**Health Information and Quality Authority
Regulation Directorate**

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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003988
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Jillian Connolly
Support inspector(s):	Philip Daughen
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
08 April 2015 10:00	08 April 2015 18:00
09 April 2015 10:00	09 April 2015 12:00
10 April 2015 07:00	10 April 2015 12:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

The designated centre is a residential service for individuals with an intellectual disability. The service is operated by St. John of God Community Services Ltd. and is located in Co. Louth. The centre consists of five units in a campus setting and is the home of nineteen people. On the day of inspection one of the units was vacant. This was the second inspection of the designated centre. The first inspection took place in September 2014.

This inspection was unannounced and took place over three days. The findings of this report were gathered by inspectors speaking to staff, observing practice and reviewing documentation. Overall inspectors found that there were inconsistent practices in the designated centre. In some areas there was evidence of positive outcomes for residents based on appropriate positive behaviour support, opportunities for activities, the size of their living environment and the staff supporting the residents. However in other areas, there was clear evidence of negative outcomes for residents due to an absence of appropriate behaviour support and their living environment. As a result of the eight outcomes inspected, major non - compliance was identified in the following seven:

- Resident's Rights, Dignity and Consultation
- Safe and Suitable Premises
- Health and Safety and Risk Management, primarily in the fire management systems
- Safeguarding and Safety
- Notification of Incidents
- Governance and Management
- Workforce

Moderate non - compliance was identified in the Health care needs of residents.

The failings are identified at the end of this report including the actions the provider and the person in charge are required to take to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres (Children and Adults) with Disabilities) Regulations 2013.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Major non compliance was identified on the inspection conducted in September 2014 in respect of this outcome and resulted in six breaches of regulation. Inspectors found that improvement had been made in some areas as of this inspection; however significant improvement was still required to ensure that the rights of residents were respected. Improvements had been achieved in the opportunities residents had to take part in activities internal and external to the campus. On arrival to the designated centre, inspectors observed residents in the process of preparing to go out. In the main, inspectors found that over the course of the three days, residents were not present in their home during the day as they were engaging in activities. There was an activation schedule also located in a prominent position and in an accessible format which the provider had committed to developing in response to failings identified on the previous inspection.

Inspectors also observed that the menu was available in an accessible format for the residents which was an action taken by the provider post September 2014. However, inspectors determined that the resources were not utilised consistently and therefore effectively. In one dining area, inspectors observed meals being served to residents. Two of the three main meals of the day are served from a central kitchen. There was an absence of choice offered to residents. Staff stated that choice occurs when the meals are being ordered, which is done twice weekly. Inspectors found this to be an unsuitable arrangement as it suggests that individuals should know what they would like to eat two days in advance. However in contrast to this, inspectors observed in other areas, if a resident did not like their meal, an alternative was offered. Due to the inconsistency in

practice observed, the failing in respect of choice is repeated in the action plan at the end of this report.

As stated in Outcome 8, inspectors reviewed the systems in place for safeguarding residents' finances. Whilst they were robust as regards protecting residents from potential financial abuse, they limited residents' access to their own monies. This was as the persons responsible for accessing the funds worked office hours. Therefore if a resident required access to their monies it had to be identified in advance.

In September 2014, there were also deficits identified in the language utilised regarding residents, therefore the designated centre was not operated in a manner which respected each resident. Improvements were noted by inspectors, who observed staff to engage with residents in a dignified and respectful manner. However, the failing remained, as inspectors reviewed documentation which utilised terminology such as 'not allowed.' This, again, is indicative of a culture of residents' freedom being limited and an absence of choice and control.

Inspectors reviewed the procedures in place regarding the management of complaints and found that it was in compliance with Regulation 34 and there were no complaints recorded as of the day of inspection. There was an independent advocate available and there was evidence that referrals had been made on behalf of residents. This was inconsistent and inspectors found it was primarily influenced by the motivation of the key worker of the resident as opposed to general practice. For example, inspectors found positive examples of residents being supported by the advocate. However, there was also instances where a resident could benefit from the support of an independent advocate. The environment and the collective needs of residents resulted in the designated centre being an unsuitable living environment for the resident. Staff had attempted to advocate on behalf of the resident however there was no evidence that this was effective, and the resident continued to experience negative outcomes as a result.

There were also numerous instances of peer to peer inappropriate behaviour which is discussed further in Outcome 8, however fundamentally significantly impinged on the rights of individuals.

