area.

Residents did not have freedom to exercise choice and control in their daily lives for example there was no evidence of a forum/meeting for residents or relatives in order to listen to their views so that they could be involved in making decisions about the day-to-day operations of the household and there was no evidence that residents were supported to make and take decisions about their daily lives. Staff members were unsure whether any residents had access to an advocacy service or received information about their rights.

There was a complaints policy and procedure for the management of complaints and the person in charge is the nominated person to deal with all complaints. However, the inspectors found that a complaint made regarding the inappropriateness of the environment for a resident had not yet been acted upon. The person in charge was unable to inform the inspectors of the outcome of the complaint nor any action taken on foot of the complaint and whether or not the complainant was satisfied.

The complaints procedure for residents was not in an accessible and age appropriate format and was not displayed in a prominent position in the designated centre. The inspectors saw that the majority of residents had access to and control of their personal property and possessions for example their clothing was maintained well in their own wardrobes and monies were kept safe through appropriate practices and record-keeping. However, inspectors learned that a resident was unable to access his own bank account to withdraw money and make purchases which would enhance the resident’s lifestyle. Instead, this process was delayed because it was reliant on the signatories of staff who were not available.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Individualised Supports and Care
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
An agency staff member was rostered to work in the afternoon in one of the houses of the designated centre. This was the staff member’s first time working in this house. It was identified that the staff member was unfamiliar with the communication modes/methods used by the residents.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Each resident had an Individual Personal Plan (IPP). These were developed in respect of each resident’s care and addressed key aspects of residents' needs. However, the care plans have not been developed in a format/medium relevant to each individual resident.

A key worker system has been set up which has identified staff members who are responsible and coordinate the care to a number of residents.

Inspectors identified a resident whereby the current living arrangements were not meeting his needs. However, there was no evidence of training and support provided for this resident to acquire life skills in order to achieve further independence. There was no support plan and the resident did not have his needs assessed by an occupational therapist.

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):**
No actions were required from the previous inspection.

**Findings:**
The designated centre consists of two houses situated within a short walking distance of each other.

Overall, the premises, was not designed to meet the aims or needs of residents’ because residents’ private (bedroom) and communal accommodation (social, recreational and dining) was found to inadequate.

The communal space consisted of open plan sitting, dining and kitchen areas and there was a conservatory in one house. For periods during the inspection, residents and staff on duty occupied the space. Some residents were constantly walking around in the area while others were sitting. The area was continuously congested with a high level of noise, including the preparation of food which was being served from the kitchen. There was no designated private place for residents to receive visitors.

The communal hallways are narrow, to the extent that it would not be possible for two persons to walk side-by-side and inspectors were advised by a staff member that it is an area where altercations between residents occur because residents are forced to be in close proximity.

A large laundry container of clean linen was delivered to one of the houses during the morning and left in the hallway. A resident in a wheelchair had to move this container before being able to access the corridor leading to his bedroom.

There is a shortage of storage space as equipment, for example, a chair weighing scale, a wheelchair and the table for sorting linen were stored in the conservatory and a trolley containing three linen baskets and a privacy screen were stored in the main bathroom.

In one of the houses each resident has their own bedroom while in the other house there are two twin bedrooms. Inspectors found that the residents’ private bedroom space was not of a suitable size. Inspectors saw that a residents’ single bedroom (which is reflective of the majority of bedrooms in the designated centre) can only comfortably accommodate essential bedroom furnishings. This space does not allow for mobility aids, for example wheelchairs and comfortable seating. A privacy screen (stored in the
bathroom adjacent to a resident’s bedroom) is used by staff to enlarge the bedroom space as they attend to the residents’ personal care needs.

It was found that procedures consistent with the standards for the prevention and control of health care associated infections were not followed as there is insufficient additional bedroom space in the event of a resident(s) having to be isolated. See outcome 7 for details.

A written entry in a resident’s care plan stated “Ensure resident is given an opportunity to enjoy activation of choice”. This included “mobilising in a large area”. However, internally there is no large area in the centre.

The system of maintenance was not effective as repairs were not carried out as quickly as possible so as to minimise disruption and inconvenience to residents. For example, a wheelchair was out of commission for 10 days from 8 February 2015 because the lap strap clasp was missing.

Facilities were not maintained regularly as the flooring in a shower room was cracked at floor and wall level and the varnish on kitchen cupboards was worn.

**Judgment:**
Non Compliant - Major

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**Outcome 07: Health and Safety and Risk Management**

_The health and safety of residents, visitors and staff is promoted and protected._

**Theme:**
Effective Services

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

**Findings:**
Although inspectors found that fire safety equipment was well maintained and serviced effective fire safety management systems were not fully in place as follows:

- An emergency evacuation pathway was blocked and a garden gate leading to the pathway was difficult to open.
- Staff in one of the houses had not practiced a fire drill.
- Some staff did not know the arrangements for the evacuation of individual residents.
- A staff member did not know the coding system on the fire panel
- Staff on duty did not know the fire evacuation location.
- A staff member did not know the number of residents in the centre in the event of an emergency evacuation.

The risk management policy had not been fully implemented to minimise/control risks.
Some of the bedrooms have a fire exit door and inspectors noted that some of these doors were unlocked, with the result that a member of the public could walk directly into the residents' bedroom.

Procedures consistent with the standards for the prevention and control of health care associated infections were not followed as the staff member working with three residents in a house who were diagnosed as having an infection left this house to go and work in another house in the designated centre, and was in both houses on multiple occasions.

A medical practitioner had advised that particular residents should be isolated to avoid cross-infection. However, staff explained that this was not possible due to the size of the house and two of the residents affected were occupying twin rooms.

The shower screen was not clean and rubber at floor level was loose. An acid cleaning liquid and 2 bottles of unlabelled liquid were found in an unlocked cupboard.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
There was a policy and procedure in place for the prevention, detection and response to abuse. There was also evidence that staff had participated in training and had knowledge of what constitutes abuse and their duty in respect of any allegation, suspicion or witness of abuse. A notification of an allegation of abuse and misconduct identified that staff witnessing an event intervened to protect the resident and reported the matter to the person in charge. The safeguarding policy and procedure had been initiated and currently the matter is under investigation.

Staff were not available to respond to behaviours that were challenging. Inspectors saw a resident pushing another resident's feet off a sofa so that she/he he could sit down. When this was achieved the resident engaged in self injurious behaviour hitting her/his
own face. Inspectors saw one resident hit another resident on the back. These incidents occurred during periods when there was no staff visible.

