

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by St John of God Community Services Limited
<b>Centre ID:</b>	OSV-0003642
<b>Centre county:</b>	Kildare
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St John of God Community Services Limited
<b>Provider Nominee:</b>	Philomena Gray
<b>Lead inspector:</b>	Conor Brady
<b>Support inspector(s):</b>	Sheila Doyle
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	22
<b>Number of vacancies on the date of inspection:</b>	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: 01 October 2015 07:00 To: 01 October 2015 16:30

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

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

**Summary of findings from this inspection**

HIQA became significantly concerned about the safety and the quality of life for residents in St Raphael's campus, a residential service operated by St John of God Kildare Services. St Raphael's residential campus contains seven designated centres providing residential services to 137 people with intellectual disabilities.

Following the initial inspections in 2015, inspectors undertook a series of ten planned inspections to assess the progress of the provider in addressing the issues of concern which were impacting on the lives of residents.

These unannounced inspections found evidence of institutional practices, poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued a series of immediate actions, warning letters and held regulatory and escalation meetings with the provider and members of senior management.

Due to a failure of the provider to implement effective improvements for residents, HIQA issued notices of proposal to cancel the registration of three of the centres on this campus. The provider subsequently issued HIQA with plans for the closure of one designated centre, and transitional plans to provide alternative living

arrangements for a number other residents which addressed the resident's safety, welfare and quality of life.

The most recent inspections have confirmed that the provider has undertaken substantive changes in governance and management across this campus. There have been improvements in staffing, persons in charge and other management positions. While there continues to be non compliances, and further improvements are required in relation to the quality of life for residents, the provider has demonstrated that they are now taking effective action to achieve these improvements.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection report specifically relates to an unannounced inspection of one designated centre owned and run by St. John of God Services in North Kildare. The centre provides care for 22 residents and at the time of this inspection there was one vacancy. This was a follow up inspection that looked at specific outcomes since HIQA's previous inspection whereby substantive non compliance with the Regulations and Standards was found.

The centre is comprised of a large 'secure unit style' building that was separated into 4 individual units. It was built/opened in 2001 and was described as providing care for residents with high dependency needs and complex behaviours that were challenging. In addition to the main centre, there was an apartment located across the campus in which one resident lived, according to the Statement of Purpose this apartment also featured as part of this designated centre. Inspectors did not inspect this apartment as part of this inspection but did meet the resident who lived there.

Inspectors saw some evidence of good practice and individualised service provision within the centre for example, while the centre was a secure unit by design there were some clear and evident efforts made to make it homely in some respects.

However, there were a number of areas of concern found for example, inspectors were concerned with the mix of residents, high levels of risk prevalent, a number of accidents, incidents and safeguarding concerns, governance and management deficits and staffing/workforce issues. Some of these specific issues were highlighted to the provider on the previous inspection in March 2015. Inspectors found this centre remained in substantive non compliance with the Regulations and Standards in all 7 outcomes inspected against.

These outcomes are discussed in more detail in the main body of this report and accompanying Action Plan.

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

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspectors found examples of both positive and negative areas of practice development in this area. Since the previous inspection the inspectors noted some work that had occurred in the completion and updating of annual health assessments and the reviewing and updating of some residents personal outcome measures. In addition, there was some evidence found of the setting of new social goals and objectives. Inspectors also observed some residents being offered activities and choices on this inspection.

However, further improvement was required in terms of a consistent approach to social care planning with residents and ensuring plans were comprehensive, effectively monitored. Improvement was also required to ensure that the plans in place guided staff appropriately and were accessible to residents.

On the day of inspection many residents were observed getting up and going out on activities. For example, a resident was seen going out with staff down the town, another resident was observed going to buy a new mobile phone and another resident was being offered choices in activities such as aromatherapy, massage and going to the cinema.

