

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | A designated centre for people with disabilities operated by St John of God Community Services Limited |
| Centre ID: | OSV-0002893 |
| Centre county: | Co. Dublin |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | St John of God Community Services Limited |
| Provider Nominee: | Sharon Balmaine |
| Lead inspector: | Deirdre Byrne |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 14 |
| 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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

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| From: | To: |
| 19 May 2015 09:30 | 19 May 2015 19:00 |
| 20 May 2015 09:00 | 20 May 2015 16:00 |

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 09: Notification of Incidents |
| Outcome 10. General Welfare and Development |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection

This was an announced inspection which took place over two days and was carried out for the purpose of informing an application for registration. This report sets out the findings of the inspection.

The service provided care and support to 14 adults: nine adults in long term residential care and respite care for five adults (referred to as residents throughout the report). The provider confirmed they were applying to register the centre for 14 places after the inspection. All residents had an intellectual disability. The inspector met all residents, and staff during the inspection.

This was the first inspection by the Health Information and Quality Authority (the Authority) of the designated centre. Overall, the inspector found the provider demonstrated a willingness to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The inspector found evidence of good practice in all areas, however, a number of areas for improvement were identified. These non-compliances were mainly related to documentation and record keeping, and are outlined below.

The inspector found there was a committed management team, who ensured a good governance structure was in place. The inspector met the person in charge and senior management at the inspection. The provider nominee (to be referred to as the provider in the report) was not present during the inspection and had met with inspectors prior to the inspection. Both the provider and person in charge suitably demonstrated their fitness and commitment to meet the requirements of the Regulations.

The inspector found that residents received a good quality service in the centre by staff who supported and assisted them to have a range of choices in how they went about their day. There was evidence of good consultation with residents forums and meetings, and residents' communication support needs were met effectively.

The centre comprises of three units, all located in close proximity to each other. They were well maintained, clean and homely and had a domestic, homely atmosphere. There were systems in place for residents to voice concerns and an advocacy service was available. Collective feedback in both conversation with, and questionnaires read from residents and relatives reflected overall satisfaction with the service and support provided.

The provider and person in charge promoted the safety of residents, and the staff had an in-depth knowledge of residents and their needs.

However, there were improvements identified to ensure compliance with the Regulations. The complaints procedures in place required review. The arrangements around privacy and dignity in multi-occupancy bedrooms required improvement. The contract of care did not contain all information required by Regulations. Improvements were required in the system of supervision and recruitment practices in place.

The actions are outlined in the body of the report and the Action Plan at the end of the report.

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):

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

Findings:

The inspector found residents were consulted with, and participated in the organisation of the centre, and enabled to exercise choice and control over their life in accordance with their preferences and to maximise their independence. However, an area of improvement in the complaints policy was required.

The provider ensured there were systems in place to manage and respond to complaints. A complaints policy was seen by the inspector at previous inspections of the service. However, it did not contain all the information required by Regulations. For example, the person nominated to ensure complaints were responded to and recorded appropriately. The inspector was updated during the inspection that a person had been identified and the policy would be updated to reflect this information. There were procedures displayed in each unit, that described how to make a complaint. A notice board contained information on an external advocacy service available to residents if they wished to access it.

The complaints were held centrally and 13 complaints were on record. These was information maintained on each complaint made and the action taken. However, it was not consistently recorded if all complaints had been resolved, and the satisfaction of the complainant.

There were measures in place to safeguard residents monies. The inspector reviewed procedures in one unit. It was evident that residents monies were appropriately managed on their behalf by staff. For example, there was a transaction book for each resident with records of all monies withdrawn and lodged, dual staff signatures were

maintained and invoices of purchases carried out. A sample of residents monies were counted and the balance was correct. The staff also carried out a daily stock check of each residents monies. The social care leader carried out unannounced audits of the safeguarding measures in place. These had yet to be extended to reviewing the procedures when residents are supported by staff in making withdrawals from their bank or post office accounts. This was discussed at feedback and the inspector was advised it would be considered.