Behavioural support plans have been drawn up for a number of residents to manage their behaviour which is challenging. The inspectors examined documentation in relation to a resident with a gastric disorder and the information was clear in relation to the type of behaviour, the triggers, control measures, and the impact of the control measures. Inspectors were informed that it was drawn up by the key worker (who was absent from the centre) and personnel from the broader managerial team. A staff member on duty was not familiar with the document.

**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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors observed the serving of the lunchtime meal. The housekeeper explained that the lunchtime food arrives in heated boxes and is served to residents from the kitchen in the designated centre.

The inspectors were informed that residents were assessed by the speech and language therapists regarding the consistency of their meals and for this group of residents two were able to have regular food/meals that were not pureed. However, the cauliflower was not consistent with each resident’s individual dietary needs as it was pureed for all the residents.

**Judgment:**
Substantially 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):
No actions were required from the previous inspection.

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

The designated centre did not have appropriate and suitable practices relating to the storing of medicines as the medication trolley and cupboard doors where the overstock of medicines was kept were left unlocked during periods of the inspection.

Some residents were administered medicines which were prescribed in the name of another resident as the medicine trolley had been insufficiently stocked. A staff member remarked that there was not sufficient time to do all tasks in both houses and therefore have to "use this as there is none with the resident's name on it".

There was only one refrigerator for medicines which was used by staff from both houses with the result staff had to leave one house to go into the other house to obtain refrigerated medicine prior to administering to a resident.

The lid of the medicine trolley in 1 house was not clean and the table of the trolley was broken.

An out of date bottle of solution for the relief of mouth and throat infections prescribed for a resident was in a cupboard in shower/bathroom which was unlocked and not stored in a secure manner.

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):
No actions were required from the previous inspection.
Findings:
There was a clear defined management structure but it did provide good outcomes for the residents. From November 2014, and for an interim period, an experienced person in charge was in an acting position. This person is a qualified intellectual disability nurse with many years experience in the area of intellectual disability and registration with the professional body is up-to-date. However, the person in charge was not in the designated centre on a regular and frequent basis. Reasons given for this were responsibility for two designated centres (6 houses), on-call duties, participation in managerial meetings and not working in a full-time capacity.

Inspectors found evidence that the designated centre was not resourced and did not have effective management systems to ensure the delivery of safe and consistent services appropriate to residents’ needs. For example:
- Although there had been meetings and discussions about the unsuitability of the environment for some residents and consideration given to the reduction in the number of residents being accommodated, this had not been progressed.
- There were inadequate staffing levels to meet the needs of residents.
- Arrangements were not in place to meet the needs of each resident, as assessed.
- Agency staff were recruited and were working in various different designated centres. Residents had received care from 30 newly inducted staff since November 2014. Therefore there was no continuity in care for residents.
- Staff had advocated on behalf of a resident to have a new bed as the current bed did not suit the resident’s needs. The bed had not been delivered. The person in charge and management did not know the up-to-date situation regarding the provision of the bed.

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):
No actions were required from the previous inspection.

Findings:
There were insufficient staff numbers to meet the assessed needs of residents. There was evidence of negative outcomes for residents due to staff shortages.
The staffing levels on the morning of the first day of the inspection in one of the houses of the designated centre were; a staff nurse, a care staff member and a housekeeper to care for 8 residents. Inspectors were advised that there should have been another care staff member on duty. Later in the morning an agency staff member did arrive at the house but could not work there as the staff member had not carried out an induction specific to this house. The member of staff went to work in the other house of the designated centre and returned at lunchtime when the staff nurse on duty was free to provide the induction.

The staffing levels in the other house comprised of a student nurse, 2 care assistants who were employed from an agency and a housekeeper to care for 8 residents. The student nurse had been working in the designated centre for 6 weeks and had received induction training. Inspectors were told that normally there is a staff nurse working in this house in addition to the student nurse. Due to staff shortages, the only staff nurse working in the designated centre had to leave one house and go into the other house to administer medicines, but in order to do this had to await the arrival of a staff member from another location. This resulted in a delay in residents receiving their medication. An additional staff nurse was working in the designated centre on day 2 of the inspection.

The staff roster made available to inspectors identified that a CNM 1 (clinical nurse manager 1) would be working on the first day of the inspection. However, this was crossed out and replaced by the person in charge. When queried by inspectors they learned that the designated manager of the centre was absent for 2 weeks. On the second day of the inspection no management staff was rostered to work. However, the person in charge attended the centre briefly and assisted staff to escort residents to mass. The inspectors learned that the person in charge was on-call duties for the centres on the campus.

Residents had not received continuity of care and support because the staff who have been employed on a less than a full-time basis (agency staff) to complement the core team have not been rostered to work in a specific designated centre. With the result agency staff who communicated with the inspectors demonstrated that they were not fully knowledgeable of residents' life histories and family support circles and behaviour management plans where appropriate.

While the inspectors saw staff assisting some residents to engage in social and recreational activities, in the main there were insufficient staff to assist residents to participate in activities of their choice. See outcome 1 for details.

Night time staffing levels also required review as there was one nurse and one care staff member on duty.

There was insufficient staff on duty to carry out household tasks. Inspectors found that there was a malodour from the bathroom/toilets in one of the houses of the designated centre for a period in the morning. Inspectors were informed that the housekeeper’s role is to attend to matters in the kitchen while care staff are responsible for cleaning bathrooms and toilets but all of the care staff on duty were involved in providing direct care to residents.

From review of documentation and discussion with staff it was evident that there were
negative outcomes for residents due to staff shortages. Inspectors read that on Friday 13 February 2015 three residents in one of the houses had an infection and staff were advised to limit contact with residents in the other house. However, there was only one staff nurse on duty working between the 2 houses. See outcome 7 for details. Also a resident who was prone to falling had attended weekly physiotherapy sessions (ATS) which had improved the resident’s gait and reduced the resident’s risk of falling. However, it was recorded that on Friday 13 February 2015 the resident was unable to attend due to staff shortages. Another entry in the diary on 14 February 2015 reported “impossible to keep to meaningful schedules this week due to staff shortages”.