Inspectors reviewed a number of personal plans as part of this inspection. It was evident that a new 'My Personal Plan' was being implemented and information was being transitioned from old plans to new plans. However, inspectors did find gaps whereby information had been archived in the absence of plans being formulated in the residents' new folders.

Inspectors found some evidence of residents meeting social goals such as a resident who wanted to go to the beach was taken to the beach for a day trip. Another resident had new goals set since the previous inspection whereby he wanted to pursue hillwalking and photography. This was positive.

Inspectors also found instances whereby social care planning and outcome based priority goal setting needed further improvement. For example, inspectors found instances whereby residents' goals not achieved in 2014 were being reintroduced in 2015 to be achieved by 2016. This demonstrated a lack of meeting residents goals and the acceptance of long time frames afforded for the pursuit of basic activities.

For example, a resident seeking to go for dinner in a restaurant, to go on a holiday and to have an overnight stay with family. This resident did not go on holiday (as outlined as a social goal) and the reason in his personal plan was recorded as 'not achieved due to changes to policy in regard of using service users personal finances to fund supports'. This was dated 7/3/2015.

Inspectors found evidence of very basic annual goal setting in some residents' plans as opposed to meaningful skills teaching or the pursuit of life skill enhancement objectives. For example, a goal to 'go for coffee' or 'go for lunch' which are basic social activities that should feature in residents everyday lives.

Personal plans reviewed were not accessible to residents. For example, residents who could not read could not relate in any way to their plans. While a number of plans had been reviewed since the previous inspection the content and time frames of some plans required further attention as highlighted above.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

Inspectors found that while there were some measures in place regarding the management of risk, including a risk management policy which met the requirements of the Regulations, further improvement was required in this area.

Inspectors found evidence that risk management training had been provided to a number of permanent staff since the previous inspection. However, this training did not extend to agency staff according to records reviewed.

Residents highlighted on the previous inspection as a risk of falls had subsequently been reviewed by the physiotherapist. In addition, residents' individual personal evacuation plans had been updated since the previous inspection which was a previous failing identified.

Risk was now observed to be on the agenda of team meetings and the person in charge highlighted a clear commitment to managing risk in a proportionate manner. However, inspectors were concerned that due to the resident mix in this centre that levels of risk prevalent and the potential for serious incidents remained high in this designated centre. this will be discussed further under Outcome 8.

Inspectors found that preliminary data collection of risk had taken place however, the person in charge highlighted that a risk register was yet to be formed. The inspectors found that due to the high number of risk areas identified in residents' personal plans that mainly pertained to residents behavioural risks, a more comprehensive and robust management system pertaining to risk was required.

The inspector was informed that two external bodies had recently been involved in separate investigations of incidents within the centre. Reports regarding these matters were requested from the provider and information was subsequently provided. These reports/information relate to serious/critical incidents that had occurred within this centre. The inspector was concerned that in one case a residents' multidisciplinary support team highlighted the centre was not an appropriate environment to support the resident.

Documentation reviewed highlighted clinical concerns that the intensity and severity of the incidents were the concerning issue opposed to the frequency of the incidents. Three serious incidents since January 2015 were highlighted regarding a resident whereby another resident and staff all received injuries. 50-60% of behavioural incidents with this resident were highlighted as 'linked to the environment' as it was not 'low arousal' and was 'naturally stressful' which failed to meet this resident's needs.

From a fire safety perspective, inspectors were concerned to observe a practice whereby fire doors were being held open (against each other) rendering them ineffective should a fire occur. For example, residents' bedroom doors were opened and toilets (located outside residents' bedrooms) were also opened and the two doors were held open against each other. This issue was highlighted to the provider to be immediately rectified and assurances were given to the inspectors at preliminary feedback that this practice would cease immediately.

**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:**

Inspectors found that there had been some developments since the previous inspection in certain areas highlighted. For example, inspectors were informed that the purposely designed seclusion room was no longer to be used to seclude residents. However, inspectors found that the centre remained restrictive by design and were concerned in reviewing documentation that there was a substantial number of safeguarding incidents and a mix of residents that was not appropriate.