Residents had opportunities to plan their day and inputted into the running of the their home at weekly house meetings. A sample of the minutes (which were also in accessible format for residents) were read, and outlined a range of matters being discussed such as grocery shopping, the menu, activities, and the HIQA inspection. The respite unit held a weekly forum with new residents. These meetings included an introduction to the house and the staff and what to expect from their respite stay in the centre.

During the inspection, staff were observed treating the residents with dignity and respect, and supported routines and practice in a manner maximising residents' independence and exercise their rights. A rights charter was displayed in each house, within the centre.

Judgment:

Substantially Compliant

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):

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

Findings:

The inspector found there were systems in place to assess and meet residents' needs however, improvement was required to ensure all residents' communication needs were met.

There was a policy in place that set out the importance of identifying and meeting residents communication needs, and a system for identifying the level of support individuals would need to receive. Some residents were seen to have plans in place that gave an overview of their communication needs and the supports required along with key information people may need to know about them. Additionally, there was good input from the psychology team in the development of positive support plans to enable better communication with the residents. The residents in one unit were non-verbal. The inspector reviewed a sample of residents files from the unit however, there was no clear

document in place that identified their communication needs and how they were to be met, along with the recommendations from allied health professionals.

Throughout the inspection, the inspector saw that staff were communicating well with residents, and understood their individual ways of speaking and communicating. Residents appeared confident in making themselves understood.

Residents had access to telephones, TV, stereos, radios, DVDs. Some also had access to mobile phones as was their choice. Residents were seen to be accessing local shops to buy papers and magazines of their choice.

The inspector saw guidance documents were provided in an easy read format that would support some residents to understand them. For example, the complaints procedures, safeguarding systems and a charter of rights.

Judgment:

Substantially Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

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

Findings:

The inspector was satisfied that the residents' were well supported to develop and maintain personal relationships and links with the wider community.

Support plans set out the key relationships in residents' lives as part of their support network, and any support that was needed to maintain those relationships. There were records of the contact residents had with their family and others.

There were no relatives visiting at the time of the inspection. Residents spoken to confirmed that where they had relatives and friends who were important to them and they had been able to continue to have regular contact with them.

The inspector was informed by staff that family members and friends could visit at any time and that they looked forward to spending time with their family. Residents informed the inspector that they visited their family home regularly and often spent weekends and holidays with their family. Other residents had gone on holidays or weekend trips with the support of staff members who knew them very well. One resident had recently visited Manchester and told the inspector how much he enjoyed

the trip.

The provider had a volunteer team to support individual residents access to hobbies and leisure activities. The inspector found that this provided residents with an opportunity to lead full and meaningful lives through active and interesting social and recreational activities.

Each resident met during the inspection had lots of interesting things to do every evening. Activities included attending regular clubs, social nights out to local restaurants, pubs, cinemas and shopping centres, weekly discos, table tennis, walks and swimming. The residents in one house told the inspector about their weekly music lesson, where they had individual classes.

The residents were also supported to develop and maintain personal relationships, and there was evidence of goals in place for some residents in relation to this and what supports they may require to achieve this.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

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

Findings:

The inspector found the provider ensured admissions and discharges to the service were timely and with the appropriate supports in place for each resident. However, improvements were required in relation to the contract of care were required.

There was a written agreement of the provision of services in place for each resident. A sample of the contracts reviewed included general information on the service provided. However, the services were not clearly outlined for example, the furnishing, decoration and if assistive equipment was provided. In addition, the contracts were not signed by all of the residents or representative where required. These matters were discussed with the person in charge and regional services manager at feedback who assured the inspector that this would be reviewed.

The centre was divided into two types of service: long term residential care and respite care. There was a comprehensive policy and procedures in place for the admitting and

discharge of residents. The residents were admitted in line with the Statement of Purpose. There had been no new admissions or discharges to or from the long term residential units of the centre in a number of years, with all of the residents residing in the centre since their admission

There were local procedures and guidelines on the assessment, allocation and admission process for respite residents. The inspector noted they were not contained in one overall document to guide staff. This was discussed with the person in charge who undertook to address this and later the inspector was shown a revised document that addressed this.

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):

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

Findings:

The inspector found each resident had a personal plan in place however, improvements were identified in the assessment and review process.

