Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003642
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Julie Pryce
Support inspector(s):	Gary Kiernan; Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	2

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:
23 March 2015 09:30	23 March 2015 18:30
24 March 2015 09:30	24 March 2015 15:30

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

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

Summary of findings from this inspection

This was an unannounced inspection of a designated centre located on a large campus based setting operated by St. John of Gods Community Services Limited.

As part of this inspection, the inspectors met with the person in charge, staff members and residents. The inspectors observed practice and reviewed documentation such as personal plans, healthcare plans, medical/clinical information, accident and incident records, risk assessments, medication records, meeting minutes, policies, procedures and protocols, governance and management documentation, staff training records and staff files. Twenty one residents resided in this designated centre which was an old institutional type premises located on a campus based setting. The centre comprised four wings, one of which was locked at all times when residents were in, and a self contained, securely fenced outside area.

Overall the inspectors found that there was substantial non compliance in all of the areas inspected against within this designated centre, in particular relating to the failure of the provider to ensure that management systems were in place to ensure that the service provided was safe, appropriate to residents' needs and effectively monitored. Negative outcomes for residents as a result of this included the management of restrictive practices, social care needs and the provision of behaviour support to residents who required it.

These areas are discussed in more detail in the main body of the report and in the action plan at the end.

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
Overall the inspectors were concerned that there was insufficient evidence of a meaningful day for residents. For the most part residents attended one of two day services on the campus of the provider. Residents had historically attended these day services, and their continued attendance was not based on an assessment of need. For example, there were two or three goals set for each resident in their personal plans, but there was no evidence that these goals were based on the needs or preferences of the individual residents, and it was not clear how the goals had been identified. Goals related to daily activities or basic care rather than supporting the maximisation of residents' personal development as required by the regulations. For example, a goal for one resident was 'speech and language therapy plan to be followed'. A recent audit had identified the need for staff training in the area of personal planning, but this had not been provided, as further discussed under Outcome 17.

Engagement in activities was, for the most part, in groups. For example a group of residents would go shopping, or a group would go out for a drink. Staff were aware of the need for individual activities, and these would occasionally be accommodated, but this was based solely on the availability of staff, not on the assessed needs of the resident. Staff reported that residents had to 'take turns' at individual activities as there were insufficient staff to support the needs of residents.

The need for a healthcare needs assessment had also been identified, and a system for conducting these assessments had been introduced, however, they were not yet completed for the residents reviewed by the inspectors.

Inspectors reviewed a sample of personal plans, and found that these plans were disorganised and that the information was very difficult to retrieve. For example, the personal plan for one resident was in three large files, in amongst large quantities of documents which were not part of the personal plan. Inspectors were concerned as to how these plans could guide practice. Whilst there were some plans in relation to some areas of healthcare needs, as further discussed under Outcome 11, they were not readily available to staff.

In addition, the recording of the implementation of care and support was also maintained in several different documents. For example, the care and support for one resident was recorded in four different documents, one of which was based on headings which were irrelevant to the information recorded in it. Inspectors were concerned as to how this information could inform a review of the effectiveness of care and support when it was so inaccessible.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors found that while there were some structures and processes in place in relation to the management of risk, including a risk management policy which met the requirements of the Regulations, they were insufficient to manage all the identified risks in the designated centre. For example, inspectors were concerned that the management of some of the risks was not adequately resourced, so that if additional staff were required to manage a significant risk such as violence and aggression, no additional staff were available. The matter of staffing is further discussed under outcome 17.

In addition not all identified risks had been addressed, or adequately addressed. For example, a falls assessment for one resident identified increase numbers of falls resulting in repeated minor injuries. Two referrals had been made to the falls clinic by the staff, initially on 24th February 2015, but no response had been received and the inspectors were concerned about the continuing and on-going risk to the resident given that an appropriate falls management strategy had been put in place.

