### Centre name:
A designated centre for people with disabilities operated by St John of God Community Services Limited

### Centre ID:
OSV-0002947

### Centre county:
Kildare

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
St John of God Community Services Limited

### Provider Nominee:
Sharon Balmaine

### Lead inspector:
Julie Pryce

### Support inspector(s):
Louise Renwick; Jim Kee

### Type of inspection
Unannounced

### Number of residents on the date of inspection:
13

### Number of vacancies on the date of inspection:
0
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
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:** 30 July 2015 11:30  
**To:** 30 July 2015 21:30

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

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**Summary of findings from this inspection**

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 one designated centre on this campus. This was the third inspection of a designated centre operated by St John of God Kildare Services, and was conducted as a follow up to inspections conducted on 5th March 2015 and on the 14th and 15th April 2015, in order to monitor on-going compliance. As part of this inspection, inspectors met with residents and staff, observed care practices and reviewed documentation such as care plans, person centred plans, risk assessments, fire safety records and documentation relating to governance and management.

Thirteen residents resided in this designated centre which was an old premises located on a campus based setting. As highlighted in previous inspection reports the design and layout of the premises was not suitable to meet the assessed needs of the residents. Since the last inspection the provider had made some significant improvements to the premises, including the addition of two domestic kitchens, the upgrading of heating and ventilations systems and the reallocation of the bedroom areas to afford residents more appropriate space. However, the design and layout of the premises did not meet the assessed needs of the residents currently residing there.

Other improvements had been made, for example in the development of residents’ personal plans and in the preparation and service of meals. However some of the agreed actions from the previous inspections had not been implemented, for example in the assessment of social care needs for residents and in the review of staffing numbers.

Inspectors remained concerned about the management of risk in the designated centre, and required an immediate assurance that residents would be safeguarded in the event of fire, particularly at night time. The provider responded appropriately to this requirement the following day and assurances were given that appropriate corrective action had been taken.

These issues are discussed further in the body of the report and in the action plan at the end of the report.
### Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

### Outcome 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:

Inspectors found that some improvements had been made in the activities and choices being offered to residents. A weekly discussion was held with each resident in relation to their preferred activities, and these discussions were documented in their records. Activities offered and undertaken were then recorded on a daily basis. There was evidence that more varied options were being offered to residents.

However, there was still no comprehensive assessment of the social and activation needs of residents, and no change in the staffing levels to ensure that residents’ activities were based on assessed needs and not the availability of staff or the availability of a day service on the campus. As a result, there was insufficient evidence that arrangements were in place in relation to a meaningful day.

Improvements had been made in the development of personal plans for residents. Personal plans were now maintained in a manner in which information was instantly retrievable and available to staff. There was now evidence of family involvement in ‘circle of support meetings’, and some areas of personal plans had been reviewed and updated.

Further improvements were still required, for example, many areas of personal plans had not been reviewed and personal plans were still not in a format accessible to residents. However, inspectors were satisfied that the progress made so far was compatible with the agreed action plans and timeframes from the previous inspection reports to be completed by 30 September 2015. There was evidence that where areas
of personal plans had been put in place or reviewed since the last inspection, these new documents were based on the assessed needs of residents and contained sufficient information as to guide staff.

**Judgment:**
Non Compliant - Moderate

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**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:**
Whilst the provider had made significant modifications and improvements to the designated centre since the last inspection, which improved outcomes for residents, the overall building design and layout was not suitable to meet the assessed needs of residents.

Space was very much limited in the designated centre. Residents’ space was spanned over two adjoined narrow houses with one living/dining/kitchen area in each house. Hallways were narrow in each house. Residents’ private accommodation, with the exception of one resident who now had two rooms for his personal use, comprised a small room with a single hospital style metal framed bed. Some rooms had a chair and wardrobe and some had a television. There was insufficient storage despite the efforts of staff to utilise a communal storage space for unseasonal clothing for residents.

However, the provider had installed two domestic kitchens, so that residents could be involved in the planning, preparation and service of meals, and there was a plan in place to cease the supply of meals from a central catering unit the week following the inspection. Further improvements had been made, for example, one of the residents had been allocated a second room to have a living area for their sole use, and the door to another resident’s room had been adapted to address a risk identified on the last inspection. Improvements had been made to an activities room so that it was now appropriate to be used by residents, in that it was no longer used for storage, and appropriate heating had been installed.

