

**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-0002936
<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>	Gary Kiernan, Conor Dennehy
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	23
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
21 September 2015 10:00	21 September 2015 18:45
22 September 2015 09:30	22 September 2015 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 10 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 unannounced inspection of this designated centre that is operated and run by St. John of God Services. This centre was described as a secure unit and catered for 24 full time residents with complex needs. The centre, which opened in 2001, was based on a large campus based setting and comprised of a large single storey dwelling divided into four secure units. The internal doors to these units were locked and inspectors found that the centre was a highly restrictive environment by design and layout, although some measures had been made to alleviate this since HIQA's last inspection on 22 July 2015.

Overall while inspectors identified some improvements, there was continued significant non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and adults) with Disabilities) Regulations 2013 across the majority of outcomes inspected. Inspectors found that the institutional nature of this setting and the resources available within it were having a negative impact on the residents' safety and quality of life. There was an inappropriate mix of residents with highly complex needs. As a result the admission practices did not protect residents from peer to peer abuse.

As part of this inspection, inspectors met with residents, the newly recruited residential programme manager, the person in charge, clinical nurse managers (CNM), staff nurses, a social care leader, social care workers and health care assistants. Persons participating in the management of this centre attended preliminary feedback following this inspection.

Inspectors observed practices and reviewed documentation such as care plans, communication plans, person centred plans, behaviour support plans, accident and incident records, risk assessments and risk management plans, meeting minutes, safeguarding referrals and follow up plans, training records and policies and procedures. The provider had submitted an action plan and quality enhancement

plan since the previous inspection on 22 July 2015.

While some improvements had taken place since the previous inspection and since a serious critical incident, inspectors remained concerned that all necessary risk management procedures had not yet been put in place. Additionally, while two 'internal transitions' (for residents) had taken place in this centre, inspectors remained very concerned at the resident mix in this centre based on on-going accidents and incidents and safeguarding referrals.

Areas of non-compliance identified on this inspection included governance and management, staffing, risk management and infection control, positive behavioural support and person-centred planning.

Inspectors found that of 11 Outcomes inspected, 9 remained non-complaint with the requirements of the Regulations.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Overall the inspectors noted some improvements in the areas of information provision, complaints management and consultation in terms of residents' meetings. However inspectors remained concerned at the levels of choice and control available to residents to maximise their independence. In addition, inspectors found that residents' rights, dignity and privacy were not upheld at all times in this centre.

Inspectors found that there had been residents' meetings held whereby some issues pertinent were discussed, such as activities and food. In addition, there was a complaints log in place that showed complaints were now being recorded locally and follow up was noted regarding the complaints reviewed. For example, inspectors noted a complaint in relation to proposed changes to the care planning documentation had been appropriately followed up by the person in charge.

New plans were being introduced regarding residents meaningful days and communication regarding same. These plans were at the early stage of implementation and this is discussed further under Outcome 5.

Inspectors found that residents' choice and actual control was limited in terms of opportunities to engage in activities. For example, residents ate when meals came from the canteen, residents engaged in activities when there was enough staff on duty to take them and residents access to external community based activities remained very minimal. For example, in reviewing residents progress notes it was evident that the majority of residents spent most of their recreational time within the unit or within the limits of the campus setting. Choice to engage in other activities, wishes and

preferences was very limited in this centre. For example, in the case of a resident who had an identified goal of going on outings using public transport, inspectors found that these had been often cancelled and had not occurred at the frequency set out in the residents' care planning documentation. Another area of lack of choice was evident when all residents returned from day services, evening activities and recreation was observed to be limited. Inspectors noted some resident's choices and schedules exclusively focused on their day service. In terms of resident's activity, recreation and preferences within their home environment, there was not the same level of choice available for all residents. Arrangements in place to meet residents' identified goals are further discussed under Outcome 5.

Inspectors found that resident's privacy and dignity was not maintained at all times within this designated centre. Two residents were observed in a state of undress on this inspection. One resident was in the living room wearing no upper body clothing while another resident was observed walking around the unit naked from the waste down for a short period of time. This was observed by inspectors at a time when all residents had returned to the unit and other residents could clearly observe both of these residents. Inspectors were not satisfied that both of these residents' privacy and dignity rights were promoted appropriately in this instance. It was noted that there was not the appropriate number of staff on duty to supervise residents in the unit when this issue was observed. This will be discussed further under Outcome 17.

**Judgment:**

Non Compliant - Major

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that progress had been made in the area of communication and communication planning since the previous inspections.

