**Centre name:** A designated centre for people with disabilities operated by St John of God Community Services Limited  
**Centre ID:** OSV-0003015  
**Centre county:** Louth  
**Type of centre:** Health Act 2004 Section 38 Arrangement  
**Registered provider:** St John of God Community Services Limited  
**Provider Nominee:** Clare Dempsey  
**Lead inspector:** Raymond Lynch  
**Support inspector(s):** Conor Dennehy  
**Type of inspection:** Unannounced  
**Number of residents on the date of inspection:** 20  
**Number of vacancies on the date of inspection:** 0
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 06 January 2016 10:00  
To: 06 January 2016 18:30

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

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<thead>
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<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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Summary of findings from this inspection
This was a follow up unannounced inspection to a previous inspection carried out in March 2015 and was to assess how the centre was progressing with their action plan submitted to the Authority in 2015 and level of compliance with regulations. The centre comprises of four individual houses on a campus based setting supporting 20 residents. The inspection took place over one day and as part of the process, practices were observed and relevant documentation reviewed such as individual personal plans, health care records and policies and procedures.

Since the last inspection a new clinical nurse manager 1 (CNM1) and person in charge (PIC) had been appointed. The PIC was supernumerary in his role and the CNM 1 had adequate protected management hours. Inspectors found that this new management structure had improved the governance and management arrangements of the centre.

Overall inspectors found that improvements had been made across all outcomes. Significant issues remained with regard to the suitability and layout of premises
however, inspectors were informed that a de-congregation implementation planning committee had been initiated in May 2015. During the course of the inspection documentation of the scheduling of these meetings was observed.

Of the ten outcomes assessed, five were found to be compliant, including governance and management, residents' rights, dignity and consultation, notification of incidents, social care needs and medication management. One outcome, health care needs was found to be substantially compliant. Moderate non compliances were found in safeguarding and health, safety and risk management, while major non compliances were found in safe and suitable premises and workforce.

Over the course of the inspection, inspectors found staff to be courteous, supportive and helpful with the inspection process and it was found that the quality of service delivered to the residents had improved. The CNM 1 was able to demonstrate her knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities in Ireland throughout the inspection process.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Since the last inspection improvements were found across this outcome. More options with regard to day services and community based activities were offered to residents, the centre had been redecorated, access to bathrooms had improved which had enhanced the privacy and dignity of residents and procedures for dealing with complaints were reviewed. A new person in charge (PIC) and clinical nurse manager 1 (CNM 1) had also been appointed to the centre since the last inspection.

Inspectors found that a consultation process had progressed with residents with regard to what they wanted from the centre. For example, in order to ascertain what activities they would like to participate in, staff commenced and progressed an activity sampling process where residents could chose what they liked to do best from a range of activities offered to them.

From a sample of personal plans viewed, each resident had their own individual plan that was informative of the supports required to maintain and enhance their dignity and independence. Individual plans also detailed how residents' privacy and dignity were to be maintained, specific to individual needs and wishes.

Residents' bedrooms were decorated to individual preferences and with personal possessions. For example, in one resident's individual plan it was reported that he liked
to watch certain TV programmes. On viewing his bedroom inspectors observed that he had pictures of his favourite TV characters on the wall. Issues were identified with regard to the size and layout of some bedrooms however, this was further discussed under outcome 6: safe and suitable premises.

A complaints policy was available in the centre. Records reviewed showed inspectors that complaints were being logged and dealt with accordingly. For example, a complaint was made relating to a staffing issue in the centre. This was recorded and dealt with at local level in a manner which addressed the needs of the residents. It was also recorded that this outcome was adequate in addressing the matter to the satisfaction of the complainant.

During the course of the inspection staff members were observed to treat residents with dignity and respect. Inspectors also noted that staff spoke about residents warmly and in a dignified manner.

Judgment:
Compliant

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

Findings:
Inspectors found that the wellbeing and welfare provided to the residents had improved since the previous inspection. From a sample of files viewed, each resident had comprehensive individual personal plans in place.

Social care plans had been developed, were personalised and reflected residents' individual requirements in relation to their social care needs. Residents were actively
involved in the development of their individualised personal plan and in discovering their own social preferences.

For example, the CNM1 informed inspectors that she, the person in charge and staff team had undertook a process of ‘sampling activities’ with some of the residents in the centre. Through this process, staff were able to establish the activity preferences of each resident. These activities had then been transferred to, and provided at a separate day service in order to promote a meaningful day for each resident outside of the centre. It was also observed that one resident enjoyed gardening and a small herb garden had been developed for him, which he tended to with the support of staff.

Since the last inspection some residents' had been supported to use the local amenities in the community and nearby village. For example, one resident had used the local barber, others frequented the local pubs and shops and from a sample of individual social care plans viewed, outings to restaurants, hotels and trips to nearby local towns had been facilitated. The person in charge informed inspectors that a number of residents had also gone to the ploughing championships in County Laois. Photographs of residents enjoying themselves at this outing were observed during the inspection.