Premises also impacted on the privacy and dignity of residents. Within the four units the risk associated with this varied. For instance, in one area, there was sufficient communal and dining space, however the size of the bedrooms resulted in residents being transferred from their bed into the corridor utilising a hoist. In other areas, there was insufficient communal and dining space for the eight residents residing there. Inspectors determined that the environmental restrictions resulted in an increase in the behaviours of some residents, which impacted on the rights of other residents. One resident was also residing in a room, which in a neighboring unit was a storage room as there was inadequate lighting. Bathrooms were also located off the main communal area. The control measures in place to compensate for this varied throughout the centre. In one area staff ensured that the door was closed at all times. Whilst in another area a screen was in place, however inspectors found that occupants in the communal area could hear all of the activities occurring in the bathrooms.

Judgment:
Non Compliant - Major

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Three failings were identified in respect of premises which resulted in major non - compliance in September 2014. Improvements had been made, however fundamentally inspectors determined that the premises were not fit for purpose as it represented an institutional atmosphere as opposed to a home.

Re-decoration had occurred as stated by the registered provider in the action plan response and inspectors found that the premises were overall in a good state of repair. Inspectors also found that while the provision of communal living space was overall generous throughout the centre, there was limited private accommodation provided for the residents. Inspectors identified that while three units contained a generous amount of communal space for its residents, the fourth unit in the centre had half the communal space and in this case, the communal space was observed to be crowded and with a hectic atmosphere at meal times and other times when all residents were occupying the living space. Each unit in the centre was provided with basic kitchen facilities but most hot meals arrived from the central kitchen on the campus. There was also a unit currently unoccupied that was part of this centre. This unit was provided with seven bedrooms and a communal living space. This unit was found to be a pleasant premises with a homely layout and in a good state of repair. Although it was noted that due to the size of the communal area it would be unsuitable for seven residents. It was also noted that the corridors and access points to this unit were not suitable for residents who required support to mobilise. Two of the units were adapted for use as apartments for individual residents. While the building layout for these units was found to be fundamentally unsuitable as an apartment, the staff had responded to the failings from the previous inspection and had made the units seem as homely as possible through the use of suitable decoration and furnishings.

Inspectors found that while residents were accommodated in single bedrooms in the main, many of the single rooms were not of a size or layout suitable for the needs of the residents. Many of the bedrooms were small, with a number measured by inspectors at

approximately 6 - 9 square metre gross floor area. One room identified was approximately 6 square metres gross floor area and was provided with a very small window at a high level only. The bottom of the window was more than 3 metres above floor level in this case. The limited room sizes lent many of the rooms an institutional feel even though attempts had been made in many cases to personalise the bedrooms through the hanging of photos/pictures and display of personal effects. One of the bedrooms was of a size that made it particularly unsuitable for a resident who required the assistance of a hoist to get in and out of bed. The limited room size meant that it was often necessary to move the hoist into the hall in order to assist the resident in to their wheelchair. This room and the room with the high level window mentioned above were, in the view of the inspectors, clearly not of a size and layout suitable for the needs of the resident.

Inspectors found that some rooms formerly used as bedrooms were now used for the storage of various items throughout the centre. Residents were provided with limited storage within their rooms, which was a failing identified in September 2014 and therefore is repeated at the end of this report. The bedroom doors were provided with key locks on both sides instead of a thumb turn on the bedroom side of the door. This meant that the residents were unable to lock their door if they required privacy as appropriate.

Given the location of the centre within a bigger campus, inspectors found residents had good access to shared facilities for social, cultural and religious activities with the provision of a swimming pool, coffee shop, church and a variety of other facilities on the campus. Inspectors also found the grounds around the centre to be well tended and maintained.

Toilet and bath/shower facilities were found to be provided communally with one communal bathroom being provided within each unit in the designated centre. The layout of the units resulted in residents having to travel from their bedroom through the communal living space in order to use the toilet or bathroom facilities. This layout is not conducive to maintaining the privacy of the resident. There was also significant differences in the standard of bathrooms throughout the unit. Inspectors found some to appear unclean. Therefore the failing is repeated at the end of this report from September 2014.

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):

No actions were required from the previous inspection.

Findings:
Inspectors concentrated on fire precautions in relation to this outcome and did not review risk management or infection control practices in this centre.

With respect to fire safety management, inspectors found that records were maintained largely on a unit by unit basis throughout the centre rather than one set of records for the designated centre as a whole. Inspectors reviewed fire safety management documentation for one of the units and found the standard of record keeping satisfactory in the main. The records included records of daily and weekly fire safety checks by staff and also periodic servicing of fire safety equipment, although there was a sheet provided for contractor inspection of fire doors which was blank. It also included fire drill and training records. The service records for the emergency lighting were unclear in the documentation reviewed.

There was evidence of regular fire drills taking place in the centre including one night time fire drill. However there were no drills recorded that involved evacuation of the centre simulating night time conditions or the use of night time evacuation methods. Therefore inspectors could not be assured that the procedures and staffing level were adequate in the event of a night time evacuation being required at the centre. This was communicated to the provider at the close of inspection.