Inspectors found that a speech and language therapist had been recruited specifically for this designated centre to focus on resident's communication needs and communication care plans. The inspectors found new communication care plans had been completed and were being introduced in consultation with the speech and language therapist. In addition, some residents had activity schedules drawn up that were in pictorial format and were accessible to some residents.

Staff were in the process of introducing 'My meaningful day' pictorial format plans for residents. The inspectors observed that this involved multiple pictures and activities whereby residents could go into a specific room and choose/interact with photographs/picture exchange. It was noted that the SALT was observing residents on inspection and offering professional direction regarding the implementation of communication plans. This was found to be a positive development.

Staff members observed on this inspection were observed to know residents very well and were observed communicating with residents in a caring and professional manner. For example, resident's (who did not communicate verbally) were observed making slight gestures/body movements and staff were very responsive to same in attempting to meet individual residents needs.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were not satisfied with admissions and discharge criteria in this designated centre. In addition, there were no written contracts or agreements in place regarding terms and conditions (inclusive of fee's charged) for the provision of services to residents. This does not comply with the requirements of the Regulations.

Inspectors found that there was not clear and transparent criteria for admission and discharge within the designated centre. For example, one resident who did not reside in the centre continued to have a bedroom within the centre. Staff stated that this resident left the centre at the start of 2014 because their needs changed. However it was apparent that a bed was retained for this resident and had not been discharged formally. Inspectors did not find clear admission and discharge arrangements in this case and were informed that this matter was now being reviewed by the social worker'. This issue is addressed under Outcome 5 in the accompanying Action Plan.

The inappropriate mix of residents in the centre was leading to poor outcomes for residents with regard to peer to peer incidents and this is further discussed under outcome 8.

Contracts for the provision of services were not in place for any resident in this centre, which is a requirement of the regulations. There was no contracts or agreements in place with any resident or their representative regarding the financial charges they incurred, the service they received and the support, care and welfare provided to the resident.

**Judgment:**

Non Compliant - Major

**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:**

While some steps had been taken since the previous inspection, inspectors remained concerned regarding residents' quality of life, opportunities to pursue individual interests, social activities and to enjoy meaningful days. There were no satisfactory arrangements in place to meet each resident's social care needs and there remained an absence of sufficient social care assessment and individualised personal plans in place for each resident, as required by the regulations.

Inspectors found that a new template of 'My Personal Plan' was being introduced at the time of inspection. However, this process had not yet been introduced for all residents. For example, inspectors were informed that one plan was fully completed out of 12 residents in one part of the designated centre. The inspectors found that this new personal planning template was a comprehensive document and there was a schedule of implementation of same highlighted in the provider's quality enhancement plan.

Regarding the provision of residents' social care needs, inspectors remained concerned that there was no comprehensive assessment in place yet for all residents regarding their social care needs. In addition, as highlighted in the previous inspection, the standard of goal setting and person-centred planning was poor and very basic for several residents. For example, a resident's annual person-centred goal was 'to go for lunch' and 'to go out once a month'. Through speaking with staff and reviewing daily

progress notes it was not demonstrated that arrangements were being put in place to meet these goals. For example, in the case of a resident who had a goal of attending mass in the community, it was found that this resident had only been supported to attend mass on two occasions in 2015. On these occasions the resident had attended mass on the campus and not in a community setting.

Personal plans remained inaccessible to residents as highlighted in the previous inspection report. Inspectors were informed that the SALT had suggested incorporating planning goals into accessible format for residents however this had not happened at the point of inspection.

The quality of social and personal planning was found to be directly related to residents lack of opportunities to pursue meaningful activities and participate in their surrounding communities. For example, inspectors examined a number of residents' daily progress notes (from the time period since the previous inspection) and found that residents reviewed had very limited opportunities to participate in activities and in particular activities that were outside the providers campus. For example, while some residents went swimming, for walks, to mass and to the gym, all of these activities were found to have occurred within the boundaries of the campus.

The inspectors found one resident had achieved his personal goals to attend an international rugby match and meet the Irish Rugby Team, this was very positive. There was additional plans in development to pursue for this resident and the inspectors found that the staff involved had supported the resident to join the local library. However of the personal plans reviewed it was noted that this residents opportunities/goals were of a substantially better standard than of other resident's plans reviewed.

There were new activity schedules for some residents, however these were being implemented for the first time on the inspection dates for residents. The inspectors found that some residents had experienced 'activity sampling' since the previous inspection but other residents had not yet had any new activities since the previous inspection.

A number of residents were found to have only participated in 'off campus' activities on very limited occasions. For example, in a 2 month period one resident was found to have engaged in meaningful activities off the provider's campus on two occasions. This was consistent across a number of residents reviewed. Inspectors found that a nearby garage/petrol station was the predominant destination for many residents who did leave the providers campus.