Staff did not have access to education and training to meet the needs of residents. An agency staff member informed the inspectors that she had not participated in training in epilepsy, yet residents diagnosed with epilepsy were being accommodated in the house. A staff nurse was unaware of the overall level of dependency of residents.

There was no evidence that staff received regular supervision and support by appropriately qualified and experienced staff.

**Judgment:**
Non Compliant - Major

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**Outcome 18: Records and documentation**

_The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013._

**Theme:**
Use of Information

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

**Findings:**
The resident unique identifier used to inform the Authority on relevant notifications is not consistent with the unique identifier used in the designated centre and therefore, staff were not able to confirm with accuracy the identification of the resident.

**Judgment:**
Substantially Compliant
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:

Siobhan Kennedy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003008</td>
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<tr>
<td>Date of Inspection:</td>
<td>17 and 18 February 2015</td>
</tr>
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<td>Date of response:</td>
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Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have the freedom to exercise choice and control in their daily lives as follows:
The noise levels in the resident’s house was so great that he was unable to have a conversation and there was no private quiet area.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
There was no forum/meeting for residents or relatives in order to have their views heard so that they could be involved in making decisions about the day-to-day operations of the household.

Residents were not supported to make and take decisions about their daily lives.

**Action Required:**
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**
1. The Person in charge has met with staff to introduce a routine that will assist staff to include residents in all decisions relating to their day. This includes the use of:
2. Circle time has been introduced at breakfast table utilising pictures relating to the events of the day and these are placed behind the breakfast table.
3. Each resident has in place a pocket of pictures showing activities on offer. commenced and on-going.
4. Staff will use a number of mediums to convey information including sign language, pictures and use of object cues.
5. Staff will receive mentoring by the Person in charge to develop these skills. These skills will also prove beneficial for other forums including advocacy meeting (s).
6. Notice boards have been positioned behind the table in the dining area which facilitates residents to observe activities available to them each day. Staff will receive mentorship from the person in charge to develop these skills. This is in place.

7. The Person in charge has corresponded with the Day Service Programme Manager in regards to accessing activities which take place every day both in the residential setting and in the community. This has included proposals for activities for residents who are older persons and would benefit from pre-retirement type activities.

8. The Person in charge is currently in the process of sourcing the resources for activities such as baking, gardening, gentle exercise classes. Support shall be provided to staff to develop programmes skills teaching etc relevant to individual residents’ needs. However many of these activities can be developed to take place in the home or in the garden area outside the home.

9. The Person in charge has met with the families/representatives of the residents to begin the process of including their opinion and contribution to the resident’s life style and activities of choice. This first meeting took place on 22/02/15. Already feedback from relatives has influenced changes to specific support required for two individuals.

10. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of a meaningful day for residents. As a result staff in conjunction with the residents have completed the social assessments and identified individual specific activities that residents appeared to enjoy. This work is continuing staff are to be encouraged by Person in charge to advocate on behalf of resident’s to develop individualised lifestyles.
11. The Role of the keyworker is promoted at staff meetings and in all interactions with team members. The Person in charge will continue to support each member of staff to develop their understanding of same. At staff meeting’s each staff member is invited to give feedback on positive developments/progress for their key person. The Person in charge will take opportunity at staff meetings to give support guidance and direction to individual staff members.

12. Since the inspection the Person in charge held two staff meetings to discuss the importance of conveying information to residents throughout the day. The utilisation of soft voice, pictures and communication styles suitable to residents understanding are to be used. Opportunities to increase use of sign language and object cues to be explored person by person, communication profiles to be developed accordingly.

13. To reduce noise levels within the house, residents have greater access to meaningful day activities which results in reduced number of residents within the houses at times throughout the day. A plan is in place on a daily basis to support residents engage in meaningful day activities.

14. One resident from this Designated Centre has transitioned to another Designated Centre on 14/04/15 to support a more spacious living environment for him.

15. As an Interim measure, a proposal is in place to relocate a number of residents from this Designated Centre following completion of their Individual Transitional Plans.

16. A De-congregation Planning Committee Phase 2 has been established. The scope of this committee will be to put in place an action plan for the transitioning of residents based on priorities identified by Admission, Discharge, Transfer Committee due to addressing lack of space and unsuitable premises to meet resident’s needs. The Development Planning Committee Phase 2 will highlight the risks and barriers to transitioning. It is envisaged that Phase 2 will identify temporary arrangements while the individual’s transitioning plans can be completed.

17. All residents have been referred to the Positive Behaviour Support Sub Committee for the completion of a full Behaviour Support Plan with a functional analysis of behaviours that challenge. A meeting to progress these referrals took place on 6/04/15.

18. A multi-disciplinary review meeting took place for all residents within this Designated Centre on 17/04/15 with actions agreed.

19. Resident’s House Meetings have commenced at both a house level and designated centre level. Terms of reference has been finalised. This forum will promote greater involvement of residents in their living environment and to promote personal choice and greater control and exercise rights. The Person in charge is notifying residents and family/representatives of the scheduled dates and give everyone the opportunity to attend.

20. A schedule of key worker training for all staff is in place which will provide awareness to staff on their roles in promoting residents rights.
21. This Designated Centre is commencing a Pilot Project which is looking at the commencing of a new model of service for the resident’s. As part of this Pilot Project each resident will have a Supports Intensity Scale Assessment completed which will assist in identifying staff skill mix and level of staffing supports to best meet the needs of residents. Terms of Reference were finalised for this Project on 27/03/15

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

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Each resident’s privacy and dignity was not respected as follows:
- Staff intruded upon a resident’s personal space by entering and using a resident’s bedroom to sort the general laundry for all of the residents in the house.
- There was no signage on the shower room door, residents’ bedroom doors and staff facilities.
- The entrance into one of the houses of the designated centre was not clearly identified as there are 3 doors and one of these leads directly into a resident’s bedroom.

**Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
1. The Peron In Charge is exploring a range of options to address the issue of space and the need to afford individuals greater space.

2. The Person in charge has also met with the household staff on the 16 and 17/03/2015 within the designated centre to communicate the importance of maintaining and protecting the resident’s privacy and dignity.

3. The resident’s laundry is no longer being sorted within a bedroom in this Designated Centre and it is now being sorted in the laundry.

4. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of maintaining and protecting the resident’s privacy and dignity.

5. As part of the roles and responsibility of the Shift Leader in each house they will conduct daily walkabouts and observational audits this will include hazard identification.