A trip to Funderland had also been organised and on checking the roster inspectors noted that additional staff had been secured for the outing to ensure there was adequate individual support for each resident.

Inspectors were informed that family members visited the centre to see the residents. However, one resident had requested to visit his family home as he had not been there in a number of years. This goal was achieved since the previous inspection and the CNM 1 informed inspectors that the trips home were now a regular part of the resident's routine and overnight stays had also been supported and facilitated.

The weekly activity timetable was viewed and activities such as art therapy, cinema, chair and aqua aerobics, seated yoga, outings, stay active programmes, swimming, cinema and massage therapies were offered to each resident depending on their individual abilities and preferences.

Overall inspectors found that substantial progress had been made with regard to providing for the social care needs of the residents in the centre. While some activities such as swimming and cinema continued to be facilitated on campus, the CNM 1 informed inspectors that they would continue to explore social and community based options so as to further enhance a meaningful day for each resident.

**Judgment:**
Compliant
### Outcome 06: Safe and suitable premises

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

#### Theme:
Effective Services

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

#### Findings:
The physical layout of the centre continued to provide challenges to the provision of a quality based service and major non compliance was found in this outcome. However, inspectors found that some improvements had been made since the last inspection which enhanced the overall living experience for residents.

On entering one house of the centre, inspectors noted it was warm, clean, redecorated and some partitioning had been removed which had improved the overall layout of the sitting room, making it more spacious and welcoming. This in turn also meant that residents had more communal living space to avail of. Walls were also decorated with pictures and shelving had been added decorated with ornaments.

The previous inspection identified that there were issues with regard to the temperature of water and radiators. Inspectors found that these had been addressed and there was adequate hot and cold water available on a constant basis, The hot water temperature had been assessed and radiator temperatures had been checked and reduced where necessary.

The CNM 1 informed inspectors that thumb turns had been introduced in some parts of the centre, which had also enhanced privacy for residents.

However, the layout of the centre remained inadequate for its stated purpose. Many bedrooms were small (approximately five to seven square metres gross floor area), windows in each bedroom were inadequate as residents could not access them or view the outside gardens from them, storage space for personal belongings was inadequate and the layout of the bathrooms compromised the dignity and privacy of individual residents. For example, some bathrooms comprised of communal facilities. It was also observed that while bathrooms were clean and warm, they required some updating and repair. For example, some of the tiling was cracked and broken.
These issues were identified and actioned in the previous inspection and during the course of the inspection the CNM 1 reaffirmed to inspectors that a de-congregational implementation committee had been initiated in May 2015. This committee was to commence transitional plans for each individual residing in the centre and would be informed by a support intensity scale assessment for each resident.

These support intensity scale assessments were completed in December 2015 and were to address the current unsuitable living environment while identifying a more appropriate environment in a community based setting for each resident. This initiative was to be further progressed in early 2016 and the management and staff of the centre were continuing to work on addressing the non compliances identified in the previous inspection.

**Judgment:**
Non Compliant - Major

<table>
<thead>
<tr>
<th><strong>Outcome 07: Health and Safety and Risk Management</strong></th>
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<tbody>
<tr>
<td>The health and safety of residents, visitors and staff is promoted and protected.</td>
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| **Theme:** |
| Effective Services |

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

| **Findings:** |
| Individual risk assessments were in place and were viewed by inspectors in residents’ individual personal plans. Of the sample viewed, it was found that they provided a good overview of risks associated with each individual and how to mitigate each risk. They were last reviewed in August 2015. The person in charge also informed inspectors that he was completing a risk register for the centre. |

Fire drills were carried out routinely, and records from one house of the centre informed that the last fire drill was conducted in August 2015. According to the fire register it took one minute and twenty eight seconds to evacuate all residents from the house and no concerns were noted. Individual personal emergency and evacuation plans were also found to be in place and from a sample viewed, it was found they were updated in October 2015.

Weekly checks took place for emergency lighting and fire extinguishers and on viewing records they were last checked in January 2016. Annual maintenance records for all fire equipment, such as fire extinguishers were viewed and it was found that they were up
to date. The next annual review was not due until March 2016.

The CNM 1 informed inspectors that since the last inspection a fire panel that was broken had been repaired and the fire alarm was serviced and tested in September 2015 by a professional external body. Inspectors viewed the certificate provided to the centre by the professional body.

Management had also commissioned a full review of the centre by a fire safety consultant company. This resulted in a fire safety plan being compiled for the centre. The implementation of this plan had addressed areas of non compliance from the last inspection with regard to opening and closing of fire doors, escape routes, and adequate visible signage for escape. The same company also provided house specific fire training and evacuation to the staff working in the centre. However, it was noted that there were some gaps in fire training for some staff. This was dealt with under outcome 17: workforce.