Inspectors observed residents who were agitated and displayed behaviours that may challenge. For example, residents were observed hitting out and attempting to hit/strike staff over the course of the inspection. Familiar staff were observed on duty who knew residents and were observed attempting to support residents with dignity and respect during these incidents.

In terms of resident safety the inspectors found that a number of residents were identified as a risk due to the behaviours they presented with. For example, a number of residents were described in care planning documentation and by staff as aggressive and displaying behaviours such as self injurious and violence towards other residents and staff. Inspectors found incidents whereby a number of different residents were physically aggressive towards other residents. Inspectors were therefore not assured that all residents were being protected from harm in this centre.

Inspectors were made aware of a serious critical incident that occurred in the centre whereby seclusion was highlighted as necessary and a staff member was injured. A full report was requested from the provider in respect of this incident.

Inspectors found that one resident who was very vulnerable due to their behaviours, presentation and lack of awareness of risk, was living in a centre with residents who were identified to the inspector as posing a sexual risk. This resident was observed walking into a unit unaccompanied and inspectors observed staff redirected the resident from the unit. When the inspector questioned why the resident was in the unit staff stated the resident should not be in that unit. While inspectors were informed there had been no incidents, the arrangements in place did not provide assurances that all



residents would be safe from possible abuse.

The inspector reviewed this resident's 'Are you Safe' care plan and 'Intimate Care Plan' (both dated 30 September 2015). Inspectors found these plans to be contradictory. For example, one plan stated the resident required a lot of support with intimate care while the other plan stated the resident carried out this task independently. This contradiction meant that staff could not be sure of the appropriate care needs of this resident.

Regarding positive behavioural support inspectors noted that while referrals had been made for residents all were not yet in place. For example, the inspector did see referrals made by the provider for a resident dated 9 March 2015 but no assessment had been conducted. The person in charge stated this was due to a decline in the resident's mental health.

Regarding restrictive practices the environment in this centre was found to be restrictive by design. While a staff member clearly highlighted that there was an increased and growing awareness of the rights restrictions prevalent within the centre and highlighted that some doors had been opened in recent months, this centre remained a restrictive environment. For example, there were signs highlighting the kitchen should not be locked however, the kitchen was observed to be continually locked with food provided to residents through a hatch window.

Inspectors were concerned with the use of an operational camera in a resident's bedroom which had an observation monitor in the staff office. Staff spoken with stated the purpose of the camera was to observe the resident at night. Inspectors were informed that this was due to this resident's presentation and risk of falls. While multi-disciplinary input had been involved, there was not sufficient evidence to indicate lesser restrictive alternatives had been tried to ensure the residents privacy dignity and safety were maintained.

When inspectors asked for the organisations policy on the use of CCTV it was not available and staff were not familiar with this issue.

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

**Findings:**

Improvements were required to ensure that each resident's wellbeing and welfare was maintained by appropriate medical, nursing and allied health care.

Inspectors reviewed the management of nutrition. Some residents had been referred to a dietician and recommendations were in place. However, these were not used to inform a specific care plan on nutrition. Inspectors did see that residents' weights were recorded on a regular basis however, some gaps were noted in the assessment tools. Some residents had this completed whilst others did not.

Inspectors were concerned about the quality and safety of food served to residents. Staff spoken with were unclear of the procedure for the chilling and reheating of meals which were provided from a central kitchen. In addition, inspectors could not find evidence that additional choices were available to residents who required their meal in a modified consistency.

Inspectors saw that in some cases residents did not like what was available on the menu for dinner. One resident told the inspector that they had bought noodles themselves which they enjoyed. Staff confirmed that residents did buy some food themselves such as particular cereals, tins of fish, crackers and yogurts. This was discussed in detail with the provider at the feedback meeting.