The inspectors found that 'bus trips' using the centre's bus were also a consistent feature in most residents off campus activities in the period since the last inspection. In examining resident's 'bus trips' with staff , the inspector found on the majority of occasions residents remained on the bus, as opposed to driving to a location to engage in a specific social activity.

In discussing this matter with staff, inspectors found that the limited ability to pursue meaningful activities was being attributed and linked directly to both the resident mix in the centre and staffing levels in this designated centre. For example, of the 23 residents

in the centre at the time of inspection, 14 remained in the designated centre (due to behaviours/complex needs) as opposed to attending a day service/vocational programme. Many of these residents demonstrated behaviours that challenge/behaviours of concern and therefore had complex support needs. These residents attended activities directly from the designated centre.

Staff highlighted that many residents would require the support of two staff if going out and some residents were found to have risk assessments outlining the necessity of same. Other staff highlighted that some staff were not as 'comfortable' with certain residents and highlighted that 'unfamiliar staff' would not be as effective in this task. This created a difficulty in terms of having appropriate staffing levels to both take residents out and remain on the unit to support other residents. This was resulting in a resource-led approach to activities with residents opportunities' being managed collectively in most of the instances reviewed.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Effective Services

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

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

**Findings:**

Inspectors found that the designated centre had started to place a greater emphasis on the management of risk to ensure the health and safety of residents since the previous inspection. However, a serious infection control issue was identified by inspectors during the course of this inspection.

Since the previous inspection, new procedures had been put in place to highlight issues of risk within the centre. In addition to an organisational risk management policy which was in operation, each unit within the centre had its own unit-specific risk management policy which highlighted key areas of risk such as accidental injury, self-harm, fire and violence and aggression. Risk registers for each unit were under development at the time of inspection. Individual risk assessments for residents were being reviewed in line with the schedule to update personal plans as discussed under Outcome 5.

While these arrangements were not yet fully implemented, some progress was noted in terms of increased risk awareness and risk assessment of post-incident risk.

New induction folders for agency/relief staff had been introduced in each unit which provided an introduction to the centre, the unit, residents and associated risks. Agency

staff on duty were observed to know residents well and had engaged with the induction folders provided. In addition, support and control measures to reduce such risks were outlined for staff. This was a positive development. New risks and recent incidents were highlighted in a daily handover folder. The Person in Charge spoke of staff within the centre's individual units taking greater responsibility for identifying risks within their assigned units while she would retain oversight. Risk management policy training had been provided for six staff members during September and the Person in Charge's intention was to provide further training in this area for all team leaders with the centre.

However inspectors noted that while positive developments had been made since the previous inspection, such measures had only been recently introduced and at the time of inspection there had not been a significant reduction in the number of incidents and accidents. Inspectors reviewed an accident and incidents log and found that in the two months since the previous inspection that there had been 51 recorded incidents compared to 111 recorded incidents in the preceding four months. The 51 incidents included instances of falls, self injurious behaviour, residents hitting other residents and observed/unexplained marks/bruises on residents.

Inspectors found evidence which showed that such incidents were now being more appropriately followed up. For example residents who fell were being reassessed after such falls and were being referred to the physiotherapist/falls clinic for review. All incidents were now found to be reviewed and signed off by the person in charge while risk management and accidents/incidents had been a standard agenda item on fortnightly staff meetings since 26 August 2015.

Since the previous inspections the actions relating to fire had been addressed. Fire training had been provided for staff members who had not undergone such training and emergency lighting/exit sign faults had been fixed. A fire drill had been conducted in the centre since the previous inspection. Internal staff checks on fire exits and emergency lighting were now being done at the required intervals. Such checks identified glass panels missing from two fire alarm activation points which had not been replaced at the time of inspection.

During day two of the inspection a very strong odour of urine was detected by inspectors while walking through part of the designated centre. This odour was found to be emanating from a pressure relieving mattress in a resident's bedroom which was visibly stained in urine and had not been appropriately cleaned. Upon closer inspection it was also found that the space under this mattress had not been cleaned in some time as there was a significant amount of dust, dirt and mould present. Inspectors were very concerned with this issue in terms of infection control systems within the centre.

In examining this resident's care plan, this individual was highlighted as having long standing incontinence and skin integrity issues. This lack of cleaning and infection control was observed by inspectors directly after cleaning staff had been present in the centre and was immediately brought to the attention of the Person in Charge. Inspectors directed this matter be dealt with immediately and on completion of inspection noted the issue was addressed, cleaning complete and a new pressure relieving mattress was ordered for this resident.