Inspectors did note that fire safety training was ongoing on the campus and staff attended fire safety training and as conducted a day time evacuation of one of the units during the inspection.

Upon inspection of the centre, inspectors found the building to be divided as appropriate into compartments with fire resistant construction. However, inspectors found many fire doors which had not been provided with self closers, including but not limited to doors to bedrooms and also doors between fire compartments. Inspectors also identified multiple instances of fire doors not provided with the necessary intumescent seals between the door and the frame. Inspectors also observed incidences where the fire door had been provided with a self closer but the self closer was removed or disabled.

Inspectors identified inconsistency in door fastenings on escape routes with some escape doors being provided with thumb turns while others were provided with key locks with a key located in a break glass unit adjacent to the door. This inconsistency applied to internal doors on escape routes as well as to final exits from the building, and is not consistent with good fire safety practice. Inspectors also learned of practices in the centre from speaking to staff where internal doors on escape routes were locked by staff to prevent residents from leaving the centre.

The centre was provided throughout each unit with a fire alarm system and emergency lighting as appropriate. Inspectors also noted that fire fighting equipment was provided where required.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The designated centre had policies and procedures in place for the protection of vulnerable adults. Staff present during the course of the inspection, were in a position to inform inspectors of the appropriate action to be taken in the event of an allegation or suspicion of abuse. However inspectors reviewed the training records and found that some staff were not documented as receiving training in the protection of vulnerable adults. There was also an incident reviewed by inspectors, which was clearly an allegation or suspicion of abuse. There was no evidence that this had progressed through the appropriate procedure or that a preliminary screening had occurred. Inspectors reviewed the systems in place for safeguarding residents' finances and found that there was a clear record maintained of all transactions. However as stated in Outcome 1, the system did reduce the control residents had over their personal finances and the opportunities to access same within a timely manner.

In September 2014, inspectors found that restraint procedures were not applied in accordance with national policy. On this inspection, inspectors reviewed the restrictive practice in place and found that whilst improvement had been made, practice was inconsistent. There were numerous residents who engaged in behaviours that challenge and socially inappropriate behaviour. Of the sample of personal plans reviewed, inspectors found that residents had positive behaviour support plans in place and had been re referred to the positive behaviour support committee. There was a variance in the quality of the behaviour support plans. Inspectors found some plans were comprehensive, reflective of the individual, reviewed regularly and fundamentally had resulted in positive outcomes for residents and a significant improvement in their quality of life. In other instances, inspectors found that the plans were inadequate and did not reduce the instances of behaviour or improve the quality of life of the resident and/or their peers. For some residents it was clearly documented that where and with whom they lived was a factor. There was no evidence that this had been appropriately addressed. There were residents who were prescribed medication as required as a result of behaviours that challenge. In the main, there were appropriate guidance documents

in place to support staff on the administration of same. However improvements were required in the documentation completed to evidence that it was the least restrictive option and the last resort.

Judgment:
Non Compliant - Major

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
An incident which should have been investigated as an allegation or suspicion of abuse had not been investigated in line with policy. Therefore the Authority was not notified as required by Regulation 31 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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):
No actions were required from the previous inspection.

Findings:
There was evidence that residents had regular access to their general practitioner. There were plans of care in place which informed of the actions to be taken to meet the health care needs of residents. Residents were supported to attend appointments with external professionals. There was also evidence that referrals had been made and

residents had been reviewed by Allied Health Professionals such as physiotherapy, occupational therapy and speech and language therapy. Improvements were required in the daily records maintained to ensure that interventions such as clinical observations were recorded daily and if not the rationale for same documented.

A review was also required of the staffing level and skill mix of staff at night to ensure the healthcare needs are met. In one unit non - nursing staff supported residents. However the residents' clinical needs were quite prevalent and nursing care was required regularly. This resulted in nursing staff moving between designated centres regularly to provide this care, however inspectors determined that this was insufficient as it resulted in an absence of continuity of care throughout the night. This also occurred for the administration of medication.

Inspectors reviewed the systems in place regarding the nutritional needs of residents. Staff stated that it was standard practice for the weight of a resident to be recorded monthly. Inspectors reviewed a sample of residents' records and found there had been inconsistency in the regularity and accuracy of the weights recorded. This had been identified by the dietician and subsequently rectified. However inspectors were concerned that due to the gravity of some discrepancies this had not been proactively identified by staff. In one instance a resident was recorded as gaining 12 kg in one month. An entry beside it stated that a recheck was required. There was a one month delay in this occurring. Once checked it was identified that the weighing scales was not operating correctly.