Inspectors also noted that desserts were not available within the centre even though some residents required additional nutrition as they had lost weight. Residents told inspectors how much they liked to get a dessert occasionally and described in detail the desserts that were previously available.

Inspectors were also concerned regarding the lack of documentation of care relating to pressure area management. Inspectors were told that a particular resident was nursed on a specialised mattress when in bed. Staff spoken to were not aware of the required setting of this mattress and the care plan in place for skin integrity did not provide sufficient detail to inform practice.

Similar gaps were noted in the documentation of other clinical issues such as difficulty with breathing and dry skin conditions. Staff spoken with were aware of the procedures to follow for these issues but these were not documented in a specific care plan.

Residents had access to general practitioner (GP) services and out of hours cover was provided. An annual health check was carried out including routine bloods, blood pressure recordings etc. Residents also had access to a range of other services on referral including speech and language therapy (SALT) and occupational therapy (OT) services and physiotherapy. Chiropody, dental, audiology and optical services were also provided. Inspectors reviewed residents' records and found that some residents had been referred to these services and results of appointments were written up in the residents' notes.

**Judgment:**

Non Compliant - Moderate

## **Outcome 12. Medication Management**

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

### **Theme:**

Health and Development

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

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

### **Findings:**

Inspectors were not satisfied that the centre had appropriate and suitable practices relating to the receipt, prescribing, storing and administration of medicines.

Inspectors reviewed a sample of prescription and administration records and noted that improvements were required. Issues identified at the previous inspection had not been addressed although the agreed timescale had passed.

As at the previous inspection, inspectors were concerned that medications which were to be crushed were not individually prescribed as such, in line with professional guidelines. Prescriptions for medications to be administered as and when required (PRN) did not consistently state the maximum dose that could safely be administered in 24 hours.

In one case reviewed, it was unclear how soon a second dose could be administered. Protocols in place were not sufficiently detailed to provide adequate guidance. Inspectors remained concerned that, in some cases, staff were administering medications from prescription records which they could not read.

A secure fridge was provided for medications that required specific temperature control. Inspectors reviewed the temperature which was within acceptable limits at the time of inspection. However, inspectors saw that the required daily monitoring of the temperature was not consistently recorded. Several gaps were evident and staff spoken with were unclear what the acceptable range of temperature was. In addition inspectors noted that food items were stored in the fridge including yogurts and a can of coke.

Previous safeguarding practice in relation to checking the medication against the prescriptions on receipt from pharmacy had not taken place for the most recent orders, staff spoken with were unclear why this was the case. In addition inspectors could not find evidence that any recent audits were carried out in the centre.

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

**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):**

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

**Findings:**

Overall inspectors were not satisfied that the governance and management systems in place were fully effective and required further improvements to be in compliance with the Regulations and Standards.

Inspectors found that while there was a person in charge in place who knew residents well, this centre required a full time person in charge that was not also responsible for other designated centres. The person in charge in this centre managed two large campus based designated centres for residents with complex needs. This was not found to be resulting in effective levels of operational governance and management of this centre as evidenced in the non compliance found on this inspection.

Inspectors found some evidence of actions completed since the previous inspection. For example, a Quality Enhancement Plan (17 September 2015) was reviewed and highlighted areas of governance and management that were addressed since the previous inspection. For example a review of organisational structures. This was communicated with all staff via an email sent out on 10 August 2015. A new Residential Service Programme Manager was recruited since the previous inspection. However, this plan was not fully implemented at time of inspection and there were areas such as safeguarding, restrictive practice and positive behavioural support that remained incomplete.

The person in charge in place met the requirements of the Regulations in terms of experience and qualifications. The person in charge informed the inspector that she was involved in this centre since it opened in 2001 and presented as knowledgeable about the residents, their families and their complex needs. The person in charge stated she also assisted in frontline care if required particularly if staffing levels were low and

agency staff could not be attained in the centre.

The inspector found that the levels of oversight, auditing and effective governance had not substantively improved since the previous inspection. For example, inspectors were very concerned given the high levels of incidents, accidents and safeguarding concerns/referrals occurring within the centre.