The inspector reviewed three residents' personal plans. There was evidence of an annual assessment with participation of residents in the development of their plans. The inspector spoke to staff who were fully aware of the residents plans. Although it was apparent from talking to staff and residents that goals set had been achieved, the system of review required improvement. While there was very good access to a range of allied health professionals in the service, a multi-disciplinary input into the assessment process was not evident. In addition, it was not clear from the reviews carried if the goals had being achieved or not. This was discussed with the person in charge and she outlined plans she had for the annual assessment process which would enhance the experience, participation and inclusion of the resident and their families in goal setting.

There was evidence that plans were developed on an annual basis. An interview was held with each resident and families were invited to participate in the reviews of the

plans. The personal plans which were available in an accessible format, held evidence of residents involvement and knowledge of their personal plans. Some residents discussed their personal plan and the goals they had identified with their key worker. One resident told the inspector he was happy with his goals which included taking a trip abroad, forming relationships and using technology.

The personal plans also contained information such as, details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests. The inspector also found that there were comprehensive health plans to guide the care required for residents.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Overall, the centres physical design and layout met the requirements of the Regulations, with an area of improvement in relation to multi-occupancy bedrooms (this is actioned under outcome 7). The centre comprised of three houses (referred to as units in the report), all of which were visited by the inspector who found them to be well laid out and met the individual needs of the residents. The units were clean, warm, well maintained and homely.

As reported above, there were three units all located in the same geographic area.

Unit one is a two storey house. It provides respite care for up to five adults. There are four bedrooms (three single and one two bedded room), with one communal toilet and wash-hand basin, and one communal shower room. The inspector visited the bedrooms with the prior approval of residents. Along with three single bedrooms, there was a two bedded room. In the two bed room there was no screening provided. A risk assessment had not been carried out to identify any risks to residents' privacy and the control measures (see outcome 7: health and safety). The room had sufficient room for storage and to personalise the space around residents' beds.

The provider had originally applied to register a sixth emergency bed in the house. The

inspector was shown the bed which was located in the twin room. However, it was a pull out camp type bed stored under a bed when not in use. The inspector was not satisfied that this would meet the individual and collective needs of residents. The room was not large enough for a third bed as the bed had to be placed between two beds when needed. In addition, a third bed would not afford residents in the room adequate privacy and dignity. As reported above, there were no screens provided. This was brought to the attention of senior management and the person in charge at feedback. Following the inspection, the Authority was advised that the provider would not be applying to register the emergency bed, and had submitted an amended application to reflect this.

Unit two is a two story house. There are four bedrooms (three single and one two bedded room). The inspector visited the two bedded room along with one of the residents who resided in it. It was of adequate size, with sufficient storage space and room for residents to personalise around their bed. A screen was provided between the two beds. However, there was no risk assessment to identify any risks to residents privacy (outcome 7). There are two toilets and a communal bathroom provided.

Unit three consists of a two story house. There are four residents' bedrooms (all single occupancy). Two bedrooms had an en-suite with toilet and shower, and there are two communal toilets, one with a bath. The inspector visited one of the bedrooms with the permission of the resident. It was of adequate size to meet residents' individual needs. The bedrooms were very nicely furnished and decorated. There was adequate space to personalise their room and had ample storage. There were two sitting rooms where residents could meet family or friends in private. The design and layout of this house met the individual and collective needs of the residents.

In the three units, there were appropriate numbers of bathrooms, showers and toilets in the centre to meet the residents' needs. Each of the houses were provided with a kitchen/dining and sitting rooms. An accessible garden was provided. A separate office with bed for sleep over staff was provided.

The centre was maintained to a high standard cleanliness and hygiene. Rooms were decorated in accordance with the wishes of the resident and contained personal items such as television, family photographs, posters and various other belongings.

The inspector was informed that staff and the residents both carry out the cleaning procedures. There was external housekeeping support provided once a week. There was suitable cleaning equipment provided.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

The inspector found the provider had put measures in place to ensure the health and safety of residents, staff and visitors to the designated centre was promoted and protected. However, there were improvements required in relation to the assessment of risk and an aspect of fire safety.