Inspectors observed mealtimes and found that in general residents were supported in a dignified manner to have their meal. However improvements were required. In one area, there was insufficient space to accommodate all residents. In another area, staff were supporting more than one resident at once, which is not appropriate practice. There were also residents who received their nutritional needs via Percutaneous endoscopic gastrostomy (PEG). There were plans of care in place for the resident, however inspectors observed that the supports required were not implemented in practice. For example, for one resident it was documented as the support of two staff was required. The inspector observed only one staff present.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The line management structure of the designated centre involved the person in charge being supported by a clinical nurse manager 2. The person in charge reported to the Director of Care and Support who in turn reports to the Director of Service. There had been two Clinical Nurse Managers in place prior to the inspection, however this structure had changed due to staff absenteeism in recent months. The person in charge was not present on the three days of inspection. Therefore the inspection was facilitated by the Clinical Nurse Manager 2 and front line staff.

As stated throughout the report, there were variances in the quality of care provided to residents. Inspectors spoke to staff who stated that this was due to the change in management structure and the reduction in front line management. This was further supported by deficits identified in the planned roster. Inspectors identified that there were gaps in the roster for the coming days however staff were not in a position to confirm if the gaps had been identified to the allocations team and if arrangements had been made to fill the gaps. Inspectors determined that this practice did not promote continuity of care to residents. There was also evidence that in the absence of the Clinical Nurse Manager 2, there was no clear reporting structure to ensure that there were appropriate numbers of staff available.

There was no evidence that a review of the quality and safety of care provided.

The cumulative findings of this inspection demonstrated that the systems in place were ineffective and that areas of positive outcomes for residents were due to competence of individual staff as opposed to robust systems.

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):
Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:
An action arising from the previous inspection was that the number of staff to meet the needs of residents were not appropriate. Inspectors observed improvements in this area on this inspection particularly in relation to residents' opportunities to engage in recreational activities. However additional improvements were required as:

- The skill mix of staff at night in one area was inappropriate
- Inspectors observed a resident being delayed having their shower as they required the support of two staff, however only one was available
- Staff were assisting numerous residents at once during mealtimes

Staff supervision was also required to ensure that deficits identified by inspectors were proactively identified and staff were provided with the appropriate training and support.

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:

Jillian Connolly
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-0003988
Date of Inspection:	08 April 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 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:
There was an absence of choice for some residents at mealtimes. Residents were also restricted in the times that they can access their personal finances.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
Choice at mealtimes:
1. The Person In Charge will introduce Menu Planning discussions for residents and staff to ensure their involvement in choosing meals, which will take place between two and three times a week. One of these discussions will take place during the weekly Residents Meetings and will be noted in the minutes.
2. The Person In Charge will ensure that a variety of alternative food choices continues to be stocked in all locations in this Designated Centre.
3. The PIC will ensure staff are aware of all alternative options available for residents in all locations in this DC.
4. In addition to the pictures of main meals posted daily on the menu boards in each location, the PIC will organise pictures of available alternative food options to be taken, printed and laminated for each location to support meaningful communication with residents while choosing their preferred meal choices.
5. The PIC has confirmed with the Catering Department that should the need arise, when available alternatives in the location are not chosen, an alternate meal can be prepared and provided for any resident in this DC at short notice.
6. The General Manager of this Service is currently Chairing a review of menu options with the Catering Department in conjunction with the Dietician, with the objective of increasing choices of food on the menu each day.

Access to finances:
1. The process of Reviewing residents long stay charges has commenced for all residents of this Designated Centre. This process will entail looking at resident's bank accounts and financial records.
2. A Committee has been established to review compliance with Saint John of God Service Users Finance Policy and national best practice. As part of the work of this committee, a review will be taking place with regard to signatories for residents accounts.
3. All recommendations from this Committee will be actioned and implemented. 30/11/2015
4. The PIC will arrange for residents to participate in their financial affairs through residents having a lived experience of withdrawing monies from their bank accounts, should they wish to do so and this will be contained within each residents financial passport with the involvement of their circle of support.

Proposed Timescale:
Choice at mealtimes:
1. 24/07/2015
2. Completed
3. 31/07/2015
4. 14/08/2015
5. 9/07/2015.
6. 14/09/2015

Access to finances:

1. 30/11/2015
2. 30/11/2015
3. 30/11/2015
4. To commence by the 17/07/2015

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Language utilised in documentation was not appropriate.

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

Please state the actions you have taken or are planning to take:
1. The Person In Charge will organise the re-induction of all staff members in the Saint John of God Community Services Policy on Rights Protection and Promotion of Rights in Intellectual Disability Services in this DC, which will also incorporate the HSE document Towards a Restraint Free Environment for Nursing Homes.
2. The Person In Charge will place Regulation 9 (1) on the agenda once a month for staff meetings.

Proposed Timescale:

1. 30/09/2015
2. 14/08/2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistent advocacy supports for residents.