Processes in relation to unsafe hoisting practices were still ongoing in the designated centre, for the most part due to the unsuitability of the premises for meeting the needs
of residents with compromised mobility. For example, residents with mobility issues were transferred from their bedrooms to the bathrooms in a hoist, despite risk assessments indicating that this was not best practice, as the corridors and layout of the premises were not designed to allow appropriate transfers.

The agreed action following the previous inspection was that a development committee would identify fit for purpose accommodation for residents by 22 April 2015, but there was no evidence that this had taken place.

**Judgment:**
Non Compliant - Major

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

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

**Theme:**
Effective Services

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

**Findings:**
Inspectors were not satisfied that the structures and processes in relation to fire safety were adequate to ensure the safety of residents. Whilst a night time fire drill had taken place since the last inspection, it had not adequately ensured the safety of residents, in particular two of the residents would require either two or three staff members to assist them with evacuation. The complement of staff on night duty was two, and the time taken during the drill for staff from nearby areas on the campus to attend and assist in the evacuation was almost seven minutes.

In addition the instructions in the evacuation plan which was on display in the designated centre differed to those in the emergency folder, and to those described by staff. This incorrect version of the plan was removed immediately, and the person deputising for the person in charge undertook to ensure that all staff were aware of the correct procedure.

The floor plan on display which highlighted the exit points in the building was not a true reflection of the exits actually in place, and presented misguiding information to visitors. The floor plans submitted had not been upgraded since internal doors had been removed. While some internal doors had been upgraded to fire doors in one part of the centre, there were no fire doors in place between the two units of the centre, and inspectors were concerned that staff were guided to complete partial evacuation in the event of a fire without these appropriate protections in place. The person participating in management undertook to seek immediate advice from appropriately qualified fire safety professionals, and this was carried out the day following inspection. An extra staff
member was immediately allocated to night duty, and inspectors were given assurances that this would remain the case pending the advice from the fire safety report. This report was furnished to the Authority immediately that it was available, and a satisfactory remedial plan was submitted.

Whilst there was a system in place for the recording and reporting of accidents and incidents, this process did not always result in appropriate actions or improvements relating to identified risks, for example, several incidents of one resident engaging in challenging behaviour during intimate care had been reported, but this information had not informed the assessment or updated care plan for this resident. Inspectors were concerned that this could result in inconsistent care practices.

In addition, the recording process was not always completed appropriately. For example, the accident and incident form requires information about the learning that took place following the incident, and one of the forms was completed with ‘the resident can be very rude to staff’, rather than outlining information that may be useful to prevent a recurrence of the incident, or offer guidance if the situation arose again.

Some improvements had been made in the management of risk, for example, the door of a resident’s room had been adapted to manage a risk identified on the last inspection, and a recent risk in relation to the functioning of a bed alarm for one resident had been immediately identified and mitigated by the provision of an extra staff member.

However, the inspectors were still concerned that not all risks had been identified or managed appropriately. For example, a resident with epilepsy was monitored whilst present in the designated centre, but went unaccompanied to a day service across the campus on a daily basis. Whilst staff reported that if this resident did not arrive in the day service within half an hour of leaving the centre the staff in the day service would make contact, inspectors were not satisfied this procedure was adequate to manage the situation. In addition, there had been two reported incidents of this resident having been found on the ground on the campus and queried to be post seizure, but there was no risk assessment in relation to these incidents and no care plan or safety protocol in place.

In addition, a risk identified by inspectors on the previous inspection in relation to a choking incident for one resident had still not been followed up appropriately, appropriate assessments had not taken place as discussed under Outcome 11.

**Judgment:**
Non Compliant - Major

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**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Some improvements had been made in this area since the last inspection. For example, all staff had now received training in the management of challenging behaviour, and in safeguarding of vulnerable adults.

There were behaviour support plans in place for residents who required intervention in this area. Some of the plans examined by the inspectors were current and contained sufficient information as to guide staff. In particular a behaviour support plan had recently been put in place following documented incidents of challenging behaviour. However, not all plans were of a satisfactory standard. For example, one of the plans, which had not been reviewed for 18 months, referred to 'behaviour of high intensity' but did not include an objective description of the behaviour that the plan was intended to address. Inspectors were concerned that this could lead to inconsistent care practices.