There was a risk management policy that met the requirements of the Regulations. However, it was not fully implemented in relation to the assessment and identification of risk. For example, the risk register contained risk assessments of individual persons but environmental risks were not fully identified. For example the interior and exterior the individual units and the multi-occupancy bedrooms.

There were systems in place to review risks that were rated orange and red. These were escalated to senior management for review. A health and safety committee met to review escalated risks and the risk register. In addition, there were systems in place to manage adverse events. Adverse incident review forms were read by the inspector, in which a range of incidents were recorded. There was evidence that incidents were discussed at quality and safety meetings, at which the person in charge presented a review of incidents every two months. Any follow up action or further investigations would be discussed at these meetings.

An up-to-date safety statement was provided in each unit. The inspector read an emergency evacuation plan, which provided clear guidance to the staff on what to do in the event of an emergency. There was alternative accommodation available if an evacuation was required.

There were systems in place for the management of fire safety. The inspector found staff were knowledgeable of the fire prevention and evacuation procedures. All staff had received training in fire prevention and the use of extinguishers. There were up-to-date personal evacuation emergency plans (PEEP) for each resident and staff were familiar with the plans and described them to the inspector.

There were regular fire drills carried out that included both staff and residents. In addition, night drills were carried out. The records of drills contained details such as the length of time and if improvements were required. It was noted in the records for one unit that staff were named but residents were not consistently accounted for. This was discussed at the feedback meeting. A weekly drill also took place in the respite unit, to reflect the turnover of residents and ensure they were familiar with the procedures in place. The inspector read daily, weekly, monthly and quarterly checks of safety equipment and alarms and exits. There was documented evidence of regular and up-to-date servicing of fire fighting equipment. Fire orders were displayed prominently in each unit of the centre.

There were some improvements required in the provision of fire doors. Following the

inspection information was submitted to the Authority on the fire doors in the centre. There were fire doors provided throughout one unit. The fire doors in the other two units are on the ground floor, there are no doors located on the first floor or at the kitchen. The person in charge submitted a detailed fire safety action for the two units in the absence of fire doors.

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):

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

Findings:

The inspector was satisfied that the provider had measures were in place to safeguard and protect residents from abuse; ensured positive behaviour supports were provided promote a positive approach to behaviours that challenge, and that the management of restrictive practices were in line with the National policy.

There was a policy on and procedures in place for the prevention, detection and response to abuse that was comprehensive, and guided practice. Staff were familiar with the types of abuse and how they would respond if an allegation of abuse was made. Records of training read at previous inspections of designated centres of the organisation confirmed staff had up-to-date training in the safeguarding of residents. The person in charge was also a train the trainer in this area and she would update her staff on safeguarding measures frequently.

The Chief Inspector had been notified of allegations of abuse prior to the inspection. Additional reports on the investigations carried out and the action taken had been submitted to the Authority. These matters were discussed with the person in charge who was familiar with the procedures to follow to carry out an investigation. A designated person was also nominated to oversee the investigation of allegations of abuse, and the person in charge was familiar with her role and responsibilities in relation to these procedures.

Each resident had an intimate care plan that was incorporated into their personal plans.

There was clear guidance to staff within these that reflected the residents' wishes and procedures they liked to follow.

There was a policy relating to positive behaviour support that was seen to be operating in practice. A number of residents in one presented with behaviours that challenged. Where behaviors had been identified, behaviour support plans had been developed. The support plans for two residents were read. The plans provided clear, comprehensive guidance to staff on the supports to be provided for the residents. There was good access to and input from psychiatry and psychology services as evident on residents files. There were reviews of the plan by an internal psychology team every six months. The minutes of these meetings were maintained on residents files also. The staff described the supports in place and the strategies they carried out as reflected in residents plans. In addition, staff were aware of any updates following residents reviews. The inspector was informed by staff that they found the positive support plans enhanced the positive outcomes for residents.

The person in charge ensured restrictive practices in place were in line with National Policy. The inspector found that restrictive procedures were minimal. There was a restrictions log that outlined the restrictions which were all mechanical. These were reviewed every three months at a mechanical restraint committee. The multi-disciplinary committee included a behaviour practitioner, occupational therapist (OT) and physiotherapist. The committee developed agreed around the use of the restraint in place. Additionally, the OT carried out risk assessments of each resident prior to any form of restriction being used.