6. Appropriate signage has been placed on the residents’ bedroom doors and the Person in charge is currently in the process of sourcing the most appropriate signage.
for the shower room door and staff facilities.

7. Signage directing visitors to the front door of the house has been put in place.

**Proposed Timescale:** 31/05/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The notice boards did not detail any events/activities or relevant information in an appropriate format/medium to inform the resident group of anything meaningful to their daily lives with the result they were unable to participate and consent, with supports where necessary.

**Action Required:**
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

**Please state the actions you have taken or are planning to take:**
1. The Person in charge has met with staff to introduce a routine that will assist staff to include residents in all decisions relating to their day. This includes the use of:
2. Circle Time has been introduced at breakfast table/ throughout the day utilising pictures relating to the events of the day and these are placed behind the breakfast table.
3. Each resident has in place a pocket of pictures showing activities on offer.
4. Staff are using a number of mediums to convey information including sign language, pictures and use of object cues. Staff will receive mentoring by the Person in charge to develop these skills. These skills will also prove beneficial for other forums including advocacy meeting(s).
5. Notice boards have been positioned behind the table in the dining area which facilitates residents to observe activities available to them each day. Staff will receive mentorship from the Person in charge to develop these skills. This is in place.
6. The Person in charge has met with the Day Service Programme Manager in regards to accessing activities which take place every day both in the residential setting and in the community. This has included proposals for activities for residents who are older persons and would benefit from pre-retirement type activities.
7. Weekly Meaningful Day Schedules are developed to maximise community participation for each resident in accordance with their choice and this is supported by the Quality Team in terms of practice development.
8. These schedules are reviewed at the end of each month which inform each resident’s Social Assessment and in turn promote resident’s preferences and access to experience
new activities.

9. A schedule of key worker training for all staff is in place which will provide awareness to staff on their roles in promoting residents' rights.

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**Proposed Timescale:** 30/06/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The designated centre was not operated in a manner that respected residents' age/adult hood and disability as follows:
- Reference was made to “my fallers”
- The television remained on in the communal sitting room, even though no residents were watching it.
- Both the radio and television were on at the same time in the same communal area.

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

**Please state the actions you have taken or are planning to take:**
1. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of the use of appropriate language. This will continue as part of the practice development programme.

2. The Person in charge has met with staff on 16 and 17/03/2015 to communicate the St John of God Policy and Procedure on Values in Practice which incorporates the area of dignity, privacy and respect and the use of appropriate language. It has also been communicated to staff the importance in relation to the resident’s experience, this includes ensuring the TV and radio are switched off when not in use or ensuring they are not in use at the same time.

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

4. A template has been introduced to support the role of Manager/Shift Leader on a daily basis. This encompasses a wide set of requirements including the need to promote an appropriate homely environment.

5. The Person in charge is in the process of mentoring Shift Leaders in each house by means of, informal supervision, on the spot supervision, a guidance document on the roles and responsibilities of the shift leader. The Person in charge is currently shadowing the Manager/Shift Leader and providing written and verbal feedback. This is
an opportunity for one to one supervision and covers many areas of skills development including framework for decision making, risk assessment, interactional support styles and management styles.

6. The Person in charge will undertake a review of current activities and plans for each house with the Clinical Nurse Manager. The aim is to look at opportunities to maximise resident’s access to community activities and reduce occasions when people are together in a large group.

Proposed Timescale: 29/05/2015
Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident was unable to access his own bank account to withdraw money and make purchases which would enhance the resident’s lifestyle, this process was delayed because it was reliant on the signatories of staff who were not available.

Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
1. The Person in charge will undertake a full review of the process of each individual’s resident finances and bank accounts and how they are managed.

2. The Person in charge will meet with the Management Team to agree a more person centred approach to each resident’s management/access to their monies.

3. Senior Management is establishing a Residents Finance Committee to ensure compliance with corporate and national best practice policy and legislation. All recommendations will be actioned and implemented. Terms of reference for this committee has been agreed.

4. Through the development of the role of the keyworker and introduction of Personal Outcome Measures each keyworker will receive support to assess each individual’s in order to maximise their potential in a wide variety of areas. The Person in charge will facilitate training for both staff teams in both houses within the Designated Centre.

5. Residents and family/representatives will be involved in the consultation of the process through advocacy meetings and Person centred planning meetings.

Proposed Timescale: 30/06/2015
Theme: Individualised Supports and Care
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have opportunities to participate in activities which provided meaning and purpose for them and suited their needs/capacities and interests, similar to their peers.

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

Please state the actions you have taken or are planning to take:
1. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of a meaningful day for residents. As a result staff in conjunction with the residents have completed the social assessments and identified individual specific goals for each resident. On-going

2. Each resident’s meaningful day plan is being updated in light of the social assessment review which takes into account residents, age profile and interests and preferences. On-going

3. The Person in charge has met with the Day Service Programme Manager in regards to accessing activities which take place every day both in the residential setting and in the community. This has included proposals for activities for residents who are older persons and would benefit from pre-retirement type activities.

4. Weekly Meaningful Day Schedules are developed to maximise community participation for each resident in accordance with their choice and this is supported by the Quality Team in terms of practice development.

5. These schedules are reviewed at the end of each month which inform each resident’s Social Assessment and in turn promote resident’s preferences and access to experience new activities.

6. A schedule of key worker training for all staff is in place which will provide awareness to staff on their roles in promoting residents access to meaningful day activities.

7. Staff are supporting residents to engage in Circle Time at the breakfast table on a daily basis which encourages residents to participate in decision making and social skill teaching. Staff will receive mentorship from the Person in charge to develop these skills.

Proposed Timescale: 30/06/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in
### The following respect:
Staff members who communicated with the inspectors were unsure whether any residents had access to an advocacy service or received information about their rights.

### Action Required:
Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

1. Contact details of the advocacy services available for the residents, has been put on the notice boards in each house for staff to access and staff have been informed of same.

2. The Person in charge has met with staff to note that all staff in particular keyworkers are to advocate on behalf of residents where required.

3. The Person in charge inducted all staff into the role of the key-worker in championing the needs of the residents at a staff team meeting and this included the process to engage in making a complaints on behalf of the resident. Clinical Nurse Manager is to assist keyworker in ensuring that these processes are appropriate to meet the needs of residents.

4. The Person in charge is setting up an advocacy meeting for residents and family/representatives on a monthly basis. Residents will attend with family members.