Intimate care plans were in place for residents, and as discussed in Outcome 5, where these had been put in place since the last inspection they contained sufficient detail as to guide care delivery. However, many of the intimate care plans still required review, and were missing important pieces of information, for example, one of the plans referred only to the manual handling requirements of the particular resident, and made no mention of the actual care needs.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Health and Development

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

**Findings:**
Significant improvements were underway in the provision of food to residents. The
provider had installed two domestic kitchens in the designated centre, and on site food preparation was commencing on the following Tuesday. The inspectors were satisfied with the plans to introduce home cooking. A budget had been allocated, plans were in place to involve residents in the choosing of menus, and the new kitchens were adapted to meet the needs of all residents.

The inspectors were satisfied that residents had access to appropriate healthcare professionals, for example, speech and language therapist, diabetes care and occupational therapy. However, referrals to these allied healthcare professionals had not always been made where indicated. For example, at the last inspection inspectors had highlighted a resident who had not been reassessed by a speech and language therapist following a choking incident. This reassessment had still not occurred, and there was no mention of this in the resident’s care plan. Food and eating care plans had not been reviewed and updated for this resident following the incident of choking, and inspectors found conflicting information in the outdated care plans, the medication kardex and current practices regarding this resident’s support requirements for food, fluid and elimination. Inspectors were concerned that these gaps in documentation could pose a risk to residents receiving inappropriate care.

In addition, there was some inconsistency in the delivery of healthcare for some of the residents. For example, while a fluid balance chart was in place for one of the residents, the recordings of fluid intake were intermittent, the daily totalling was inconsistent and there was no evidence that the fluid balances were being reviewed to ensure appropriate care interventions were applied if necessary.

Judgment:
Non Compliant - Moderate

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**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:**
There were written operational policies implemented within the centre relating to the ordering, prescribing, storage and administration of medicines to residents. However, inspectors found deficiencies relating to certain medication management practices, including the documentation of administration of medicines to residents, information provided regarding the use of certain PRN (as required) medicines, and lack of segregation of expired medicines. Inspectors also identified prescribing issues, and
issues relating to the documentation system used for prescribing.

Medicines were supplied by a retail pharmacy business in individual ‘pouches’ where appropriate, and all medicines were stored securely within the centre on a medication trolley, and in a locked cupboard within a small room that had been designated for storage of medicines. On the day of inspection the door to this room was damaged and could not be locked to prevent unauthorised access. A locked fridge was also available for medicines or nutritional supplements that required refrigeration, and the temperature of this fridge was monitored and recorded on a daily basis. Controlled drugs were securely stored within the centre, and the balances were checked and recorded daily within the controlled drug recording book.

Staff informed inspectors that all medicines received from the pharmacy were checked by staff against the current cardex (prescription sheet). Dates of opening were not consistently marked on prescribed nutritional supplements or eye drops to indicate their subsequent expiry dates. Inspectors also found that an expired medicine was stored on the medication trolley, and had not been appropriately segregated from other medicinal products. This particular medicine was no longer prescribed for the resident, and the associated PRN (as required) protocol had not been removed from the resident’s medication folder. Inspectors were concerned that this could increase the risk of inappropriate administration of medication.

Inspectors observed the administration of medicines to residents, and noted that in some cases the nurse initialled the administration sheet before administering the medicines to the residents which is not in line with current best practice guidelines. Nursing staff were knowledgeable of residents’ individual medicines, and all medicines were administered in a patient, respectful manner. There were charts in place to document the application of transdermal patches.

Staff were aware of procedures to be followed for disposal of unused and out of date medicines, and records were maintained. All medication errors were recorded on medication variance/near miss reporting forms. These forms included an action plan section that identified contributing factors and also named people responsible for completing any required actions. There was an incident learning notice incorporated in these forms to identify relevant learning points. A log of medication variances was maintained, and the inspector noted that there had been no recent medication related incidents documented within the centre.

Inspectors reviewed a number of the medication prescription (cardex) and administration sheets and identified a number of issues that did not conform with appropriate medication management practice:
- the prescriber had not signed for each individual medicine on the prescription sheet.
- the times of administration were not consistently indicated on the prescription sheet by the prescriber.
- the maximum daily dose for PRN (as required) medicines was not always clearly indicated on the prescription sheet.
- the section available for prescribers to document prescriptions of PRN (as required) medicines did not contain sufficient space to record all residents’ PRN medicines, resulting in some PRN medicines being written in another section of the document. This
had been highlighted in previous inspection reports.