In inspecting another sample of residents' bedrooms it was noted two rooms were in an appropriately clean state while another one room was not clean with stained sheets observed on the resident's bed.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

While some measures had been taken by the provider, inspectors remained concerned with the designated centre's ability to protect all residents from potential harm. Residents were not protected from peer-to-peer abuse as evidenced by ongoing safeguarding referrals to the designated liaison person, the resident mix and staffing levels prevalent in this designated centre.

Since the previous inspection, inspectors found that two residents had 'internal transitions' on safeguarding grounds. This meant that they had been moved to an alternative unit within the centre which comprised of four separate secure units within the same building. One of these residents had been moved to another unit as a trend was noted whereby he was continually targeting another resident and striking/assaulting this individual. This resident was now residing in another unit within this centre and had just recently been transitioned prior to this inspection. While an internal transition did show some action on the part of the provider, as a direct result of this resident targeting another resident (physically), inspectors remained concerned that this resident's challenging behaviours would continue to be a concern in the unit he has transitioned into due to his own presentation and the profile of residents residing in this unit. For example, there had already been an aggressive incident involving another resident in the short time since the transition had taken place. The mix of residents within the centre meant that some residents were very vulnerable to peer-to-peer incidents. This issue is highlighted under Outcome 4 and in the accompanying Action Plan.

On the previous inspection it was noted that there were 26 safeguarding referral in a

three month period whereby on this inspection inspectors found that there were 12 safeguarding referrals in a 2 month period. These included instances of peer/peer violence/aggression, self injurious behaviour and unexplained injury. As highlighted above while two 'internal transitions' had taken place/were in process, since the previous inspection, a continuous occurrence of physical and emotional abuse and aggression amongst residents was not acceptable in terms of ensuring all residents were adequately protected from harm in accordance with regulatory requirements.

Inspectors observed an instance whereby a resident highlighted as a risk to other residents (who was recently transitioned from another part of the centre) began to have an episode of challenging behaviour at a time when the required number of staff were not present in the unit. As a result other residents were at risk of assault. Inspectors were not satisfied at the centres ability to protect and or supervise all residents in this instance.

Regarding the management of behaviours that challenge inspectors found that the majority of staff spoken to on this inspection had good knowledge of residents behaviours and support plans. Inspectors found of 3 residents with complex behaviours reviewed, each now had an updated and reviewed behavioural support plan. Residents requiring further psychological assessment had been referred for same. For example, one resident who required an updated Multi-Element Behavioural Support Plan had been referred for same with increased psychological support granted according to the Clinical Nurse Manager (CNM).

Inspectors noted one resident whose behavioural support plan highlighted a 'tea program' in place, whereby his requesting tea/coffee was prescribed as requiring an immediate/quick response from staff as this was a potential trigger/antecedent to behaviours of concern. This resident was observed on two occasions requesting tea but staff at the time were supporting other residents and therefore could not meet this need, this resident was then observed to begin screaming and becoming very agitated.

This same resident was highlighted as enjoying a 'low arousal' environment and staff explained he liked to relax in the back garden lying on the grass in the sun. Inspectors observed this resident attempting to do this on day two of inspection. However shortly after the resident lay down on the grass a member of maintenance staff was observed putting on ear protection and started mowing the lawn around this resident (who was lying on the grass). This issue was flagged to the person in charge as a concerning and institutional approach to care provision as inspectors found this was in complete contravention to this resident's assessed behavioural needs.

Regarding restrictive practices in this centre inspectors were continually concerned at the restrictive nature of the physical environment. As highlighted in the previous report this centre was environmentally designed as 4 units that were all locked at all times. However there were some measures introduced that aimed at improving this. For example, inspectors were informed that there was now a discontinuing of the use of the 'seclusion rooms' that were in the centre. In addition, residents' now had some access to their kitchen facilities.

However as this was a purpose built secure unit, the centre remained very restrictive by

nature and physical design. For example, the use of cage panelling around the staff office, perspex screening, fixed beds and fixed furniture fittings within the centre. The CNM highlighted this area was being reviewed and will be continually reviewed to remove restrictions that are no longer deemed necessary in accordance with residents' assessed needs.