Due to the high levels of challenging behaviour in the designated centre, training in the management of aggression and violence had been identified as required training for all staff. However, not all staff had received this training, and two staff who had recently received training had received a shortened version of the full course, which did not include all of the de-escalation techniques as required by the regulations, as further discussed under Outcome 17.

Inspectors noted there were not adequate precautions to prevent against the risk of fire within the designated centre. Whilst external maintenance checks of the fire alarm system had been carried out quarterly and fire fighting equipment had been serviced twice a year, inspectors noted that some of the fire doors were not closing correctly. This had been identified by the designated centre, and emails relating to this issue to the maintenance department were seen by the inspectors, however the required work had not taken place. A local evacuation plan was in place, and all residents had a personal evacuation plan. However the personal evacuation plan for one resident had not been updated to include information relating to difficulties encountered in the last fire drill. Inspectors reviewed a sample of staff files and noted that not all staff working in the centre had undergone fire safety training, as further discussed under Outcome 18.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
While some systems were in place to protect residents, areas of major non compliance were identified under this outcome. Inspectors were concerned about restrictive interventions, including the use of seclusion which included the use of a specifically designed seclusion room, which, although not used frequently, had not been managed in line with best practice and impacted negatively on residents. Inspectors were also concerned about the failure of the provider to respond proportionately to an in-houe audit of restrictive practices.

A specifically designed seclusion room was available in the designated centre, and while the use of this was infrequent, the inspectors were particularly concerned about the management of an episode of seclusion which had taken place recently. There was insufficient evidence in the documentation to support the use of seclusion, in particular the continuation of the period of seclusion following an attempt to end it. This was an emergency use of seclusion, and a protocol for further use of seclusion was developed for an individual resident. This was inconsistent with the centre's policy on restrictive practices, which indicated that a protocol for the use of seclusion should only be developed after three emergency uses. In addition, the protocol which had been developed was too vague, and inspectors were concerned that it would lead to

subjective decision making. For example, it referred to 'intense aggression', and did not give an objective description of the behaviour which it had been decided would warrant the use of seclusion.

Some behaviour support plans and reactive strategies were in place and were reviewed by the inspectors. However, the reactive strategy for one resident referred to the use of seclusion, but staff informed the inspectors that this was not current information. In addition where there were plans relating to behaviour support they were in various sections of the files relating to the individual residents, and there was no one clear record providing guidance. In addition, the staff and person in charge could clearly identify contributory factors to the challenging behaviour for some residents, for example, where two residents were incompatible staff identified this as an antecedent to episodes of challenging behaviour. There were no clear plans of action in place to resolve these issues and guide staff. This resulted in potential for inconsistent care practices and potential poor outcomes for residents.

Inspectors were not satisfied that every effort had been made to identify and alleviate the cause of residents' challenging behaviour. In particular the recent audit of restrictive interventions had identified the need for a broad range of remedial actions, including many residents who required behaviour support plans. None of the required actions identified in this audit had been implemented in the six months since this audit. In addition, identified actions currently referred to only six of the residents, and indicated that six to nine months of assessment was required. Inspectors found that this was not a timely response to the issues raised. This lack of behaviour support had negative outcomes for both residents and staff. For example, one staff member had just returned to work following a period of absence due to an injury incurred by a resident.

There were, however, some systems in place in relation to safeguarding residents. For example, staff had received training in relation to the protection of vulnerable adults, and were knowledgeable about the types of abuse, signs of abuse and the procedure to follow if any kind of abuse was suspected.

There were processes in place within the designated centre to protect residents from financial abuse. For example, the management of residents' spending money in the centre was robust. Transactions were receipted and signed, and balances were checked by two staff on a daily basis. In addition, unannounced audits were conducted by the accounts department.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

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

Findings:
Inspectors were concerned that the provider was not providing sufficient resources to meet the health care needs of the residents, for example, adequate staffing was not provided for attendance at appointments, as discussed under outcome 17.