3. Action Required:
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

Please state the actions you have taken or are planning to take:
1. The Person In Charge has advised all staff about the National Advocacy Services and has ensured that all locations in this Designated Centre have signage regarding NAS

and the specific local external advocate for this Designated Centre.
2. The PIC will contact NAS and invite the external advocate to visit the DC and meet with residents and staff
3. The PIC will organise the re-induction of all staff members in the Saint John of God Community Services Policy on Rights Protection and Promotion of Rights in Intellectual Disability Services in this DC, which will also incorporate the HSE document Towards a Restraint Free Environment for Nursing Homes.

Proposed Timescale:
1. Completed
2. Completed
4. 30/09/2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The privacy and dignity of residents were impinged on due to the unsuitability of the environment and the collective needs of the residents residing together.

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

Please state the actions you have taken or are planning to take:
1. The Person In Charge is organising a risk assessment of bedrooms/bathrooms on an individual basis in order to organise a self closing device to be placed on the door leading to the main bathroom in the identified location to provide privacy for residents.
2. One resident will transition to an alternative house within the Designated Centre to provide more appropriate living and sleeping accommodation to meet his needs which will promote his privacy and provide more appropriate communal and dining space.
3. The Person In Charge will has identified the environmental areas requiring improvement in relation to the current toilets and bathroom facilities and a plan of work is being scheduled for completion.
4. As part of the De-congregation Implementation Planning Committee which commenced on 28/05/2015, a transitional plan will be completed for each resident within this Designated Centre which is informed by the results of a Supports Intensity Scale Assessment carried out for each resident with regard to ensuring the most appropriate living environment within the community for each resident.
5. The De-congregation Plan will address the unsuitable living environments for residents on a longer term basis while identifying a more suitable living environments for residents within the campus based residential services on a shorter term basis should this option be available.

Proposed Timescale:
1. 30/08/2015
2. 31/07/2015
3. 30/11/2015
4. 30/08/2015
5. 30/10/2015

Proposed Timescale: 30/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate communal space for the number of residents residing in one unit. There was also an absence of private space inclusive of the inability of residents to lock their bedroom doors if appropriate. There was inconsistency in the suitable standards of bathrooms.

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

Please state the actions you have taken or are planning to take:
1. The number of residents living in one area will reduce to alleviate the overcrowding in the communal dining and living environment with one resident transitioning to another house.
2. The PIC will review on an individual basis, and where required, will complete a risk assessment for residents regarding the use of thumb turn locks on their bedrooms.
3. The PIC will has identified the environmental areas requiring improvement in relation to the current toilets and bathroom facilities in one identified location and a plan of work is being scheduled for completion.
4. As part of the De-congregation Implementation Planning Committee which commenced on 28/05/2015, a transitional plan will be completed for each resident within this Designated Centre which is informed by the results of a Supports Intensity Scale Assessment carried out for each resident with regard to ensuring the most appropriate living environment within the community for each resident.
5. The De-congregation Plan will address the unsuitable living environments for residents on a longer term basis while identifying a more suitable living environments for residents within the campus based residential services on a shorter term basis should this option be available.

Proposed Timescale:
1. One resident will commence transitioning on Monday 13th July 2015 which will reduce the numbers in this location by one.
2. 31/07/2015
3. 17/07/2015

4. 30/10/2015

Proposed Timescale: 30/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In one area of the centre, the corridors and the access points were not suitable for residents with limited mobility.

6. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
1. Works are currently underway in this location which includes ramps to the front.
2. The preadmission assessment of potential residents prior to moving to this location will include mobility assessment.
3. Each resident will have a Supports Intensity Scale Assessment completed by 30/08/2015 and this will inform their individualised support needs in all aspects of their lives and it will also inform the model of service to best meet their needs and the appropriate skill mix of staff.

Proposed Timescale:
1. 10/7/2015.
2. 10/07/2015
3. 30/10/2015

Proposed Timescale: 30/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors determined that the designated centre was fundamentally unsuitable in meeting the needs of the residents as: -
- There were too many residents residing in one area
- The layout of the apartments were unsuitable
- The bedrooms were of an inadequate size
- The windows in some bedrooms were of a height that residents could not look out
- The location of the bathrooms

7. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed

and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
1. As part of the De-congregation Implementation Planning Committee which commenced on 28/05/2015, a transitional plan will be completed for each resident within this Designated Centre which is informed by results of a Supports Intensity Scale Assessment carried out for each resident with regard to ensuring the most appropriate living environment within the community for each resident.
2. The De-congregation Plan will address the unsuitable living environments for residents on a longer term basis while identifying a more suitable living environments for residents within the campus based residential services on a shorter term basis should this option be available.

Proposed Timescale: 30/10/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear from documentation as to whether the emergency lighting had been serviced when required.