-the allergy section had not been completed on all prescription sheets to indicate if the resident had any known allergies.

The PRN (as required) medicines on a number of the prescription sheets and a number of the associated PRN protocols for psychotropic medications were also reviewed. The prescribed dose of one PRN medicines as indicated on the cardex (prescription sheet) did not correspond with the doses detailed in the associated PRN protocol. The administration of PRN medicines was also recorded in a separate folder to facilitate review of the use of these medicines. The residents’ medication folders also contained medication management plans, and for residents diagnosed with epilepsy, epilepsy management plans that included a general advice sheet and an emergency management plan that included instructions on the use of PRN medicines during epileptic seizures. The general advice sheet did not advise staff to time the length of the seizure or to administer PRN medicines as prescribed.

A pharmacist from the retail pharmacy business supplying medicines to the centre visited the centre on a regular basis to conduct audits. There were internal medication management audits conducted that included observation of administration practices within the centre. However this internal audit had not been conducted since February 2014. Therefore the frequency of audits was not sufficient to provide for adequate oversight of medication management practices.

**Judgment:**
Non Compliant - Moderate

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**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:**

A person in charge had been appointed since the last inspection. This person was on annual leave at the time of the inspection. However, there was evidence of some improvements having been made. For example, the person in charge had undertaken an audit of personal plans which highlighted improvements which were required in each of
the plans. There was also evidence that action on these required improvements had commenced.

However, there was no other evidence of any audits having been undertaken since the last inspection. For example, there had been no medication audit since early 2014. The provider audit, which had been examined by the inspectors on the last inspection and found to be of poor quality, had not been revisited. In addition, the provider had not conducted six monthly unannounced visits as required by the regulations, and there was no annual review of the quality and safety of care and support available.

While some positive changes were evidenced on this inspection, inspectors found that the oversight of adverse events and risks in the centre had not ensured changes and improvements had not been made where they were most needed. For example, residents at highest risk were not prioritised to have their care plans updated, or patterns of incidents with residents had not resulted in clear risk assessment and plans.

Staff meetings were held regularly, and minutes of these meetings were maintained. A system of staff who were absent from the meeting reading and signing a sheet had been introduced. However, this sign off sheet was not monitored, and on every occasion of a meeting several staff members had not read the minutes.

Judgment:
Non Compliant - Moderate

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:
Some of the actions agreed from the previous inspection had been implemented. For example, staff had now received training in all mandatory areas including manual handling and the safeguarding of vulnerable adults. Training had been provided in food safety in preparation for the move from centrally provided meals to preparation of meals in the designated centre. Evidence was presented to the inspectors of the implementation of an annual appraisal system for staff.
Arrangements had been put in place to provide staff for a resident who on the previous inspection had been paying for a staff member to assist with his social care needs during the periods of time when the day service was closed. The day service was due to be closed the week following the inspection and a duty roster was available that clearly outlined the extra staff member required to meet the needs of this resident.

However, inspectors were concerned that the other issues relating to staffing levels highlighted in the previous report had not been addressed in that staffing levels had not changed, and no review of the needs of residents in relation to staffing had been undertaken by 30 June 2015 as agreed by the provider after the previous inspection.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Julie Pryce  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<td>Centre ID:</td>
<td>OSV-0002947</td>
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<tr>
<td>Date of Inspection:</td>
<td>30 July 2015</td>
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<td>Date of response:</td>
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Requirements

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

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

Outcome 05: Social Care Needs

**Theme:** Effective Services

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

There were no comprehensive assessments to incorporate all the needs of residents.

1. **Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
A comprehensive range of assessments will continue to be carried out with the support of the Multidisciplinary team as appropriately and monitored by CNMs and the PIC.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was insufficient evidence that arrangements were in place in relation to a meaningful day

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

**Please state the actions you have taken or are planning to take:**
1. All personal plans will be updated by the keyworkers in conjunction with the resident / their representative.
2. Social and activation support needs will be incorporated within the updating of the personal plan to support residents having a meaningful participation in activities of their choice.

Proposed Timescale:
1. 30/11/2015
2. 30/10/2015

| Proposed Timescale: 30/11/2015 |

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### Outcome 06: Safe and suitable premises

| **Theme:** Effective Services |

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The premises are not designed to meet the needs of residents.

3. **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: 
A committee has been established and a meeting is scheduled for 2/10/15 to take place to identify and plan suitable accommodation for residents in the DC.