Residents had access to some members of the multi-disciplinary team, for example, speech and language therapist, occupational therapist and general practitioner. However inspectors were concerned that the need for behaviour support identified in the audit of restrictive practices was not available. Staff reported that the referral for six of the residents identified as requiring behaviour support plans had been accepted, but there was no evidence of a plan of action relating to the other residents who required this support. Inspectors were concerned that the plan to provide behaviour support involved six to nine months of assessment, and that it had already been six months since the audit identified the need for this support, resulting in a delay of over a year.

While information was difficult to retrieve in the personal plans of residents, as discussed under Outcome 5, where there were care plans for the healthcare needs of residents, these plans were appropriate and in sufficient detail as to guide staff, implementation of the plans was recorded, and they were regularly reviewed.

However, there was insufficient information to guide staff in the administration of PRN medications for healthcare needs, for example the instruction for one medication was to 'administer if the issue arises'. Inspectors were concerned that this would lead to subjective decision making around the administration of this medication, as further discussed under Outcome 12.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Systems were in place to promote safe medication management, however, improvements were required.

Inspectors reviewed prescription, administration records and procedures for the storage and administration of medication. Practices, for administration of medications were in place guided by a detailed policy. Medications were administered by the nursing staff who had received training in medication management.

Inspectors found that some medication records did not contain all of the required information to allow staff to consistently administer medications safely. For example, the times at which medications were to be administered was not stated. In addition to this, inspectors were concerned that medications which were to be crushed were not individually prescribed as such, and that prescriptions for PRN medications were not supported by detailed protocols describing the conditions under which they were to be administered. Inspectors were also concerned that, in some cases, staff were administering medications from prescription records which they could not read.

Medications were stored appropriately. There were no medications which required special controls at the time of inspection. However, appropriate locked storage and recording systems were in place in the event that they were needed. Written evidence was available that regular reviews of residents' prescriptions was carried out.

Inspectors were shown an audit of medication management which took place in 2014. While it was evident that this audit was used to improve practice, regular mediation audits were not carried out as a matter of routine in accordance with best practice. The matter is discussed further under outcome 14 (Governance and Management) with regard to the systems in place for overseeing the safety and quality of care.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

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

An audit of restrictive practices conducted in November 2014 had not been responded to appropriately as discussed under outcome 8. The response to this audit did not

demonstrate appropriate governance and management in that it was not timely or appropriate to the severity of the findings of the audit.

A further audit reviewed by the inspectors, an audit of fire safety, had also not been appropriately responded to. There was no evidence of the action plan being fully completed and no evidence of monitoring of the completion of identified actions.

The person in charge reported that unannounced visits had been made by the provider. However there was no annual review of the quality and safety of care and support available, as required by the regulations.

The person in charge was newly appointed to the role. Inspectors were satisfied that she was appropriately qualified, skilled and experienced, and met the requirements of the regulations. She was a regular presence in the designated centre, was familiar with the health and social care needs of the residents, and was aware of her responsibilities under the regulations. Currently there were no regular or structured team meetings, however, the person in charge demonstrated plans to introduce these.

While the person in charge was responsible for more than one centre, she had not been in the position long enough for inspectors to determine whether this would impact on negatively governance and management.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
All staff members engaged by the inspectors were knowledgeable in relation to the needs of residents, and could describe the efforts undertaken to meet these needs. All interactions observed by the inspectors between staff and residents were respectful and caring.

A system of staff appraisals was in place which involved an annual performance development review.
Inspectors were concerned that the staffing levels were not adequate to meet the assessed needs of residents. For example, a resident had gone to an external appointment on the first morning of the inspection. This resident required two staff to

accompany them to ensure engagement with assessment and treatment at the appointment. As only one staff member was available, the resident was required to pay for the second member of staff themselves.

In addition another resident had been assessed as requiring one-to-one staffing. This assessed need was not met by the provider, and the inspectors were particularly concerned that repeated contact with the resident's family was documented with requests that the family resource this staff member. It was clearly documented that the family did not wish to provide these resources, and yet there was repeated correspondence from the designated centre in relation to this.