5. At the 6 weekly staff meetings the Person in charge has communicated the role of the key worker, and the importance of promoting residents individual rights including the completion of the rights awareness checklist, activity sampling and the design of individualised services.

6. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of resident’s rights.

7. The External Advocacy Service will be explored for resident’s.

8. A resident’s Advocacy Forum has been established with participation of family advocates as appropriate.

### Proposed Timescale: 30/06/2015

### Theme: Individualised Supports and Care

### The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A complaint made regarding the inappropriateness of the environment for a resident has not yet been acted upon.

### Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

1. The Person in charge is exploring a range of options to address the identified need for additional space and the need to afford individuals greater space.

2. The newly appointed Person in charge is making contact with the resident’s family to discuss the progress of the complaint and will be followed up by written correspondence. Date of letter to family 13/05/2015

3. The Person in charge is ensuring adequate resources are in place for this resident to attend a sensory development programme, which assists the resident to have greater control of their mobility and posture. As a result of attending the programme it has minimised the risk of falls and has facilitated the resident to walk with support to activities on the campus.

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

**Theme:** Individualised Supports and Care

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

The nominated person (person in charge) did not know the the outcome of a complaint nor any action taken on foot of the complaint and whether or not the complainant was satisfied.

**Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

1. The Person in charge has met with Management of the Service to review and discuss the progress of the complaint as per the complaints policy.

3. The Person in charge has met with the resident’s family to discuss the progress of the complaint and has been followed up by written correspondence.

4. The Person in charge is ensuring adequate resources are in place to ensure the resident attends a sensory development programme, which assists the resident to have greater control of their mobility and posture. As a result of attending the programme it has minimised the risk of falls and has allowed the resident to walk with support to activities on the campus.

5. A follow up meeting with resident’s family to review possible options to explore addressing the complaint will be convened.
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure for residents was not in an accessible and age appropriate format for residents.

**Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
1. The Person in charge is currently reviewing the format of the complaints process, and ensuring alternative is developed to reflect the communication skills of the residents in this Designated Centre.

2. In the interim staff have been advised at team meeting on 15/03/2015 and 16/03/2015 to advocate on behalf of residents when they observe that residents are unhappy or dissatisfied for any reason.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure was not displayed in a prominent position in the designated centre.

**Action Required:**
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Following on from the Inspection the complaints procedure is placed on the notice board in the living area.

2. Two staff meetings have taken place to improve communication. The notice board has been reconfigured to ensure it is displayed clearly.

3. The Quality Team are conducting regular practice development sessions with staff, with regards to importance of progressing the complaints process as appropriate. This includes rights awareness, the importance of key workers advocating on behalf of the
residents, restrictive practices, ensuring the rights awareness checklist is completed for each resident and ensuring staff are aware of each resident’s communication methods, to ensure if a resident is unhappy a complaint can be made on their behalf.

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

### Outcome 02: Communication

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
An agency staff member was unfamiliar with the communication modes/methods used by the residents in the designated centre.

**Action Required:**
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

**Please state the actions you have taken or are planning to take:**
1. All new staff are formally introduced to each resident by a familiar staff. Completed
2. All new staff are inducted on commencement of employment into each resident’s, critical information sheet which identifies each resident’s specific communication modes/methods. The critical information sheet is also inclusive of each resident’s behaviour support plan which also outlines each resident’s communication supports needs. Completed
3. The existing induction template will be reviewed with a view to customising it to meet the specific needs of this Designated Centre. 5/06/15
4. In the absence of the Person In Charge/Clinical Nurse Manager, a shift leader is identified to ensure continuity of care and ensure that induction takes place for new employees. Completed
5. A consistent dedicated staffing team for this Designated Centre is being secured and will be put in place to provide stability and continuity of care and to minimize the use of staff of a less than full time basis. 5/06/15

**Proposed Timescale:** 05/06/2015

### 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:**
Care plans have not been developed in a format/medium relevant to each individual resident.

**Proposed Timescale:**
**Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

**Please state the actions you have taken or are planning to take:**
1. The Person in charge has commenced work in conjunction with the key worker on making the residents Individual Personal Plans available in an accessible format for the residents and families/representatives. Individualised pictures are being collated so the resident can relate to the event for example; picture of the resident at the local barbers getting their hair cut.

2. Individual pictures will be collated for each section of the IPP and also available to the residents if they wish to have a user friendly copy in their bedroom.

3. Other mediums of making Individual Programme Plan’s more accessible are being explored.

**Proposed Timescale:** 30/06/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A resident did not have his needs assessed by an occupational therapist whose current living arrangements were not meeting his needs.

There was no goal plan identified for a resident whose current living arrangements were not meeting his assessed needs.

There was no training and support provided to a resident to acquire life skills in order to achieve further independence as the resident's current living arrangements were not meeting his assessed needs.

**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:**
1. An appointment with the Occupational Therapist to assess the resident, took place on 16th March 2015.

2. The outcome of the assessment is that the current environment is not suited to this residents’ mobility needs. This resident has transitioned to another Designated Centre on 14/04/15 which caters for his mobility needs. This resident will continue to be prioritised through the De-congregation Planning Committee Phase 2 and the
Admissions, Discharge and Transfer Committee for a more suitable placement within a
community model of residential living.

3. The Clinical Nurse Specialist did review this resident’s physical health in December
2014 and as a result of this, recommendations were made for a change of lifestyle that
would help his physical health. The resident was involved throughout this process and
will continue to be involved in all decision making going forward. This resident enjoys
greater independence when at the Day Service. A member of staff recently attended
the Day Service to demonstrate guidelines for transferring. The residents keyworker will
liaise with the Day Service regarding skills teaching that is on-going that may be
transferred to home setting.

4. Key workers will be mentored and coached by the Person in charge and the quality
team as part of the practice development programme to assist staff team in the roll out
of skills teaching for residents. 30/06/2015

Proposed Timescale: 30/06/2015

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 following matters were not provided for in the premises:

Adequate private and communal accommodation for residents, including social,
recreational, dining, hallway and private accommodation.

Bedrooms of a suitable size.

Suitable storage.

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

Please state the actions you have taken or are planning to take:
1. The Person in charge is exploring a range of options to address the identified need
for additional space and the need to afford individuals greater space and the identified
storage areas. As part of this review priority will be given to each resident having their
own single bedroom.

2. One resident from this Designated Centre has transitioned to another Designated
Centre on 14/04/15 to support a more spacious living environment.