In discussing this with the person in charge, as no risk register was yet formed, inspectors found that some data collection of risks prevalent within the centre had taken place. However, inspectors were concerned that there were high levels of risk prevalent within this centre. For example, a number of residents were highlighted as a high risk to others in this data collection completed within the designated centre. There were examples whereby residents in this centre had assaulted other residents and seriously injured staff.

Other areas of concern from a governance and management perspective were that areas that were highlighted as non compliant on the previous inspection such as medication management, staffing levels and fire doors/evacuation protocols were all found to again have deficits in terms of regulatory compliance.

**Judgment:**

Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

No actions were required from the previous inspection.

**Findings:**

Inspectors remained concerned that issues highlighted on the previous inspection were not addressed, in addition to areas of further concern with the suitability of staffing.

While inspectors met staff who had worked in the centre for many years who clearly knew residents well and treated residents with dignity and respect, inspectors remained concerned with the standard and consistency of staff provision within this designated centre.

Inspectors found that there were adequate numbers of night staff finishing duty on the

morning of inspection as highlighted on the centres roster. However, all required staff did not attend for duty at 8am which left the centre operating below its allocated staffing levels for this period. A number (2) of agency staff subsequently arrived at 9am.

Inspectors found evidence in a review of agency staff files of non evidence of safeguarding and fire safety training. This issue has continually been highlighted to this provider in respect of a number of centres operating on this campus.

Inspectors were very concerned to find one staff file reviewed that contained a reference that clearly indicated the staff member was unsatisfactory in a number of areas/competencies (communication, discipline, honesty, punctuality, quality conscious) and was deemed 'not recommended for re-employment' and that the individual was 'not recommended suitable for the position applied for'.

The inspectors observed this staff member assisting residents with personal care on the morning of inspection. The person in charge stated she did not know anything about this matter when inspectors brought this to her attention. The person in charge highlighted that she has had to send agency staff home on previous occasions due to issues with performance. Inspectors highlighted to the provider they were very concerned that appropriate awareness and or governance of the staff they were recruiting and employing to work in their centres was not demonstrated.

**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:***

Conor Brady  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by St John of God Community Services Limited
<b>Centre ID:</b>	OSV-0003642
<b>Date of Inspection:</b>	01 October 2015
<b>Date of response:</b>	20 November 2015

### Requirements

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

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

### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

Plans reviewed were not accessible to residents.

#### 1. Action Required:

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

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

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

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

1. An accessible template has been developed by the Person in Charge in conjunction with the Speech and Language therapist
2. The Person in Charge will ensure that key workers will provide an accessible version of the Personal Plan to residents, where required.

**Proposed Timescale:**

1. 29/10/2015 completed
2. 30/12/2015

**Proposed Timescale: 30/12/2015**

**Theme:** Effective Services

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

Care plans were not comprehensive. While care plans were being transitioned from an old format to a new format there were not all aspects of social and health care plans in place to appropriately guide practice.

**2. Action Required:**

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

1. The Person in Charge will prepare a schedule and audit all personal plans. The Person in Charge will meet with each resident and his/her keyworker to discuss the personal plan and to agree a plan of action.
2. The Person in Charge will ensure that comprehensive assessments by an appropriate health care professional, of the health, personal and social care needs are carried out and that all relevant social and healthcare plans are in place.
3. The Person in Charge will ensure that all care plans will be specific enough to guide practice and that all staff will be inducted into the care plans.

**Proposed Timescale: 31/12/2015**

**Theme:** Effective Services



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

The effectiveness of social care planning was not effectively assessed.

**3. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- 1.The Person in Charge will ensure that the audit identified for review of the residents entire Personal Plan will capture the effectiveness of Social Care Planning for each resident and any/ all deficits will be addressed and actioned
2. All staff will participate in practice development to ensure that they facilitate a person centred approach to care planning and the identification of meaningful goals.
- 3.The Person in Charge and Line Manager will ensure that reviews occur within the established timeframes.