8. 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. The PIC has sourced the relevant documentation which evidences the emergency lighting service was completed in February and since inspected again in May 2015.
2. The Management of the Service commissioned a Fire Safety Consultancy Company to complete house specific fire and evacuation training to all staff
3. The Management of the Service commissioned a full review of this Designated Centre by a Fire Safety Consultancy Company with recognised expertise in this area.
4. The Fire Safety Consultancy Company has presented a fire safety plan which identifies high, medium and low risks.
5. The Management of this Service is currently actioning and completing all risks associated with this Designated Centre as outlined in this report and as identified during the inspection visit relating to regulation 28 (2) (b) (i) based on priority rating.
6. Alongside this a Fire Protection and Fire Safety Company have been commissioned to assess the emergency lighting and fire signage resulting in recommendations which will be actioned and completed.

Proposed Timescale:
1. Completed

2. Completed
3. 31/08/2015
4. 31/08/2015
5. 31/08/2015
6. 31/08/2015

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no record of fire drills carried out simulating night time conditions and staffing levels in the centre.

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

Please state the actions you have taken or are planning to take:
1. The PIC will organise that an identified Clinical Nurse Manager III on night duty will organise a deep sleep drill to occur in all five locations of this Designated Centre in July 2015 which will include a full evacuation of all residents.
2. A deep sleep drill will be scheduled once a year, alongside three day time drills which will also entail full evacuations of the locations.
3. The Management of the Service commissioned a Fire Safety Consultancy Company to complete house specific fire and evacuation training to all staff

Proposed Timescale:
1. 31/07/2015
2. 13/07/2015
3. Completed

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors identified a number of fire doors which had not been provided with self closers, including but not limited to doors to bedrooms and also doors between fire compartments. Inspectors also identified multiple instances of fire doors not provided with the necessary intumescent seals between the door and the frame.

10. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for

detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
1. The Management of the Service commissioned a Fire Safety Consultancy Company to complete house specific fire and evacuation training to all staff
2. The Management of the Service commissioned a full review of this Designated Centre by a Fire Safety Consultancy Company with recognised expertise in this area.
3. The Fire Safety Consultancy Company has presented a fire safety plan which identifies high, medium and low risks.
4. The Management of this Service is currently actioning and completing all risks associated with this Designated Centre as outlined in this report based on priority rating and this includes the failings as identified during the inspection visits as outlined under regulation 28(3) (a) .
5. Alongside this a Fire Protection and Fire Safety Company have been commissioned to assess the emergency lighting and fire signage resulting in recommendations which will be actioned and completed.

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

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Doors on escape routes were not easily openable in the direction of escape.

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

Please state the actions you have taken or are planning to take:
1. The Management of the Service commissioned a Fire Safety Consultancy Company to complete house specific fire and evacuation training to all staff
2. The Management of the Service commissioned a full review of this Designated Centre by a Fire Safety Consultancy Company with recognised expertise in this area.
3. The Fire Safety Consultancy Company has presented a fire safety plan which identifies high, medium and low risks.
4. The Management of this Service is currently actioning and completing all risks associated with this Designated Centre as outlined in this report based on priority rating and this includes the failings as identified during the inspection visits as outlined under regulation 28(3) (a) .
5. Alongside this a Fire Protection and Fire Safety Company have been commissioned

to assess the emergency lighting and fire signage resulting in recommendations which will be actioned and completed.
6. The Person In Charge is risk assessing all areas which require facilities to be locked and actioning this.
7. All residents within this Designated Centre has a up todate Personal Emergency Evacuation Plan in place which outlines the most appropriate supports for residents in the event of an emergency.

Proposed Timescale:
1. Completed
2. Completed
3. Completed
4. 30/08/2015
5. 20/08/2015
6. 30/06/2015

Proposed Timescale: 30/08/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to ensure that all restrictive interventions utilised were the least restrictive method.

12. 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 PIC will conduct an audit of restrictive interventions in place for all 22 residents of this DC and will put measures in place to ensure staff awareness surrounding the requirement that interventions used are as a last resort and the least restrictive alternatives.
2. The PIC will organise Practice Development sessions relating to documenting the use of restrictive interventions; to ensure documentation addresses reason for the restrictive intervention, alternative non-restrictive interventions tried or considered and ruled out, and to justify the level and duration of restrictive interventions.
3. All staff has been inducted into the all existing Behaviour Support Plans and revised plans.
4. All new staff is inducted on commencement of employment into each residents, critical information sheet and behaviour support plan and this is managed by the Manager/Shift Leader.

Proposed Timescale:

1. 16/10/2015:
2. 30/09/2015
3. On-going
4. On-going

Proposed Timescale: 16/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in the quality of the positive behaviour support provided to residents.