3. As an interim measure, a proposal is in place to relocate a number of residents from
this Designated Centre following completion of their Individual Transitional Plans.
30/06/2015

4. A De-congregation Planning Committee Phase 2 has been established. The scope of this committee will be to put in place an action plan for the transitioning of residents based on priorities identified by Admission, Discharge, Transfer Committee due to addressing lack of space and unsuitable premises to meet resident’s needs. The Development Planning Committee Phase 2 will highlight the risks and barriers to transitioning. It is envisaged that Phase 2 will identify temporary arrangements while the individual’s transitioning plans can be completed.

5. A review is taking place to relocate existing files to create more space within this Designated Centre. Priority will be given to each resident having their own individual bedroom. 31/05/2015

6. The Person in charge at a staff team meeting highlighted opportunities to enable residents to have family visits in their home by organising trips out for residents to facilitate visits that are quiet and personal.

7. As part of the Manager/Shift Leaders role and responsibilities, it is their duty to ensure residents have opportunity for personal space, quiet time and social and recreational activities are planned for the day.

Proposed Timescale: 30/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Equipment and facilities as required for use by residents and were not maintained in good working order or not provided as follows:

A wheelchair was out of commission for 10 days from 8 February 2015 because the lap strap clasp was missing.

The flooring in a shower room was cracked at floor and wall level.

The varnish on kitchen cupboards was worn.

A printer / photocopier required for use by staff was not made available.

**Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
1. Since the inspection the wheelchair in question has been repaired.

2. The Person in charge has in place an annual schedule for the calibration and maintenance of clinical and resident’s equipment.

3. The Flooring in the Shower room has been addressed.

4. The kitchen cupboards have been varnished.

5. A maintenance schedule has been agreed to prioritise works.

6. Printing requirements are now networked to a source located in the main administration building that is accessible to all staff. A printer will also be made available in a general communal area on the campus which is accessible to all staff.

Proposed Timescale: 30/04/2015

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:
Hazard identification and assessment of risks had not been carried out throughout the designated centre as follows:

Fire exit doors in bedrooms were unlocked with the result a member of the public could walk directly into residents’ bedrooms.

An acid cleaning liquid and two bottles of unlabelled liquid was found in an unlocked cupboard.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
1. Following on from the inspection the lock on the fire exit door has been repaired and as a result members of the public can no longer gain access to the house from the outside.

2. All cleaning products which are potentially hazardous liquids are now stored in the appropriate designated locked cupboards.

3. All new housekeepers receive an induction to the house, which includes policies and procedures relating to the safe storage of all hazardous items. The Clinical Nurse
Manager/ Shift Leader will ensure all inductions are carried out as per the policy.

**Proposed Timescale:** 27/05/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Procedures consistent with the standards for the prevention and control of health care associated infections were not followed as follows:

A staff member working with three residents in one of the houses of the designated centre who were diagnosed as having an infection left this house to go and work in the other house and was in both houses on multiple occasions.

A shower screen was not clean and rubber at floor level was loose.

**Action Required:**  
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

1. Since the inspection the introduction of regular agency staff has been implemented to prevent staff having to work across the two houses. A deployment of staff has been implemented e.g. Two new members of staff have been employed. An agreed on call panel has been identified for the designated centre, to ensure consistency and familiarity with the residents. The roster is agreed at the beginning of the week, with the Clinical Nurse Manager and Person In Charge. The on call staff are to be included in all aspects of training with the rest of the team.

2. All staff been communicated to in regards to the SJOG Infection Control policies and procedures, and the importance of effective hand washing techniques to reduce the rates of healthcare associated infections and cross contamination. Staff will sign to state that they have received and understood the policy.

3. An infection control audit will be carried out and the recommendations will be actioned and implemented by the Person In Charge.

4. The cleaning of shower screen for the designated centre has also been included onto the cleaning schedule and a new shower screen is in place. Completed.

**Proposed Timescale:** 30/06/2015  
**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate means of escape was not provided as a fire escape route via a garden gate was blocked by a ramp and the garden gate was difficult to open.

**Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
1. The escape route as identified during the inspection has been addressed.
2. The management of the service has commissioned a full review of this Designated Centre by a Fire safety consultant with recognised expertise in this area.
3. This fire safety plan will be addressing the emergency lighting as reviewed as part of the overall fire safety audit.
4. This plan will identify high, medium and low risks and an action plan will be developed based on these recommendations.

**Proposed Timescale:** 31/05/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not made for evacuating, where necessary, in the event of fire, all persons in the centre and bringing them to safe locations as there was no signage denoting a fire exits from the living and conservatory rooms.

**Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
1. The management of the service is currently up-dating their overall fire safety plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.
2. All residents have Personal Emergency Evacuation Plans in place and the key workers are currently reviewing them to ensure they are up to date and reflect the residents current needs in the event of an emergency. The Critical Information sheet also details what the residents needs are if there was an emergency staff have been communicated with in regards to importance of knowing this information and keeping it up to date.
3. The signage denoting a fire exit from the living and conservatory rooms will be addressed following recommendation of the Fire consultant and full induction will be...
completed for staff relating to this.

4. An audit of all resident IPPs in the designated centre is being undertaken to ensure they are relevant and up to date in the context of emergency evacuation. All keyworkers will receive a list of documents which will require updating. The Person in charge will ensure all actions are completed as appropriate and timescales adhered too.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff had not received suitable training in fire prevention, emergency procedures and the arrangements for the evacuation of residents of residents as follows:

At a certain time in the afternoon a staff member did not know the number of residents in the centre in the event of an emergency evacuation.

Some staff did not know the arrangements for the evacuation of individual residents, for example, for a resident who primarily uses a wheelchair.

A staff member did not know the coding system on the fire panel, relevant to the rooms in one of the houses which would indicate the source of a fire.

A staff member described the fire alarm sounding as “bleep, not very loud”.

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

**Please state the actions you have taken or are planning to take:**
1. The management of the service is currently up-dating their overall fire safety plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.

2. All staff have completed fire training which included knowledge of the sound of the fire alarm system and additional training and support will be provided to staff through the engagement of a fire engineering company on local fire operational procedures.