Judgment:

Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

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

Findings:

The inspector found that the person in charge and staff had maintained records of all accidents and incidents that had occurred in the centre. These were reviewed by the person in charge.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents and all relevant incidents had been notified where required by Regulations.

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| <p>Judgment: Compliant</p> |

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
The inspector was satisfied that each resident had opportunities for new experiences, social participation, training and that employment was facilitated and supported.

Records reviewed, and discussions held with residents and staff, confirmed residents had a variety of opportunities to engage in training and development in meaningful ways. These were guided by resident's own interests and preferences and set out in their personal goals and included interests and hobbies from stable management, to music classes, going on walks, meeting friends, visiting family and partners.

A number of residents were employed in full time jobs. The inspector spoke to two residents who told the inspector about their employment and it was evident they were supported by the service to achieve these personal goals.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:

The inspector was satisfied that each resident was supported to achieve and enjoy the best possible health, and there were good supports in making choices and having variety around food at mealtime.

A sample of resident files were reviewed and it was evident that residents had good access to medical and allied health care professionals. These included, but were not limited to, a general practitioner (GP), dentist, occupational therapist, dietitian, dentist, psychiatrist and physiotherapist. The files indicated that access to these services was timely, and residents were facilitated by staff to receive any recommended treatments.

There were good practices in the identification and assessment of the residents health care needs. The inspector saw health care plans were in place if a need was identified such as dysphagia and epilepsy. As reported above, there was good access to allied health professionals, although their recommendations were not consistently incorporated in the residents care plans. The inspector found staff were familiar with the recommendations to be carried out. This was discussed with the person in charge and social care leader who explained this would be addressed.

Where residents were currently undergoing medical treatments/tests these were noted in the residents files for follow up and staff were aware of any particular current needs. Residents were seen to be actively encouraged to make healthy living choices during the inspection and to take responsibility for their own health and medical needs.

There were good practices in place for residents to make healthy choices around food across the three units visited. There was evidence of a range of choice at meal times, and the menu was planned with residents at the weekly house meetings. A pictorial menu was also displayed in each unit. Where residents were unable to verbalise staff used pictorial signs for meals to assist residents to choose the type of food and meal for the week.

The resident meals were prepared in their homes by staff, and residents supported where possible. The inspector observed dinner being prepared in one house by staff, who followed good hygiene practices although, food hygiene training had not been provided to all staff. In another unit the inspector sat with residents during their evening meal. The meal was found to be nutritious and wholesome. The mealtime experience was a relaxed social event, and were staff present to support residents if required. Snacks and drinks were available to residents throughout the day and residents were seen availing of this. There was plenty of fresh, chilled and frozen foods in stock.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

The inspector was found each resident was protected by the designated centres policies and procedures for medication management.

The inspector read a sample of completed prescription and administration records and saw they were in line with best practice guidelines. However, an area of improvements was identified. For example, the maximum dose of "as required" (PRN) medications to be administered in a 24 hour period was not consistently prescribed in one unit. This is actioned in outcome 18.

Information pertaining to each resident's medication was available in the resident's files. Staff had received training in medication management and were familiar with the medications in use.

There were no medications that required strict controls in place, but staff outlined the procedure they would follow. Staff also knew about the procedures for reporting medication errors. A number of errors had occurred and there were reports available in the incident folders, and it was evident appropriate action had been taken. It was evident that appropriate action had been taken and learning to prevent similar occurring.

There was a policy in place to guide safe practice in residents who choose to self medicate. There were no residents self administering medicating in the centre at the time of the inspection.

Medication audits had been carried out, but they were not completed for all units to identify areas for improvement. Therefore there was a missed opportunity for learning, this is discussed in more detail in Outcome 14.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector found that the Statement of Purpose met the requirements of the Regulations.

The Statement of Purpose accurately described the type of service and the facilities provided to the residents. It reflected the centres aims, ethos and facilities. It also described the care needs that the centre is designed to meet, as well as how those needs would be met

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector was satisfied there was an established management structure in place, with the roles of staff clearly set out and understood. There were systems in place to monitor and review the safety and quality of care, with an area of improvement identified.