Inspectors were also concerned that staff shortages were regularly filled with unfamiliar staff, and that the presence of unfamiliar staff resulted in negative outcomes for some residents. For example, according to their assessed needs some residents would only engage in social activities with staff they were familiar with.

While inspectors found a selection of education and training was available to staff working in the centre, this was not consistently delivered to all staff. Documentary evidence was lacking to assure inspectors that any scheduled training had been delivered. For example, training records listed scheduled dates for mandatory training, but there was no documentation available to inspectors to determine that this had been delivered and attended in line with the plan. In addition, further Identified staff training needs relating to the assessed needs of residents had not been met, including training in personal planning as previously discussed under Outcomes 5, and in the management of aggression and violence as discussed under Outcome7.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Julie Pryce
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003642
Date of Inspection:	23 March 2015
Date of response:	10 July 2015

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The systems in place for the assessment of the health, personal and social care needs of residents were not adequate.

Action Required:

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

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
The Person In charge will;

1. Identify where annual healthcare assessments are not completed for residents.

2. Develop a schedule for the completion of these healthcare assessments by the GP.

3. Ensure each resident has a health care action plan based on annual health care assessment recommendations

4. Ensure current Personal Outcome Measures (POM's) assessments are reviewed so they identify residents personal and social care goals.

5. Complete a schedule for any outstanding POM's assessments, as identified in the review.

6. Ensure each resident has a person centred plan based on the outcomes of POM's assessment which will be reviewed annually thereafter.

Proposed Timescale:
1. 30/06/2015 2. 31/07/2015 3. 31/08/2015 4. 30/09/2016 5. 30/09/2015
6. 31/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that arrangements were in place to meet the needs of each resident.

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

Please state the actions you have taken or are planning to take:
The Person In Charge:
1.Shall ensure that an activity schedule is developed for and with each resident detailing meaningful activities covering day, evening and weekend periods.
2.Shall conduct a review of staff rosters to maximise opportunities for residents to engage in community based preferred activities.
3.Shall ensure that each resident's key worker will meet with day service provider(s), on a quarterly basis to review goals and meaningful activities.
4.Shall ensure that key workers explore with each resident's circle of support to maximise increased opportunities for community based preferred activities and goals.

5.Shall ensure that all staff receives training in the areas of 'Meaningful Day' and 'Role of Key-worker'.

Proposed Timescale: 1. 31/07/2015 2. 31/07/2015 3. 30/09/2015 4. 31/10/2015 5. 31/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that personal plans included all aspects of care and support required to maximise residents' personal development.

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

Please state the actions you have taken or are planning to take:
The Person In Charge shall;

1. Review all residents' personal plans and identify any current gaps relating to each resident's care and support.

2. Ensure any current recommendations from the multi-disciplinary team are incorporated into relevant sections of the their Personal Plan.

3. Each residents 'My Personal Plan; will be re-organised in line with the revised template to reflect all aspects of care and support required to maximise resident's personal development.

4. Ensure a guidance document is developed to support staff in the completion of 'My Personal Plan', with residents and or their representatives.

5. Ensure that a schedule of the roll-out and completion of the revised 'My Personal Plan' is developed.

Proposed Timescale: 1. 30/09/2015 2. 30/09/2015 3. 31/08/2015 4. 31/08/2015 5. 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The systems in place for reviewing personal plans were not adequate. Information required to inform a review of the effectiveness of care was not available.

Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
1. A revised 'My Person Plan' will be agreed.

2. Each residents 'My Personal Plan' will be re-organised in line with the revised template.

3. The Person In Charge will ensure that the guidance document for completion of 'My Personal Plan' will support the review of personal plans.

4. A template will be developed to act as a formal record of the Annual Review of the 'My Personal Plan'.

5. The Person In Charge shall roll out the revised annual review record to all staff.

Proposed Timescale: 1. 31/08/2015 2. 31/08/2015 3. 31/08/2015 4. 31/10/2015 5. 31/11/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems were not in place for the management of some of the identified risks.