3. Following the inspection all staff are aware of the Fire Alarm sounding.

4. All residents have Personal Emergency Evacuation Plans in place and the key workers are currently reviewing them to ensure they are up to date and reflect the resident’s current needs in the event of an emergency. The Critical Information sheet also details what the residents needs are in the event of an emergency. Staff have been
communicated with in regards to importance of knowing this information and keeping it up to date through the staff team meeting with the Person In Charge.

5. Following on from the Inspection all staff do know the coding for the fire panel and this has been addressed through a staff team meeting.

6. Following on from the Inspection all staff are aware of the number of residents in the Designated Centre and all staff are inducted into this areas on commencement in the centre. This is completed by the Manager/Shift Leader and staff sign off that this has taken place.

7. An audit of all resident IPPs in the designated centre is being undertaken to ensure they are relevant and up to date in the context of emergency evacuation. All keyworkers will receive a list of documents which will require up-dating. The Person in charge will ensure all actions are completed as appropriate and timescales adhered too.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective, fire safety management systems were not in place as follows:

Some staff had not practiced a fire drill in one of the houses where they were working.

A fire notice located on the wall in the corridor provided the following information “all staff proceeds to OICG entrance” staff on duty did not know this location.

Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
1. The fire notice has been taken down which was no longer relevant.

2. The fire drill for each group home will be included as part of the induction process for all new staff and the Induction Template will reflect this,

3. A schedule of day and night time fire drills are in place for this Designated Centre.

4. The management of the service is currently up-dating their overall fire safety plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.
Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff did not respond to behaviour that was challenging as they were not available to supervise residents nor had they supported residents to manage their self injurious behaviour.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
1. The Person in charge met with the staff team to address the need to support residents who present with behaviours that challenge in an appropriate and timely manner as per each residents’ Behaviour Support Plan.
2. All staff have been inducted into all residents Behaviour Support Plans.

3. Behaviour support plan to be reviewed to ensure there is adequate guidance for staff in how to reduce the likelihood and how to respond when behaviour occurs.

4. All new staff are inducted on commencement of employment into each residents, critical information sheet and behaviour support plan and this is managed by the Manager/shift leader. The induction template has been reviewed and implemented fully within this Designated Centre.

5. The Clinical Nurse Manager will supervise staff through a mentorship programme focusing specifically of the implementation of support plan.

Proposed Timescale: 30/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A staff member was unsure of a resident's behavioural support plan.

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. The Person in charge met with the staff team to address the need to support
residents who present with behaviours that challenge in an appropriate and timely manner as per each residents’ Behaviour Support Plan.

2. All staff have been inducted into all residents Behaviour Support Plans.

3. Behaviour support plan to be reviewed to ensure there is adequate guidance for staff in how to reduce the likelihood and how to respond when behaviour occurs.

4. All new staff are inducted on commencement of employment into each residents, critical information sheet and behaviour support plan and this is managed by the Manager/Shift Leader. The induction template has been reviewed and implemented fully within this Designated Centre.

5. Person in charge to shadow all Managers/ shift leaders and give feedback on their role in supervising staff in relation to behaviours that challenge and self injurious behaviours.

6. The Clinical Nurse Manager will supervise staff through a mentorship programme focusing specifically of the implementation of support plan.

7. House induction to be reviewed with Clinical Nurse Manager and Person in charge to highlight all the critical information pertaining to behaviours that challenge for each resident.

8. Consistent staff are in place to alleviate possible causes of self -injury.

9. Person in charge met with their staff team to encourage an environment that is calm and relaxed will also reduce likelihood of behaviours that challenge.

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

### Outcome 11. Healthcare Needs

**Theme: Health and Development**

_The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:_

Residents’ lunchtime meals were not consistent with each resident’s individual dietary needs as pureed cauliflower was served to all of the residents.

**Action Required:**

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

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

1. Following the inspection a full review of appropriateness of meals for residents including consistency was undertaken.
2. Following this review, meetings took place with relevant members of support services to ensure the appropriate ordered meals are made available to residents.

3. This is monitored on a daily basis by the Manager / Shift Leader.

4. A wellbeing/Nutritional Multi-disciplinary group has been established to ensure best practice and compliance with relevant standards and as part of their work they are reviewing menus/ fortification of food at source and reviewing local Standard Operating Procedure and record keeping/documentation.

**Proposed Timescale:** 30/03/2015

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**Outcome 12. Medication Management**

**Theme:** Health and Development

*The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:*  
The designated centre did not have appropriate and suitable practices relating to the storing of medicines as follows:

The medication trolley and cupboard doors where the overstock of medicines was kept were left unlocked during periods of the inspection.

Some residents were administered medicines which were prescribed in the name of another resident as the medicine trolley had been insufficiently stocked. A staff member remarked there is insufficient time to do all tasks in both houses and have to "use this as there is none with resident’s name on it".

There was only one refrigerator for medicines which was used by staff from both houses with the result staff had to leave one house to go into the other house to pick up refrigerated medicine prior to administering to a resident.

The lid of the medicine trolley in one house was not clean and the table of the trolley was broken.

**Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
1. The Person in charge has met with the staff team to ensure that medication cupboards are kept locked as per the person centre medication policy.

2. Staff nurses as identified during the Inspection visit will undertake online medication
management training to revise their professional practices.

3. Staff nurses as identified during the Inspection visit will receive supervision of administration of medication by Clinical Nurse Managers.

4. The storage of medications for each house has been reviewed to ensure there is adequate storage and that each resident's medications are available from the medicine trolley.

5. A second medication fridge is ordered to ensure each house has its own safe storage facility.

6. A new drug trolley is currently in place.

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

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

An out of date bottle of solution for the relief of mouth and throat infections prescribed for a resident was not stored in a secure manner as it was in a cupboard in a shower/bathroom which was unlocked.

**Action Required:**
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
1. A full review of all medication storage has taken place.

2. The Person in charge has convened two staff meetings to re-induct all staff into the Medication policy and procedures to ensure practices are safe and in line with overall Corporate Medication Policy.

3. A medication Audit will be conducted for this Designated Centre and the recommendations will be actioned and prioritised.

**Proposed Timescale:** 31/05/2015

**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 designated centre did not have effective management systems and resources in place to ensure the delivery of safe care and support, appropriate to residents' needs, which is consistently and effectively monitored as follows:

There has been no progress regarding the unsuitability of the environment.
There were insufficient staff.
Residents did not receive continuity of care.
Appropriate equipment was not provided to meet the needs of residents.