Proposed Timescale:

1.31/12/2015

2.30/11/2015

3.31/12/2015

**Proposed Timescale: 31/12/2015**

**Theme:** Effective Services

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

Plans were not all clearly highlighting why goals were not being achieved for residents. There was inconsistencies found in the plans reviewed as to the standard of goal setting, responsibility and time-frames.

**4. Action Required:**

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

- 1.The Person in Charge will prepare a schedule and audit all personal plans. The Person in Charge will meet with each resident and his/her keyworker to review the social care plan.

2.The Person in Charge will ensure that goalsetting is led by the resident's likes and preferences and appropriate supports are put in place to facilitate the resident to achieve goals within realistic timeframes.

3.The Person in Charge will ensure that comprehensive assessments by an appropriate health care professional, of the health, personal and social care needs are carried out and that all relevant social and healthcare plans are in place.

4.The Person in Charge and line manager will monitor the personal plans to ensure a consistent approach to social care planning and to ensure that plans are reviewed within the established timeframe

5.Where goals are not being achieved, the Person in Charge will ensure that the reason for this is documented and alternative options will be explored at the quarterly review.

Proposed Timescale:

1.31/12/2015

2.31/12/2015

3.31/12/2015

4.31/03/2016

5.31/03/2016

**Proposed Timescale:** 31/03/2016

## **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:**

While a system was under development in line with policy a more robust implementation system was required given the nature and levels of risk prevalent in this centre.

### **5. Action Required:**

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

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

1.All hazards identification and assessment of existing risks will be reviewed for each residents within the Designated Centre

2.All staff supporting residents will be familiar with and implement the agreed control measures to reduce the impact of identified hazards.

3.The identified supports for each resident will be included in the Induction folder for all new staff.

4.A draft risk register is in place and is currently under review by the Register Provider

Nominee, and shall be operational by 16/11/2015

5. All events / adverse incidents will be discussed on a daily basis by the designated team and actions taken to address any risks identified.

Proposed Timescale:

1. 01/10/2015 completed

2. 29/10/2015 completed

3. 29/10/2015 completed

4. 16/11/2015

5. 26/10/2015 completed

**Proposed Timescale:** 29/10/2015

**Theme:** Effective Services

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

Fire doors were being held open against each other rendering them ineffective in the event of a fire.

**6. 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:**

This practice was ceased immediately

**Proposed Timescale:** 21/10/2015

## **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

The use of a camera in a residents bedroom was operational within this centre and there was not clear evidence that this was the least restrictive procedure, for the shortest duration necessary.

**7. Action Required:**

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

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

1.A full Multidisciplinary meeting has been scheduled to review all supports put in place to ensure that the resident is safe and that the least restrictive intervention is in place for the shortest duration necessary. The PIC has requested a full review with the MDT on the use of the camera.

2.The resident and / or his representative will be consulted in this review.

**Proposed Timescale:** 27/11/2015

**Theme:** Safe Services

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

All residents were not appropriately protected in this centre.

**8. Action Required:**

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

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

1.The role of PIC shall be exclusive to this DC from the 02/11/2015 to ensure the delivery of a safe, effective and responsive service.

2.The PIC will ensure a walk around will take place to ensure the appropriate level of supervision is in place.

3.The PIC has reviewed the risk in relation to the current resident mix in the DC. Additional control measures will be put in place to ensure the resident identified in the report will be appropriately protected.

- The house where the resident lives will be separated from the adjoining house.

- The office will not be shared by both houses. An alternative office will be made available.

- The kitchen will not be shared by both houses. An existing alternative kitchen will be used.

- The main entrance will not be shared by both houses. Alternative entrances will be used to ensure that residents from either house will not come into contact with one another.

- Resources will be allocated to facilitate the resident to engage in positive activities outside of the DC .