In addition, some staff were observed carrying large bunches of keys on their belts which further added to the restrictive culture within this institutional setting. Since the previous inspection, some efforts were underway to reduce this and the inspectors did see efforts to try to make the unit more homely, such as the purchase of some soft furnishings, cushions for furniture and ornaments.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

As mentioned under Outcome 7 inspectors reviewed an accident and incidents log within the designated centre. All adverse incidents which required notification to the Chief Inspector had been submitted within the required timeframe. Inspectors found instances that required notification had been followed up. For example, a resident who had a number of falls had been re-assessed, an updated risk management plan was completed and a referral to the falls clinic had been made.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

### **Findings:**

While residents were observed as having access to some appropriate allied health professionals, inspectors found that further improvement was required in certain healthcare related areas. In addition, while some measures had been implemented since the previous inspection regarding food and nutrition, further improvement was also required in this area to improve regulatory compliance.

There was good access to the general practitioner and allied health professionals. Inspectors noted SALT was in the designated centre at the time of this inspection conducting reviews with certain residents. Inspectors also saw evidence of referrals and follow up to allied health professionals such as psychology, psychiatry, dental and specialist falls clinic.

Inspectors were not satisfied to find that a resident with a history of incontinence and skin integrity issues did not have an appropriate care plan in place to demonstrate that his needs were being appropriately met and reviewed. For example, there was no evidence of staff guidance, wound/skin assessment or care planning for preventative measures. This was the same resident whose pressure relieving mattress was found in a sub-standard and unhygienic state as discussed under Outcome 7.

The documentation regarding a resident's food and fluid intake was insufficient with regard to a resident highlighted as at risk of poor nutrition and who was visibly very slight. In examining this area with staff, inspectors were not assured that all measures were in place to ensure the recommendations of allied health professionals were consistently implemented. For example, SALT and dietician recommendations. The resident's care planning documentation and documentation maintained in the kitchen to guide staff had not been updated with the most recent instructions from the dietician.

While some improvements were noted in terms of the provision of meals and menu choice to residents there was still further improvement required in this area. For example, since the previous inspection a temperature checking system had been implemented to ensure resident's food was appropriately warm. On the day of inspection the food (that arrived from the campus canteen) was not at the appropriate temperature and was subsequently heated up for residents by staff. Two residents were observed to be included in the preparation of meals which was an improvement from previous inspections whereby residents were not permitted in the kitchen area. These residents appeared to enjoy this process.

Some residents were observed queuing outside the kitchen to await to go in and choose their meals from a bain-marie. While a positive move away from the old system whereby resident's meals were provided through a 'hatch', some further improvement was required. For example, food came from the canteen in a heated trolley/bain-marie and the meal time experience observed by the inspector was not pleasant. Three residents were observed eating at 3 separate tables with one resident screaming while one resident ate his meal and another resident also began to become very agitated. Also at this time another resident used the opportunity to run through the staff office into

another unit in an attempt to get another resident's possessions. It was clear to the inspectors that the mealtime experience and recent changes to it remained difficult for staff to manage.

**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:**

While there were some positive changes since the previous inspection, inspectors found that further improvements were required in the area of medication management to ensure residents were fully protected by appropriate policies and procedures and best practice guidelines.

Inspectors noted that the provider was in the process of implementing a new medication prescription system to enhance the operational systems regarding medication. This implementation process was being overseen by the new residential programme manager. The new prescription system was also devised to be in print format to improve legibility which had been an issue on the previous inspection. In addition, a medication management folder was available on each resident's medication to ensure staff administering medications had the appropriate information available to them to do so safely.

Inspectors were not satisfied that all 'as required' (PRN) medications were appropriately written up, with maximum dosages not evident on all prescription guidance documents reviewed. In addition, there was no evidence of appropriate robust follow up on medication errors whereby medications have not been administered or not administered as prescribed. The practices reviewed did not consist of appropriate review, learning from and sign off and therefore did not offer satisfactory assurance to prevent reoccurrence.

**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):****Findings:**

The governance and management systems in place in this centre had made some improvements, however as highlighted in the outcomes discussed, the actual meaningful change for residents remained at a very basic and incremental level. From a governance and management perspective, further work was required regarding effective change management, effective auditing and action implementation and the formation of measureable transition planning for residents. While quality enhancement planning was in place there was not sufficient progress towards quality enhancement in residents' lives.

The person in charge remained responsible for two designated centres at the time of this inspection. This arrangement (as highlighted on the previous inspection) required review in order to ensure the effective governance, operational management and administration of the designated centre. Inspectors were informed that an additional person in charge had not yet been recruited but interviews were taking place regarding same.

A residential programme manager had been recently recruited and was in place at the time of inspection. This person participating in management had supervisory oversight for seven designated centres, five of which were based on the campus. This was a positive development given the vacancy in the Director of Nursing position within the organisational structure. Areas of priority for development that were highlighted by the residential programme manager included the transition of residents to the community, risk management, care-planning and person centred planning.