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

Please state the actions you have taken or are planning to take:
1. The Person in charge and management are currently reviewing potential opportunities for more individualised space for the residents which will be reflected in the De-congregation Plan for the Service.

2. One resident from this Designated Centre has transitioned to another Designated Centre on 14/04/15 to support a more spacious living environment for him.

3. As an Interim measure, a proposal is in place to relocate a number of residents from this Designated Centre following completion of their Individual Transitional Plans.

4. A De-congregation Planning Committee Phase 2 has been established. The scope of this committee will be to put in place an action plan for the transitioning of residents based on priorities identified by Admission, Discharge, Transfer Committee due to addressing lack of space and unsuitable premises to meet resident's needs. The Development Planning Committee Phase 2 will highlight the risks and barriers to transitioning. It is envisaged that Phase 2 will identify temporary arrangements while the individual’s transitioning plans can be completed.

5. A review is taking place to relocate existing files to create more space within this Designated Centre. Priority will be given to each resident having their own bedroom.

6. All residents have been referred to the Positive Behaviour Support Sub Committee for the completion of a full Behaviour Support Plan with a functional analysis of behaviours that challenge. A meeting to progress these referrals took place on 6/04/15.

7. The occupational therapist has carried out an environmental assessment in one of the houses within the Designated Centre and all recommendations will be actioned and prioritised by the Person In Charge. Following this one resident has transitioned to a more spacious living environment on 14/04/2015.

8. Following on from the Inspection visit a number of key staff have been identified and
ring fenced for each house within the Designated Centre which will ensure greater continuity of care for residents.

9. A review of staffing for this Designated Centre is underway to identify the individual needs of each individual house.

10. A recruitment campaign is underway to introduce regular skilled staff who will be fully inducted for this Designated Centre.

11. The Person In Charge/Clinical Nurse Manager will review the Roster each week to ensure needs and appropriate skill mix and continuity of staff allocation for each house.

12. Following the inspection appropriate equipment has been put in place for resident who required new bed.

13. A De-congregation Planning Committee Phase 2 has been established. The scope of this committee will be to put in place an action plan for the transitioning of residents based on priorities identified by Admission, Discharge, Transfer Committee due to addressing lack of space and unsuitable premises to meet resident’s needs. The Development Planning Committee Phase 2 will highlight the risks and barriers to transitioning. It is envisaged that Phase 2 will identify temporary arrangements while the individual’s transitioning plans can be completed. This will be supported by the work of the Pilot Project which is supporting the re-engineering of residential houses across the residential services. Terms of Reference has been finalised on 27/3/2015.

**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:
The number of staff was not appropriate to the number and 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:**
1. Following on from the inspection visit a number of key staff have been identified and ring fenced for each house within the Designated Centre which will ensure greater continuity of care for residents.

2. Through the work of the Pilot Project each resident will have a Supports Intensity Scale assessment completed which will assist in identifying the appropriate skill mix of staff and levels of supports to address the needs of residents.
3. Following a recruitment drive/campaign, regular skilled staff will be employed and fully inducted during weeks commencing 18th May and 25th May 2015. Staff will be employed to work within Designated Centre to provide continuity within the staff team. This will facilitate this Designated Centre having access to its own on call team.

4. The Person in charge/clinical nurse manager will review the Roster each week to ensure needs and appropriate skill mix and continuity of staff allocation for each house.

**Proposed Timescale:** 30/06/2015

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents did not receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**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. Following on from the Inspection visit key staff have been identified and ring fenced for each house within the Designated Centre which will ensure greater continuity of care.

2. An Additional full time nurse has been identified for this area who will work during days shifts.

3. A recruitment campaign is underway to introduce regular skilled staff who will be fully inducted to this Designated Centre.

4. The Person in charge/clinical nurse manager will review the Roster each week to ensure needs and appropriate skill mix and continuity of staff allocation for each house.

5. All new staff or staff who are employed on a less than full time basis are fully inducted into each resident’s overall needs and a reviewed Induction template has been introduced.

**Proposed Timescale:** 30/06/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not appropriately supervised.
**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
1. The clinical nurse manager has twelve hours super numary time in place on a weekly basis to provide appropriate supervision to the staff team.

2. The Person in charge /clinical nurse will review the Roster each week to ensure needs and appropriate skill mix and continuity of staff allocation for each house.

3. The roster has been reviewed to ensure that in the absence of the Manager a senior staff member is identified to work in each house every day for the purpose of providing supervision.

4. A template has been introduced to support the role of Manager/ Shift Leader on a daily basis.

5. A full gap analysis relating to training needs for staff has been completed relating to this Designated Centre and this is being actioned by the Person In Charge.

6. Each staff nurse will receive training on shift planning to improve skills across all areas relating to support and supervision of the daily running of the home.

7. The Person in charge has introduced staff team meetings every six weeks.

8. The Person in charge is commencing the process of mentoring Shift Leaders in each house by means of, formal supervision, on the spot supervision, a guidance document on the roles and responsibilities of the shift leader. The Person in charge is currently shadowing the Manager/Shift Leader and providing written and verbal feedback. This is an opportunity for one to one supervision and covers many areas of skills development including framework for decision making, risk assessment, interactional support styles and management styles

**Proposed Timescale:** 30/05/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have access to appropriate training, particularly in regard to epilepsy.

**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 full gap analysis relating to training needs for the staff team has been completed relating to this Designated Centre and this is being actioned by the Person in charge and this includes Epilepsy Training for any staff member who requires this.

2. All new staff are inducted on commencement of employment into each residents, critical information sheet and epilepsy management plan this is managed by the Manager/Shift Leader. The induction template has been reviewed and implemented fully within this Designated Centre.

3. The Person In Charge/Clinical Nurse Manager will review the Roster each week to ensure needs and appropriate skill mix and continuity of staff allocation for each house.

4. The roster has been reviewed to ensure that in the absence of the Manager a senior familiar staff member is identified to work in each house every day for the purpose of providing supervision.

5. A template has been introduced to support the role of Manager/ Shift Leader on a daily basis which is inclusive of the management of epilepsy.

Proposed Timescale: 30/06/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The resident unique identifier used to inform the Authority on relevant notifications is not consistent with the unique identifier used in the designated centre.

Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
1. Following on from the Inspection Visit both Staff teams have been made aware that unique identifying numbers need to be on all resident’s correspondence.

Proposed Timescale: 15/04/2015