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

Please state the actions you have taken or are planning to take:
1. Current personal alarm system has been reviewed and upgraded to improve response and support in an emergency situation.

2. All permanent staff have received Crisis Management training.

3. The Person In Charge and Clinical Nurse Manager will attend risk assessment training.

4. A review of staff training records will be undertaken to identify gaps in Positive Behaviour Support and Fire Safety.

5. Where gaps are identified staff will be scheduled to receive this training.

6. The specific resident as identified at being at risk of falls has now been reviewed by Physiotherapist.

7. The Person in Charge shall ensure that recommendations are included in the relevant section of the resident's Personal Plan and communicated to all staff regarding implementation.

8. All future referrals to the Falls Clinic will be acknowledged by the relevant clinician.

9. The Personal Evacuation Plan for the resident identified in the report has been updated on the 27/05/06/15 and 27/06/2015.

10. Where necessary, residents Individual Evacuation plans will be reviewed and updated to reflect the learning from fire drills.

11. The Person In Charge will meet with Clinical Nurse Manager and the staff team on a monthly basis for regular reviews and updates on risk management in the designated centre.

12. All NIMS reports will continue to be reviewed at staff team meetings with a focus on learning from adverse incidents and any learning actioned.

Proposed Timescale:
1. 26/06/2015
2. 26/06/2015
3. 31/07/2015
4. 31/07/2015
5. 31/07/2015
6. 28/05/2015
7. 08/06/2015
8. 31/07/2015
9. 27/06/2015
10. 30/09/2015
11. 31/07/2015
12. 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire doors were not adequately maintained.

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

Please state the actions you have taken or are planning to take:
1. All fire doors have been inspected to identify where necessary maintenance is required.

2. All identified repairs and improvements will be completed.

Proposed Timescale: 1. 30/06/2015 2. 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal evacuations plans were not updated adequately to inform an evacuation.

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:
The Person In Charge shall ensure that:

1. The Individual Evacuation Plan for the resident (as identified in report) has been updated and includes learning from last fire drill.

2. Where necessary, residents Individual Evacuation plans will be reviewed and updated to reflect learning from fore drill.

Proposed Timescale: 1. 30/06/2015 2. 31/08/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that all alternatives to restrictive procedures had been considered, or that the least restrictive procedures had been used.

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

Please state the actions you have taken or are planning to take:
1. A review of the remaining designated seclusion room will take place.

2. Positive Behaviour Support Policy will be rolled out to staff.

3. The current Protocol will be reviewed on the use of seclusion to reflect policy on Positive Behaviour Support.

4. Functional assessments for seven residents are currently being undertaken to identify

the function of the behaviour for each resident.

5. All restrictive practices will be reviewed quarterly to identify least restrictive practices possible.

6. Where restrictive practices are in place a Restrictive Practice Kardex will be completed giving clear guidelines on the use of any restrictive intervention. This will include proactive and reactive strategies.

7. All restrictions will be referred to the Rights Committee in September when in place.

8. All restrictions in place are now being notified to HIQA in line with regulations.

9. Meetings will take place with managers and key workers in day and residential services to ensure consistency of behaviour support needs, at a minimum of quarterly intervals.

10. Where necessary, a review of residents' mental health diagnosis is presently underway by Consultant Psychiatrist.

Proposed Timescale:
1. 30/09/2015
2. 30/09/2015
3. 31/10/2015
4. 30/09/2015
5. 31/07/2015
6. 31/10/2015
7. 30/09/2015
8. 31/05/2015
9. 31/12/2015
10. 31/12/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive interventions were not applied in accordance with national policy and evidence based practice.

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

Please state the actions you have taken or are planning to take:
1. The Person In Charge will ensure that any restrictive procedure being implemented will be in accordance with policy on Positive Behaviour Support.

2. Where restrictive practices are in place a Restrictive Practice Kardex will be

completed giving clear guidelines on the use of any restrictive intervention. This will include proactive and reactive strategies.