**Proposed Timescale:** 02/10/2015  
**Theme:** Effective Services  

The Registered Provider is failing to comply with a regulatory requirement in the following respect: 
Not all matters to be provided for in the premises as required under Schedule 6 were in place.

4. **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 residents have access to private, communal and dining accommodation, additional storage facilities have been identified and are being put in place. Kitchens have been upgraded to provide for suitable and a sufficient cooking facilities table wear and kitchen equipment.  
2. Residents have submitted and are in the process of making applications to the local authority for housing.

Proposed Timescale:  
1. 9/10/2015  
2. 1/10/2015

**Proposed Timescale:** 09/10/2015

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**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:  
Not all risks were appropriately managed.

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. An extra staff member was immediately allocated to night duty, and inspectors were given assurances that this would remain the case pending the advice from the fire safety report. A fire safety report was furnished to the Authority on the 31/08/2015 and a satisfactory remedial plan was submitted.
2. Risk assessments for all residents were completed during the period of 21/08/2015 and 22/09/2015.
3. A risk assessment was developed re one resident engaging in challenging behaviour during intimate care. A review meeting with the Psychiatrist took place on the 04/09/2015 and a clinical review meeting took place on the 14/09/2015. An MDT meeting is scheduled to take place on the 09/10/2015. The Intimate Care Plan has been updated to refer staff to the residents reactive/ pro-active and Restrictive strategies that are in place.
4. A risk assessment re a resident with epilepsy was reviewed on the 22/09/2015. Additional control measures will be put in place to ensure the safety of the resident.
5. A resident at risk of choking had a dietician review on 25/08/2015. Recommendations have been put in place. For example a place mat, bite size pieces and supervision at all times while eating and drinking.
6. The CNM2 will ensure that reviews are completed as per documented review dates or earlier if required.
7. The PIC & CNM2 have received training in risk assessments.
8. The PIC & CNM2 will lead and support staff to complete risk assessments and oversee the process when identified and in a timely manner.
9. Terms of reference and agenda for staff team meetings has been reviewed to ensure that risk assessments are a standard agenda item.

Proposed Timescale:

1. 30/07/2015
2. 22/09/2015
3. 09/10/2015
4. 22/09/2015
5. 25/08/2015
6. 31/12/2015
7. 30/06/2015
8. 22/09/2015
9. 30/09/2015

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

**Theme:** Effective Services

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

**6. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.
Please state the actions you have taken or are planning to take:
1. A fire safety report was undertaken and the Authority were advised of the necessary immediate actions required which have been put in place
2. The additional medium term measures which were identified in the report are being implemented in line with the recommendations.

Proposed Timescale: 31/08/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not adequate arrangements for evacuation of the centre in the event of fire.

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

Please state the actions you have taken or are planning to take:
1. Two residents were identified as requiring additional supports for night time evacuation. Ski sleds have been purchased.
2. All staff have been trained/inducted in the use of Ski sleds.
3. Peeps have been updated for all residents

Proposed Timescale: 09/10/2015

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:
Not every effort had been made to alleviate the cause of resident's' challenging behaviour.

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

Please state the actions you have taken or are planning to take:
1. A review meeting with the Psychiatrist took place on the 04/09/2015 a further MDT meeting is scheduled to take place.
2. Relevant residents have been reviewed by the Psychologist and a behaviour support
plan (BSP) is currently in place.

Proposed Timescale:

1. 09/10/2015
2. 24/09/2015

Proposed Timescale: 09/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all intimate care plans were adequate to guide staff in providing care to 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:
All Intimate care plans are being reviewed and updated to ensure sufficient detail is in place to guide care delivery. The PIC will monitor the process.

Proposed Timescale: 30/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all appropriate referrals to allied healthcare professionals had been made.

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

Please state the actions you have taken or are planning to take:
Reassessment of resident with a history of choking took place on the 20/08/2015. The resident's care plan and medication Kardex have been updated. A dietician review took place on the 25/08/2015 and recommendations have been put in place and implemented.
Proposed Timescale: 25/08/2015  
Theme: Health and Development  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There was insufficient evidence that healthcare was provided in accordance with residents' personal plans.  

11. **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:**  
A review of health care for a resident took place on the 25/08/2015 by the Dietician. The recommendations from the dietician are being implemented. The staff continues to monitor this resident eating and drinking plan.