The person in charge was suitably qualified and experienced, and managed the centre with authority, accountability and responsibility for the provision of the service. The person in charge was full time in her role in the organisation. She confirmed that she visited the designated centre on a regular basis and staff rosters reviewed indicated the days the person in charge was on duty. The person in charge also oversaw the management of another designated centre in the organisation and was not required to undertake staff duties in any of the centres. The person in charge regularly met the residents who were familiar with her. Questionnaires from relatives reported they were also familiar with her. The staff informed the inspector they regularly met the person in charge and found her very supportive.

There were good governance systems and suitable supervision arrangements at unit level. There were two social care leaders over the three units. One social leader oversaw the management of one unit, and the second oversaw the management of two units. They reported to the person in charge on a daily basis and had formal meetings approximately every two to three weeks, the minutes of which were read by the inspector. The person in charge also attended management meetings in relation to the designated centre, where issues were discussed and actioned if required.

There were systems in place to deputise for the person in charge. The residential services programme manager or social care leaders deputised in her absence.

The inspector found there were good systems in place to monitor the safety and quality of care provided to residents, with an area of improvement identified. An audit of medication management practices had taken place in two units of the centre. However, these audits were only carried out once and one unit was not included. Therefore it could not be ascertained what improvement or learning was required across the designated centre.

There were comprehensive audits completed by the quality and safety department within the organisation. These audits were un-announced and took place up to twice a year. Two audit reports (October 2014 and February 2015) were read. The reports included a range of areas reviewed, including interviews with residents and staff. An action plan was read that outlined the area that required improvement. These were being reviewed and actioned by the person in charge.

A report encompassing the results of the safety audits along with the quality of the service was in place. An accessible version was yet to be made available to residents. This was discussed at feedback with the person in charge and senior management.

Judgment:

Substantially Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector was satisfied that suitable arrangements were in place to cover any

absences of 28 days or more of the person in charge. These arrangements were formalised and staff were aware of them.

The provider was aware of the requirements to notify the Authority in the event of the person in charge being absent

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

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

Findings:

The inspector was satisfied from a review of residents needs that the designated centre was sufficiently resourced to support the residents to achieve their individualised plans.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Overall, the inspector found that staff were committed to providing a quality service to residents. There was an adequate number of staff to meet the needs of the residents. However, improvements were required in relation to staff documentation and the

system of supervision.

There was a planned roster in place, and an adequate staff skill mix to meet the residents' needs. The provider ensured there were suitable recruitment procedures in place. A sample of staff files were reviewed by the inspector which showed that the documentation required for all staff did not meet the regulatory requirements. For example, there was one reference and no previous employer reference in two files reviewed.

The system of staff supervision required improvement. While there was evidence of appraisals on file for staff, these were not up-to-date. This was discussed with the social care leader of one unit, who explained these were now complete for nearly fifty percent of her staff. However, supervision meetings with staff had yet to take place. The inspector was informed a formal system of supervision would be rolled once the appraisals were completed, and would take place every six to eight weeks.

Staff training records were not reviewed at this inspection. At previous inspections of designated centres of the service provider, training records reviewed by the inspector confirmed staff had be up-to-date in all the mandatory areas.

There were a small number of volunteers who visited the centre. The volunteer documentation and supervision arrangements in place were reviewed by the inspector at previous inspections of designated centres of the organisation and were in compliance with the requirements of the Regulations.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspector found that records were accurate, up-to-date, maintained securely but

easily retrievable. However, an area of improvement was identified.

The inspector reviewed the records listed in Schedules 2, 3 and 4 of the Regulations which were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. However, there was a gap in the records required to be maintained for residents. For example, the maximum dose of PRN medications administered was not stated in all prescriptions.

The provider had ensured the designated centre had most of the written operational policies as required by Schedule 5 of the Regulations.