Inspectors reviewed the quality enhancement and action plans submitted to the Authority. While some actions had been undertaken such as reviews and audits of schedules and templates, there was not a sufficient and effective system of auditing in place. For example, there had not been an audit of person centred plans within the centre and the standard of the medication management audit (the only audit completed) was found to be very basic in its scope. As a result it did not support on-going improvement in this area. Inspectors remained concerned that there was not yet a system of annual review whereby the quality and safety of care and support of residents within the centre was appropriately monitored and reviewed by the provider since

commencement of the Regulation in 2013. While there was documentary evidence of unannounced visits for the purposes of monitoring the centre, these were found to be ineffective as they did not identify and address the areas of concern highlighted over recent inspections. Inspectors found that the rate and pace of change to move towards regulatory compliance remained ineffective.

**Judgment:**

Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Inspectors were informed that the number of staff had increased within the designated centre. However, staffing levels still were in need of review in order to meet the assessed needs of residents.

Since the previous inspection, core staff teams had been established with such teams specific to individual units within the centre. This was a positive development with regard to the continuity of care. Inspectors were informed that the centre was now working with a full complement of rostered staff while the clinical nurse managers (CNMs) working in the centre had been placed in supernumerary (additional) positions to ensure that actions identified in previous inspections were addressed. This was a positive development since the previous inspection. A protocol had been introduced to ensure that staff members who were on sick leave were now replaced and the possibility of overtime was now available. To facilitate this development, agency staff had been allocated to the units within the centre. All of these measures were aimed at tackling the 'consistency' issues within the staffing of this centre.

Inspectors found that staff spoken with presented as aware of resident's needs and staff highlighted that there were a lot of changes currently occurring in the units. All staff spoken with welcomed the formation of core teams and sick leave cover within the centre. Staff were observed to have treated residents with dignity and respect through their interactions over the course of this inspection.

While inspectors noted two CNMs were supernumerary on day-one of the inspection, this was not the case on day two of inspection with one CNM on supernumerary duty. This CNM was also observed to be continually moving from unit to unit to provide varying levels of support.

Inspectors found that across the 4 units there were 12 staff allocated as a full compliment. The CNM and Person in Charge highlighted the plan for the centre was to have 3 staff on duty in each of the 4 units. Inspectors found instances whereby there were not appropriate numbers of staff on duty in each unit to respond to residents needs. For example, in one unit in particular whereby residents behavioural needs were higher, inspectors observed occasions when multiple residents' were seeking support from one staff member. In addition, in the evening of day two of inspection three residents clearly required support with individual challenging behaviours and there was not enough staff in the unit to support these residents. As highlighted under outcome 8 this placed some residents at risk of peer to peer assault.

As highlighted in the previous inspection reports the clarity of training records provided required improvement. However further progress had been made in addressing some deficits in staff knowledge and training. As mentioned previously, gaps in fire and safeguarding training had been addressed while a schedule of training was in place until the end of 2015. This schedule included training in the areas of behavioural support, therapeutic management of violence and dysphagia but did not include any additional training in the area of risk management.

The first inspection of the centre in March 2015 highlighted an absence of training in the areas of autism awareness despite the high number of residents within the centre who were on the Autism spectrum. At the time of this inspection 11 staff had received training in this area with a further training date scheduled in November. Training had also been provided in the areas of epilepsy management and meaningful days. Inspectors noted that training in social planning and person centred planning was required in this centre in order to address some of the issues as highlighted under outcome 5.

**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-0002936
<b>Date of Inspection:</b>	21 and 22 September 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 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

All residents did not have choice and control over their lives.

**1. Action Required:**

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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

freedom to exercise choice and control in his or her daily life.

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

The Registered Provider shall ensure that the person in Charge shall ensure that :

1. Residents are supported to exercise choice at meal times, by being facilitated to choose from the pictorial menu in addition to the meals being displayed in the Bain Marie. Additionally, key staff have identified a range of other preferences that are readily available in the Designated Centre
2. Through the review of rosters Residents are supported to avail of recreational opportunities in accordance with their activity schedule, identified goals and personal preferences.
3. Personal plan reviews have commenced with the participation of the residents/ representative as per schedule. 20 'My Personal Plans' (MPP) have been completed. The remaining three plans have commenced and will be completed by 30/11/2015.

Proposed Timescale:

1. 19/10/2015
2. 19/10/2015
3. 30/11/2015

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

**Theme:** Individualised Supports and Care

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

Residents' privacy and dignity was not maintained with two residents observed walking around the unit in a state of undress.