4.All staff will be inducted into the identified support needs of each resident in their area of work.

5.Residents requiring additional supports for behaviours of concern will be offered alternative living accommodation. The PIC will ensure that a detailed transition plan will be put in place with relevant stakeholders. Transition plans will commence using the Discovery Process/Visual Aids/ IPads and appropriate communication apps.

6.“I am safe” training is being rolled out for all residents. Residents will be supported to attend this training which will support and educate the residents around risk awareness.

7.A number of additional posts have being filled in this Designated Centre and a

recruitment Campaign is underway for the remaining vacancies as outlined in the action for Regulation 15(1).

Proposed Timescale:

1.2/11/2015 completed

2.2/11/2015 completed

3.7/12/2015

4.30/11/2015

5.23/11/2015

6.30/11/2015

7.31/12/2015

**Proposed Timescale: 31/12/2015**

**Theme: Safe Services**

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

There was not consistent guidance provided in terms of the provision of personal/intimate care with vulnerable residents.

**9. Action Required:**

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

1.The guidance document for Safeguarding of Vulnerable Persons has being reviewed and the identified needs and supports with regards to intimate care and safeguarding amended.

2.All staff will be advised to adhere to the Privacy and Dignity Local Operational Procedure.

Proposed Timescale:

1.10/10/2015

2.23/11/2015

**Proposed Timescale: 23/11/2015**

**Outcome 11. Healthcare Needs**

**Theme: Health and Development**

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

Care plans were not in place to manage some clinical issues and in other cases they were not specific enough to guide practice.

**10. Action Required:**

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

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

1.The PIC will audit all care plans and ensure that all clinical issues are addressed and that they are specific enough to guide practice. All identified clinical issues will have an appropriate care plan. All staff implementing the care plan will be inducted where required.

2.The Allied health professionals will be actively involved in the development of these care plans and in their on-going reviews where relevant. The PIC will ensure that where recommendations are in place an appropriate care plan will be developed and will be implemented into practice.

3.Identified health issues will have a corresponding care plan

**Proposed Timescale:** 30/11/2015

**Theme:** Health and Development

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

Staff spoken with were unclear of the procedure for the chilling and reheating of meals.

Additional choices were not available to residents who required their meal in a modified consistency.

Residents were buying some basic food items such as cereals.

**11. Action Required:**

Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

1.Procedures are in place with regards to the chilling and re- heating of meals. All staff will be made aware of the procedure for the checking and recording of food temperatures.

2.Food safety awareness will be provided to all staff.

3.Additional choices will be made available to all residents, including those who require their meals in a modified consistence. Choices are recorded and monitored to ensure

residents have access to a range of meals. Staff will support residents to prepare snacks, desserts and alternative meal options. Menus and food preferences/choices will be discussed at resident's meetings.

Residents will be supported to make choices using alternative methods of Communication where required.

4.The practice of residents purchasing items that are readily available within the Designated Centre has ceased. Additional funds will be made available to the Designated Centre to purchases food items. Residents will be supported to go shopping and to be involved in food preparation in the house

Proposed Timescale:

1.16/11/2015

2.30/12/2015

3.16/11/2015

4.16/11/2015

**Proposed Timescale: 30/12/2015**

## **Outcome 12. Medication Management**

**Theme:** Health and Development

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

Improvements were required in practices in place regarding the ordering, receipt, prescribing, storing, disposal and administration of medicines.

### **12. Action Required:**

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

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

- 1.Systems of medication management have being reviewed. Action plan to be implemented following recent medication audit.
- 2.A local procedure will be completed. All staff who administer medication will be inducted by the PIC and the procedure will be implemented into practice.
- 3.All prescriptions will be reviewed and appropriate protocols and guidance put in place with regards to the administration of P.R.N medication.

4.All staff will receive Kardex + Mar System training from the Pharmacy Provider .

5.Mar System will be introduced and implemented into practice.