An up-to-date insurance policy was in place for the centre which included cover for resident's personal property and accident and injury to residents in compliance with all the requirements of the Regulations

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:

Deirdre Byrne
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 report¹

| | |
|----------------------------|--|
| Centre name: | A designated centre for people with disabilities operated by St John of God Community Services Limited |
| Centre ID: | OSV-0002893 |
| Date of Inspection: | 19 May 2015 |
| Date of response: | 24 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 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:

The policy did not name the person nominated to oversee complaints were responded to and recorded.

Action Required:

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

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

•A designated person, namely Ms. Lia O'Shea, Administrative officer, has been assigned to the role in the service with immediate effect.

Proposed Timescale: 24/07/2015

Theme: Individualised Supports and Care

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

Records of complaints did not consistently include action taken and the satisfaction of complainants.

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:

All complaints on record to have outcome clearly outlined and satisfaction level of the resident detailed.

Proposed Timescale: 31/07/2015

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:

Residents communication needs were not consistently set out in their personal plan.

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:

All residents who present with identified Communication support needs will have a Communication Care Plan drawn up to outline their individual communication supports with input from service Speech and Language Department.

Proposed Timescale: 31/08/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The contract of care did not outline the services to be provided to residents.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

The contract of care will be updated for every Resident to include:

- 1) The services to be provided to the residents
- 2) An outline of the fees to be charged

Proposed Timescale: 30/09/2015

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:

There was no evidence of a multi-disciplinary input into the review of residents personal plans

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

Multi-disciplinary meeting minutes will now record the goals in place for resident in order for same to be incorporated to the MDT review process.

Proposed Timescale: 31/07/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The implementation of the policy in relation to the identification and assessment of risks required improvement.

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:

- An environmental Risk Assessment will be put in place to identify all environmental hazards and the control measures in place to reduce likelihood/impact.
- These Risk Assessments will be logged centrally on the Designated Centre Risk Register

Proposed Timescale: 07/08/2015

Theme: Effective Services

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

There were a number of deficits in the provision of fire doors in parts of the designated centre.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- 1) A review fire doors in locations will take place (by 31st July '15)
- 2) Interior domestic fire doors (30minute) will be sourced for the 4 bedrooms in each of the locations identified in the report (by 31st August '15)
- 3) Interior domestic fire doors (1hour) will be sourced for the kitchen/dining area of the two locations outlined in the report (by 31st August '15)
- 4) Fire doors will be installed by a builder who will be contracted by the maintenance department within SJOG Carmona Service. This will entail removing the current doors, replacing the architrave and installing intumescent strips (by 30th September 2015)
- 5) A protocol for the operation of these Fire doors will be drafted in line with manufacturers guidelines and in consultation with Health and Safety officer in Carmona Services (by 14th September 2015).

Proposed Timescale: 30/09/2015

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:

An accessible version of the annual report was not yet available to residents.

Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

- The Supervisors will liaise with the Speech and Language Department in order to develop an accessible version of the Annual Report for the Designated Centre.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

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

The system of reviewing medication management practices in the centre requires improvement.

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)Audit of Medication practices in Respite House to take place (by 31st July 2015).
- 2)Pharmacy Audit to take place in House 7 and House 59 (by 30th August 2015).
- 3)Regular bi-annual audits of medication practices to take place commencing 6 months from initial audits (in May 2015)

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

There were gaps in the documentation required to be maintained for staff as per the Regulations.

Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

- 1) Information and documents specified in Schedule 2 are in place for one staff member as identified by the inspector during the inspection (completed by 1st July 2015)
- 2) A reference from previous employer will be obtained in respect of other staff members file identified by inspector at time of inspection.

Proposed Timescale: 31/07/2015

Theme: Responsive Workforce

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

The system of staff supervision required improvement as outlined in the report.

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) All PDRs will be brought up to date by Supervisors (by 31st July 2015)
- 2) A formal schedule of agreed Supervision Meetings will be made available to staff and maintained by location Supervisor (by 31st July)
- 3) All staff will receive at least one Professional Supervision meeting

Proposed Timescale: 01/10/2015

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 maximum dose of PRN medication to be administered in a 24 hour period was not consistently recorded.

Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

- All Kardexes will include the maximum dosage of PRN medication to be administered in a 24 hours period. Supervisor will liaise with G.P and Pharmacy to complete this.

Proposed Timescale: 31/07/2015