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

Proposed Timescale: 1. 30/09/2015 2. 31/10/2015 3. 31/11/2015

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:
Medical treatment was not facilitated by the designated centre.

Action Required:
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
1. Residents will be supported to avail of recommended medical treatments.
2. Supports Agreement will be developed with residents / representatives outlining arrangements for support with preferred medical treatment.

Proposed Timescale: 1. 30/06/2015 2. 31/12/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Required services of allied health professionals was not provided.

Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
1. Behaviour Support Plans will be in place for all residents, in line with Positive Behaviour Support Policy.

2. To date, full functional assessments for seven residents are being undertaken to identify the function of their behaviour.

3. Where the functionality of the behaviour has not been ascertained for any other resident, the MDT will refer those residents for a full functional assessment to be completed, in line with Positive Behaviour Support Policy.

Proposed Timescale: 1. 31/10/2015 2. 31/08/2015 3. 30/09/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were administering medications from records which did not contain all of the required information. Staff were administering medications from records which they could not read.

Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
1. All times for the administration of medication will be clearly identified on the Kardex.

2. Method of administration will be clearly recorded on resident's kardex.

3. Audits of administration of medication will be completed bi-annually.

4. GP's will be requested to write prescriptions legibly

Proposed Timescale: 1. 10/07/2015 2. 10/07/2015 3. 31/12/2015 4. 31/07/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that management systems were in place to ensure a safe, consistent and monitored service.

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

Please state the actions you have taken or are planning to take:
1. A review of Organisational Governance structures is currently underway.

2. A Quality Enhancement Strategic Committee has been developed and takes place on

a weekly basis with the Register Provider.

3. A Person In Charge Implementation Committee has been established and meets weekly.

4. All staff will be advised of lines of management, reporting, responsibility and accountability.

5. The Quality & Safety Committee will review audits, data and other relevant reports.

6. Multi-Disciplinary reviews will continue to take place as necessary.

Proposed Timescale: 1. 30/04/2015 2. 30/04/2015 3. 07/05/2015 4. 31/05/2015 5. 30/07/2015 6. 30/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care and support available.

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

Please state the actions you have taken or are planning to take:
1. Six monthly unannounced visits to the Designated Centre by the Registered Provider have taken place.

2. A further unannounced visit will be undertaken in 2015.

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

Proposed Timescale: 1. 27/04/2015 2. 31/12/2015 3. 31/12/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the number of staff was 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. A recruitment campaign is underway in the service to fill all permanent staff vacancies.

2. Staff rosters will be reviewed in order to ensure adequate staffing resources are in place to meet the needs of the residents and to support continuity and consistency of care.

3. Where deficits have been identified following review of rosters, these deficits will be eliminated.

4. A review of each residents needs will be undertaken to validate necessary staffing.

5. A schedule of training will be developed to address any identified gaps, which will include Positive Behaviour Support, Meaningful day, Role of key worker and Fire Safety.

Proposed Timescale: 1. 30/06/2015 2. 31/08/2015 3. 31/08/2015 4. 31/10/2015 5. 31/07/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure continuity of care and support.

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. A recruitment campaign is underway in the service to fill all permanent staff vacancies.

2. Staff rosters will be reviewed in order to ensure adequate staffing resources are in in place to support continuity and consistency of care.

3. Where staff are employed on a less than full time basis (agency and relief) consultation has taken place with the agency to promote continuity of care and support.

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

5. On-going monitoring and management of absenteeism will be undertaken to maximise continuity of care and supports to residents.

Proposed Timescale: 1. 30/06/2015 2. 31/08/2015 3. 17/06/2015 4. 28/05/2015 5. 31/07/2015

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.

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. Staff are trained in TMV.

2. Staff will be trained in Meaningful Day, Role of Key Worker, Positive Behaviour Support and Fire Safety.

3. Staff will receive support and guidance in the revised personal planning format.

4. CORE training records will reflect actual staff training.

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