**2. Action Required:**

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

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

1. Intimate care plans have been reviewed by the Staff team and updated for the two residents identified and relevant staff have been informed of the additional supports required to ensure the privacy and dignity of the Residents.
2. The local Privacy and Dignity procedure has been implemented to promote a culture of Dignity and Respect for each resident by the staff.
3. Privacy and Dignity of Residents will be discussed at staff meeting on 27/10/2015.

4. Both residents identified had been referred to Psychology and reviews are in progress in line with organisational Positive Behaviour Support Policy.

Proposed Timescale:

1. 23/10/2015
2. 23/10/2015
3. 27/10/2015
4. 17/06/2015

**Proposed Timescale:** 23/10/2015

#### **Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

Admission criteria was not found to be based on the protection of all residents from abuse by their peers.

**3. Action Required:**

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

1. There are no admissions to this Designated Centre and all transitions including internal and external within the Designated Centre will be in line with the Saint John of God Support policy

**Proposed Timescale:** 01/07/2014

**Theme:** Effective Services

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

There were no contracts for the provision of services in place with residents/and or representatives.

**4. Action Required:**

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

1. Each resident will have a written Contract of Care and Support agreement setting out the services provided and all fees will be included.

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

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

All residents did not have a comprehensive assessment in place regarding their social care needs, social goal setting and person-centred plans.

**5. 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:**

The Person in Charge shall ensure that:

1. All Health Assessments are now completed for each resident.
2. The SALT communication plan for 2015/2016 continues to be implemented at Stage 1. Stage 2 of the process has begun re staff information sessions re objects of reference, choice making and visual schedules.
3. Staff training has commenced in Personal Outcome Measures (POMS) and Person Centred Planning. Some staff have completed the training and a schedule is in place for the remaining staff to complete this training.
4. Following the completion of POMS training the PIC will ensure a full review will take place of the resident's social goals.

Proposed Timescale:

1. 30/09/2015
2. 17/10/2015
3. 30/11/2015
4. 15/01/2016

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

**Theme:** Effective Services

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

Each resident's social care needs were not being met. Each resident's opportunities to pursue meaningful activities in line with their needs, wishes and preferences were not being appropriately provided for. Residents were not found to be provided with adequate social activities since the previous inspection.

**6. Action Required:**

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

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

The registered Provider will ensure that

1. Staff training has commenced in Personal Outcome Measures (POMS) and Person Centred Planning. Some staff have completed the training and a schedule is in place for the remaining staff to complete this training.
2. Following POMS training a review of social goals has commenced with the residents.
3. Additional staff will be assigned to provide residents with opportunities for social activities.

Proposed Timescale:

1. 30/11/2015
2. 15/01/2016
3. 30/11/2015

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**Proposed Timescale:** 15/01/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Personal plans were not accessible to residents.

**7. Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are 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. MPPs have been reviewed and updated for 20 residents. The remaining three plans have commenced and will be completed by 30/11/2015.
2. An accessible template has been developed by the PIC and is under review by the Speech and Language Therapist (SALT).
3. Each resident will have an accessible MPP available to them

Proposed Timescale:

1. 30/11/2015
2. 27/10/2015
3. 15/01/2016

**Proposed Timescale:** 15/01/2016

**Theme:** Effective Services

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

All personal plans were not being reviewed in terms of their effectiveness. For example, resident's social goals and person-centred plans had not yet been appropriately reviewed since the previous inspection.

**8. 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:**

The Person in Charge shall ensure that all MMPS will be reviewed and update.

1. Currently 20 MMPS have been updated and reviewed and the remaining 3 MPP's will be completed by 30/11/15

2. An audit schedule of the MPPs has been developed by the Person in Charge (PIC) in order to monitor the effectiveness of each residents identified supports and all MPP's will be audited by the PIC.

Proposed Timescale:

1. 30/11/2015

2. 31/01/2016

**Proposed Timescale:** 31/01/2016

**Theme:** Effective Services

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

There was no evidence of clear and transparent criteria for a resident who was highlighted as having left the designated centre but still had a room in the centre.

**9. Action Required:**

Under Regulation 25 (4) (a) you are required to: Discharge residents from the designated centre on the basis of transparent criteria in accordance with the statement of purpose.

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

1. The resident concerned has remained at home in the care of the family and will be formally discharged from the DC at the Application for support Committee scheduled in November.

**Proposed Timescale:** 09/11/2015

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

**Theme:** Effective Services

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

Systems were not in place to provide for adequate infection control based on the standard of hygiene and cleanliness of residents' sleeping arrangements observed on inspection.