Proposed Timescale:

1.16/11/2015

2.16/11/2015

3.16/11/2015

4.05/12/2015

5.07/12/2015

**Proposed Timescale: 07/12/2015**

#### **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:**

Improvements were required in the effective governance, operational management and administration of the designated centre concerned. It was not deemed appropriate that the person in charge manage 2 designated centres.

**13. Action Required:**

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

1.The role of PIC shall be exclusive to this DC from the 02/11/2015 to ensure the delivery of a safe, effective and responsive service. The PIC commenced on 02/11/2015 in the DC

**Proposed Timescale: 02/11/2015**

**Theme:** Leadership, Governance and Management

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

Improvements were required in a number of areas regarding the effective and consistent monitoring of services provided. For example, staffing, risk management and safeguarding, care-planning and medication management.

**14. Action Required:**

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



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

- 1.The registered provider will ensure that all safeguarding concerns are forwarded by the Person in Charge to the Designated Liaison Person and actions plans put in place to ensure the safety of all.
- 2.Dedicated PIC is being assigned to the DC to ensure the service provided to residents is safe, appropriate to resident's needs, consistent and effectively monitored. The PIC commenced on 02/11/2015
- 3.A Co-ordinating Support Team has been formed (Residential Programme Manager, Administrative Manager, Social Worker Team leader, Assistant Director of Nursing)The Support Team will conduct monthly meetings in The DC. The agenda will include staffing, risk management and safeguarding, care-planning and medication management. Issues highlighted at this meeting will be reviewed on a weekly basis. This will ensure effective and consistent monitoring of the service provided in the DC
- 4.The PIC attends weekly meetings which are attended by all PICs and chaired by the Residential Programme Manager.

**Proposed Timescale:**

- 1.6/11/2015 completed
- 2.2/11/2015 completed
- 3.1/12/2015
- 4.23/09/2015 completed

**Proposed Timescale: 01/12/2015**

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

References for staff reviewed were found to be inadequate.

**15. 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.All staff will have appropriate information and documentation in keeping with Schedule 2.

**Proposed Timescale: 11/12/2015**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

There was not the appropriate number of staff on duty on the morning of inspection.

**16. 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 appropriate number of staff will be on duty at all times and this will be reflected in the planned and actual roster.

2. Vacancies filled.

2 Social Care Workers have been recruited and commenced on 16/11/2015

3.Vacancies filled awaiting Garda Clearance.

1 Social Care Worker has been recruited and is awaiting Garda Clearance

1 Staff Nurse has been recruited and is awaiting Garda Clearance.

4.Vacancies covered by agency staff working exclusively in DC on full time basis.

1 Social Care Worker from Agency based in DC on full time basis. Following successful interview(20-11-15) will be offered a Permanent Fulltime position in the DC

5.Recruitment campaign is in place to replace existing vacancies

Posts for all grades have been advertised on Jobs.ie, Nursing Jobs.ie, Nursing Times UK. Active Link, Local Media. Interviewing has taken place.

CVs have been short listed. Further interviews scheduled the week of 23/11/2015.

Staff will be selected to fill the remaining vacancies.

6. A Recruitment Day has being arranged and is taking place on November 28th.

**Proposed Timescale:**

1.30/10/2015 completed

2.16 /11/ 2015

3.31/12/2015

4.23/11/2015

5.30/11/2015

6. 28/11/2015

**Proposed Timescale: 31/12/2015**

**Theme:** Responsive Workforce

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

All staff did not have evidence of appropriate training undertaken.

**17. Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to

appropriate training, including refresher training, as part of a continuous professional development programme.

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

- 1.All staff will have the appropriate training to ensure a safe and effective service provision, such as Safeguarding, Manual handling , Fire training , Crisis Management.
- 2.Agency Staff can no longer present to work in the Designated Centre unless they have received training in all mandatory areas. Request for training records are made to the agency on booking of staff.

**Proposed Timescale: 26/10/2015**