13. 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. The PIC will conduct a review of all Positive Behaviour Support (PBS) needs for Residents; any resident identified as requiring additional support will be referred to the Positive Behaviour Support Committee for assessment and development of a Behaviour Support Plan.
2. The PIC will put measures in place to ensure staff awareness surrounding the requirement that interventions used are as a last resort and the least restrictive alternatives.
3. The PIC will organise Practice Development sessions for staff in the DC regarding Positive Behaviour Support culture and practice and the implementation of PBS for residents.
4. The Person In Charge and Clinical Nurse Manager will meet with all staff to address the need to support residents who present with behaviours that challenge in an appropriate and timely manner as per each resident's Behaviour Support Plan.
5. All staff has been inducted into the all existing Behaviour Support Plans and revised plans.
6. All new staff is inducted on commencement of employment into each resident's critical information sheet and behaviour support plan and this is managed by the Manager/Shift Leader.
7. All recommendations from Positive Behaviour Support Sub Committee relating to immediate strategies to support residents who present with behaviours that challenge is implemented.

Proposed Timescale:
1. Review to be completed by 30/09/2015: staff discussion around review and any identified actions to be taken shall be completed by 16/10/2015.
2. 30/09/2015
3. 30/09/2015

4. 01/09/2015
5. On going
6. On going

Proposed Timescale: 16/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that all staff had received training in the protection of vulnerable adults.

14. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
1. The Person In Charge has reviewed all Human Resource Department records which shows all staff have received this training. A copy of these records is now in place in the DC for inspection.
2. All new staff will receive Safeguarding for Vulnerable Adults training before commencement in employment
3. Induction takes place for all new staff on their first day of employment which includes introduction to safeguarding policy and Designated Liaison Persons role.
4. The recommendations of the Independent Safeguarding Review as commissioned by the management of the service will be implemented for this Designated Centre.
5. Compliance with the Safeguarding Vulnerable Adults Policy will be discussed at staff team meetings.

Proposed Timescale:
1. Complete
2. On going
3. On going
4. 31/08/2015
5. 14/08/2015

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found evidence of an allegation or suspicion of abuse which had not been investigated in line with policy.

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

Please state the actions you have taken or are planning to take:
1. The PIC has advised the Director of Service in relation to this non-compliance in relation to the delay in the screening of this Safeguarding incident.
2. All incidents of a safeguarding nature are recorded by staff and are forwarded immediately to the Designated Liaison Person.
3. PIC has established a log of safeguarding report forms completed and sent to Designated Liaison Person to ensure evidence of reports completed is available in the DC for inspection and for review with staff team.
4. The recommendations of the Independent Safeguarding Review as commissioned by the management of the service will be implemented for this Designated Centre. This review is also looking at compliance at all levels with Safeguarding Vulnerable Adult Policy throughout the service.
5. Compliance with the Safeguarding Vulnerable Adults Policy will be discussed at staff team meetings.

Proposed Timescale:
1. 08/07/2015
2. Completed
3. 08/07/2015
4. 30/08/2015
5. 30/07/2015

Proposed Timescale: 30/08/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The Chief Inspector had not been notified of an allegation or suspicion of abuse.

16. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
1. The Person In Charge will ensure that the Chief Inspector will be notified within three working days with regard to an occurrence in the designated centre of any allegation , suspected or confirmed, abuse or any resident.
2. The Person In Centre continues to ensure that all incidents of a safe guarding nature is reported within the appropriate timeframes to the Designated Liaison Person as per

the policy.
3. The Person In Charge ensures that all recommendations from the preliminary screening process is implemented to safeguard residents.
4. The Person In Charge has advised the Director of Service in relation to this non-compliance, specifically the delay in the screening of this Safeguarding Submission which was outside the timeframe of the Organisational Safeguarding Policy, despite the original Allegations of Abuse / Safeguarding Report Form being sent the day of the incident (10/02/2015).
5. PIC has established a log of safeguarding report forms completed and sent to Designated Liaison Person to ensure evidence of reports completed is available in the DC for inspection and for discussion with the staff team.
6. The recommendations of the Independent Safeguarding Review as commissioned by the management of the service will be implemented for this Designated Centre. This review is also looking at compliance at all levels with Safeguarding Vulnerable Adult Policy throughout the service.

Proposed Timescale:
1. 10/07/2015
2. 30/02/2015
3. 30/11/2015
4. 08/07/2015
5. 01/06/2015
6. 30/08/2015

Proposed Timescale: 30/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to ensure daily records were reflective of the health care needs of residents being met.

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

Please state the actions you have taken or are planning to take:
The Person In Charge will organise Practice Development sessions for staff in the Designated Centre regarding compliance with this regulation, specifically in the area of daily record taking and in the upkeep of individuals Personal Plans.