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Proposed Timescale: 25/08/2015  

**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:  
The door on the room used to store the medication trolley and associated documents was damaged and could not be locked to prevent unauthorised access.  

12. **Action Required:**  
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.  

**Please state the actions you have taken or are planning to take:**  
A new door with a lock has been erected to ensure safe storage of all medicines, associated documents and to prevent unauthorised access.

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Proposed Timescale: 24/09/2015  
Theme: Health and Development  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Nursing staff administering medicines to residents were observed initialling the administration sheet before administering the medicines to the residents, which is not in
line with current best practice guidelines.
Review of the medication prescription (cardex) and administration sheets identified a number of issues that did not conform with appropriate medication management practice:
- the prescriber had not signed for each individual medicine on the prescription sheet.
- the times of administration were not consistently indicated on the prescription sheet by the prescriber.
- the maximum daily dose for PRN (as required) medicines was not always clearly indicated on the prescription sheet.
- the section available for prescribers to document prescriptions of PRN (as required) medicines did not contain sufficient space to record all residents’ PRN medicines, resulting in some PRN medicines being written in another section of the document.
- the allergy section had not been completed on all prescription sheets to indicate if the resident had any known allergies.

The frequency of internal medication management audits was inadequate to ensure that medication practices were sufficiently monitored.

The prescribed dose of one PRN medicines as indicated on the cardex (prescription sheet) did not correspond with the doses detailed in the associated PRN protocol which could lead to confusion, and possible medication administration errors.

The general advice sheet on epilepsy management included within residents’ medication folders did not advise staff to time the length of the seizure or to administer PRN medicines as prescribed, which could lead to confusion for staff members who were not familiar with the resident concerned.

13. **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. Nursing staff engaging in medication management will adhere to best practice guidelines as per SJOG Person Centred Medication Management Policy and Nursing and Midwifery Board of Ireland (NMBI) guidelines.
2. All medication Kardex’s were reviewed and updated on the 24/09/2015 by the GP.
3. A medication audit will be conducted in the DC on the 30/09/2015.
4. Epilepsy Plans will be reviewed and updated to advise staff to time the length of the seizure or to administer PRN medication as prescribed.

**Proposed Timescale:**
1. 16/09/2015
2. 24/09/2015
3. 30/09/2015
4. 30/11/2015
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:
Dates of opening were not consistently marked on prescribed nutritional supplements or eye drops to indicate their subsequent expiry dates.

An expired medicine was stored on the medication trolley, and had not been appropriately segregated from other medicinal products.

14. Action Required:
Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
1. A stock control took place in the DC on the 31/07/2015. Out of date medicines were disposed as per policy.
2. A drug stock control will be scheduled and carried out on a regular basis (at a minimum monthly) in accordance with the best practice.
3. A medication audit will be conducted in the DC on the 30/09/2015

Proposed Timescale:
1. 31/07/2015
2. 30/10/2015
3. 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:
Reviews completed were inaccurate and ineffective.

15. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.
Please state the actions you have taken or are planning to take:
A system is in place to monitor the quality and safety of care and support in the DC. An unannounced baseline audit was carried out on the 17/02/2014 and subsequently 3 unannounced visits on behalf of the Provider have been completed in line with regulation.

**Proposed Timescale:** 30/07/2015  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Findings of unannounced visits were not found to be accurate or effective.

**16. Action Required:**  
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:  
A number of unannounced provider visits have been carried as is required by the Regulations on the 17/02/2014 (baseline), 21/10/2014, 18/02/2015. A 4th visit was carried out on the 24/09/2015. These visits generate action plans to bring about positive changes.

**Proposed Timescale:** 30/07/2015  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Management systems were not sufficient to ensure the quality and safety of care and support.

**17. 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:  
All staff that are not present at the fortnightly meeting will have access to the minutes of the meeting in the shared folder

All staff will sign to acknowledge that they have read the minutes.
**Proposed Timescale:** 24/09/2015

### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider had not ensured that the numbers of staff were appropriate to the number and assessed needs of residents.

**18. Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. A change in the shift pattern has been introduced on weekends to enhance the choice for the residents. Extended shifts are in place to improve the evenings’ activities and the routine in DC.
2. Designated staff teams have been assigned to individual houses within the designated centre.

Proposed Timescale:
1. 28/09/2015
2. 05/10/2015

**Proposed Timescale:** 05/10/2015