**10. Action Required:**

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

The Registered Provider shall ensure that:

1. A replacement pressure relieving mattress and bed have been purchased for the resident identified in the report.
2. A skin integrity plan is now in place.
3. Monitoring of mattress pressure is carried out daily.
4. Daily cleaning schedules for all beds have been implemented in The Designated Centre
5. An Infection Control audit will be completed by the PIC to ensure that adequate infection control measures are in place.

Proposed Timescale:

1. 19/10/2015
2. 12/10/2015
3. 21/09/2015
4. 28/09/2015
5. 30/11/2015

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

### **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:**

Behavioural support plan techniques and recommendations were not observed to be implemented for a resident who displayed challenging behaviour.

**11. Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

The Person in Charge shall ensure that:

1. A new policy on Positive Behaviour Support (PBS) has been approved by the Board of Saint John of God Community Services on 25/06/2015.
2. The Roll out of the New Policy on PBS and practice training has commenced and 21 staff have attended.
3. The Psychologist is currently attending a monthly staff meeting to review all current Behavioural Support Plans (BSPs) and support the implementation of approved strategies.
4. Staff supporting residents will read and sign existing BSPs.

Proposed Timescale:

1. 25/06/2015
2. 30/11/2015
3. 10/10/2015
4. 31/10/2015

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

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

There was not evidence that appropriate health care was available to all residents. For example, appropriate management of skin integrity.

**12. Action Required:**

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

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

The Registered Provider has ensured that:

1. All Health Assessments are now completed for each resident and skin integrity plans are in place where required.

**Proposed Timescale:** 30/09/2015

**Theme:** Health and Development

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

The mealtime experience was significantly compromised due to the varied needs of the residents at this time and the availability of staff to meet these needs.

**13. Action Required:**

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

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

The Person in charge has put the following measures in place:

1. Protected meal time has been established to support residents at their mealtimes with the presence of all rostered staff.
2. All new and non-permanent staff have received induction into the dietary support needs of residents as appropriate and signed off on the recommended supports
3. Relevant staff have attended training in Dysphagia.
4. Allied health professional recommendations have been incorporated into residents Food diaries.

Proposed Timescale:

1. 12/10/2015
2. 22/09/2015
3. 05/10/2015
4. 22/09/2015

**Proposed Timescale:** 12/10/2015

**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 regarding medication practices such as PRN documentation and follow up on medication errors.

**14. 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:**

The person in charge has ensured that:

1. All PRN (as required) medications are now appropriately written up and include

maximum dosages.

2. Where medication variances occur, each variance is followed up, documented and that there is shared learning amongst the staff team.

Proposed Timescale:

1. 28/09/2015
2. 22/10/2015

**Proposed Timescale:** 22/10/2015

## **Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

The person in charge did not demonstrate effective governance, operational management and administration of the designated centre concerned.

#### **15. 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:**

The Registered Provider has:

1. Completed a further review of organisational structures.
2. 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.
3. The PIC shall develop a schedule of audits to oversee that appropriate processes and procedures are in place to ensure an effective and safe service provision within the Designated Centre eg. Care Plans, Risk Management, Meaningful Day, Medication management etc.

Proposed Timescale:

1. 25/10/2015
2. 02/11/2015
3. 13/11/2015

**Proposed Timescale:** 13/11/2015

**Theme:** Leadership, Governance and Management

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

**the following respect:**

There was no appropriate annual review system in place to ensure safe and quality care was effectively monitored by the provider.

**16. Action Required:**

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

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

1. The registered provider will agree a system to support the development of an annual review of care and support
2. A satisfaction Survey will be forwarded to residents and their representatives for completion , to inform the annual review of care and supports
- 2b. The data from the satisfaction survey will be analysed and inform the annual review
3. The Annual review of Care and Supports for 2015 will completed
4. The Annual review will be made available to the residents and their families

**Proposed Timescale:**

1. 30/11/2015
2. 15/12/2015
- 2b. 15/01/2015
3. 31/01/2016
4. 08/02/2016

**Proposed Timescale:** 31/01/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The number of staff on duty in this designated centre was not meeting the needs of all residents and required further review.

**17. 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 review was carried out and additional staff are being assigned to meet needs of residents in this DC

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

**Theme:** Responsive Workforce

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

While some training schedules were in place, all staff were not appropriately trained in necessary areas such as Autism Awareness and Person Centred Planning.

**18. 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:**

The Person in charge has ensured that:

1. Some staff have completed Autism Awareness Training to date. The next scheduled date is 24/11/2015.
2. Some staff have already completed POMS Person Centred Planning training. Additional scheduled dates are 29/10/2015 and 12/11/2015.

Proposed Timescale:

1. 24/11/2015
2. 12/11/2015

**Proposed Timescale:** 24/11/2015