Proposed Timescale: 30/09/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient staff at mealtimes to provide the support documented in the personal plan of the resident.

18. Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
1. The Person in Charge and Clinical Nurse Manager II will complete a review with regard to identifying each resident's specific mealtime support needs and providing individualised supports to maintain this.
2. Information Sessions will be provided to all staff to promote a culture of positive meal time experience within this Designated Centre. This will be facilitated by the Quality Advisor through Practice Development and at staff team meetings with Person In Charge and Clinical Nurse Manager II.
3. The Person In Charge will ensure all staff are aware of each residents eating support needs through discussion at formal Team Meetings and at informal staff discussions.

Proposed Timescale:
1. 30/08/2015
2. 30/09/2015
3. 31/07/2015

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:
Staff were not clear of the reporting mechanisms in the absence of front line management or the member of management responsible in the absence of the person in charge or the clinical nurse manager 2.

19. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
1. A clear organisational structure for this Designated Centre is in operation, depicting

the lines of responsibility within the designated centre and within the larger campus, all of which have been approved and communicated to staff.
2. Signage is in place regarding the management structure in each location.
3. The Person In Charge will organise Practice Development sessions regarding the Governance & Management system in place for this Service.
4. This Designated Centre has a full time Person In Charge who is Supernumary
5. In the absence of Person In Charge or Clinical Nurse Manager, a shift leader is in place who will have responsibility for the management of a person centred meal time experience.

Proposed Timescale:
1. Complete
2. Complete
3. 30/09/2015
4. 30/11/2015
5. 1/11/2015

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the quality and effectiveness of the services provided were monitored effectively.

20. 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. This Designated Centre has a full time Person In Charge who is supernumary.
2. This Designated Centre has a full time Clinical Nurse Manger 2 who has twelve hours supernumary time. All provision of service is overseen and governed by direct line management communication, and through the support of committees and meetings. There are clearly defined management structures in this DC and the quality and effectiveness of the service provided through the following:
3. The Person In Charge currently reviews all Adverse Incident Rreview Forms as they occur.
4. Safeguarding concerns / issues are discussed at Team Meeting at the end of each month.
5. Weekly Designated Centre meetings are in place which are chaired by the Person In Charge and attended by the Director of Care and Support, to progress the Quality Enhancement Plan for the Designated Centre and review all risks associated with the Centre.
6. An weekly Implementation meetings takes place with all Persons In Charge chaired by the Director of Care and Support to review all key actions to support a consistent

approach to the delivery of a person centred safe service for all residents.
7. A weekly Strategic Implementation Group Meeting takes place with the Provider Nominee, Regional Director, Director of Care and Support, General Manager, Quality Manager to review, address and progress all key actions and risks for all Designated Centres.

Proposed Timescale:
1. 30/11/2015
2. 30/01/2015
3. 29/04/2015
4. 29/04/2015
5. 29/04/2015
6. 29/04/2015
7. 29/04/2015

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient staff on duty to meet the assessed needs of residents at times throughout the day.

21. 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. The Person In Charge has rearranged staff break times to maximise staff support for residents during the meal time experience
2. The Person In Charge in consultation with the Director of Care and Support and Clinical Nurse Manager 2 is reviewing the current roster/level of staffing and skill mix following on from the completion of the Supports Intensity Scale Assessment for residents in this Designated Centre.

Proposed Timescale:
1. 22/06/2015
2. 30/08/2015

Proposed Timescale: 30/08/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no nurse on duty at night in the designated centre.

22. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
1. A full time Staff Nurse will be rostered on duty at night within the location identified and in the interim this Designated Centre is receiving nursing supports at night time.
2. The Person In Charge in consultation with the Director of Care and Support and Clinical Nurse Manager 2 is reviewing the current roster/level of staffing and skill mix following on from the completion of the Supports Intensity Scale Assessment for residents in this Designated Centre.

Proposed Timescale:
1. 30/09/2015
2. 30/08/2015

Proposed Timescale: 30/09/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of staff supervision.

23. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
1. The Person In Charge in consultation with the Director of Care and Support and Clinical Nurse Manager 2 is reviewing the provision of supervision to this Designated Centre based on the current needs of the Centre which is informed by the outcome of the Supports Intensity Scale Assessment for residents in this Designated Centre and the recommendations of the De-congregation Implementation Committee.
2. In the absence of the Person In Charge and Clinical Nurse Manger II, a Shift Leader is in place.
3. All new staff receives a comprehensive induction on the job on their first day of employment which includes introduction to each resident’s critical information sheets/health care plans and behaviour support plans.

Proposed Timescale:
1. 30/09/2015

2. 1/11/2015
3. 1/11/2015

Proposed Timescale: 01/11/2015