Overall the centre had made substantial progress in addressing the actions required from the previous inspection. However, during the course of the inspection the CNM 1 said that work had been done by the fire safety consultant in addressing issues with the fire doors (which was highlighted in the last inspection report). There was no documentary evidence available to support this and the sheet provided to record such work was found to be blank. It was also found that some bedrooms only had access to escape exits via a living space (as opposed to a circulation space such as a corridor), which could present with a possible impediment to evacuating residents. This was also highlighted in the previous inspection.

However, as discussed in outcome 6: safe and suitable premises, the CNM 1 informed inspectors that a de-congregational implementation committee had been initiated in May 2015. This was to address the current unsuitable living environment while identifying a more appropriate community based setting for each resident in the centre.

**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:
There was a policy on, and procedures in place in relation to safeguarding vulnerable adults, which provided clear guidance to staff. The CNM 1 informed inspectors there was a designated person to deal with any allegations of abuse. Personal and intimate care plans were also in place and provided guidance to staff ensuring, consistency, privacy and dignity in the personal care provided to residents.

Of a sample of individual personal plans viewed, positive behavioural support plans were in place. Positive behavioural support plans clearly identified possible triggers and antecedents to challenging behaviour and provided staff with guidelines on how to manage it proactively. Reactive strategies were also included in the plans.

Evidence presented to the inspectors demonstrated that the number of problematic behaviours and peer to peer aggression was in decline. The CNM 1 informed inspectors that this was due to multiple factors. All residents where required, had a positive behavioural support plan in place, meaningful activities were supported in the centre, there were more opportunities for outings and parts of the environment were redecorated to provide more communal living space for the residents. The CNM 1 was also a trained behavioural support specialist, having completed a specialised programme of training.

However, gaps were identified with regard to training for the Therapeutic Management of Aggression and Violence and some staff had not received training in positive behavioural support. Training for all staff in positive behavioural support was due for completion in October 2015 as detailed and required in the last action plan. The CNM 1 informed inspectors that this training would take place in February 2016. Further issues with regard to training were discussed in detail under outcome 17: workforce.

A sample of personal finance records were viewed and it was found that personal monies were kept safe through robust record keeping practices. For example, each resident had a detailed account of their income and expenditure and all purchases were logged with accompanying receipts for verification. Inspectors checked a sample of balance sheets and they were found to be transparent and accurate.

Judgment:
Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where
<table>
<thead>
<tr>
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<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
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<tr>
<td>No actions were required from the previous inspection.</td>
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<tr>
<td><strong>Findings:</strong></td>
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<tr>
<td>The inspector found that a record of all incidents occurring in the designated centre were maintained and where required, notified to the Chief Inspector. It was also observed that the centre had addressed issues of non compliance regarding notifications as identified in the previous inspection report.</td>
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<tr>
<td><strong>Judgment:</strong> Compliant</td>
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**Outcome 11. Healthcare Needs**  
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

<table>
<thead>
<tr>
<th>Theme: Health and Development</th>
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<tbody>
<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
</tr>
<tr>
<td>Some action(s) required from the previous inspection were not satisfactorily implemented.</td>
</tr>
<tr>
<td><strong>Findings:</strong></td>
</tr>
<tr>
<td>The healthcare needs of residents were being appropriately provided for while the mealtime experience had improved.</td>
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<tr>
<td>Since the previous inspection individual medical assessments had been carried out for residents which resulted in care plans for identified needs. Most actions resulting from these plans were appropriately followed up on, for example appropriate referrals made to allied health professionals.</td>
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<tr>
<td>However it was noted in one resident’s care plan that a vaccine was being discussed with the resident’s General Practitioner. Although some initial discussions had taken place around this during October 2015 this had not been followed up and as a result the resident had not received the vaccine at the time of inspection.</td>
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<tr>
<td>In line with the new individual medical assessments the monitoring of residents’ healthcare needs had also improved. Care plans resulting from the medical assessments</td>
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were reviewed at three monthly intervals or as required. Required frequent recordings such as monthly weights were documented while any issue identified during such monitoring was responded to. On the day of inspection one resident was off site receiving medical in response to a concern highlighted by monitoring.

Inspectors observed the mealtime experience in one of the units and found it be a relaxed and calm event with sufficient staff available to provide appropriate support to residents. Food for meals continued to be brought to the centre via a bain marie trolley which remained an institutional practice. However the dining area was brightly decorated with the tables set which added to a more sociable feel. The food presented to residents was in line with recommendations from dieticians and speech and language therapists.

As the food was received from the central canteen residents were asked twice a week which food they would like for the coming days. This system had not changed since the previous inspection but it was noted there was sufficient quantities of the food available in the unit to provide alternatives to residents if needed.

For example one resident was observed not wanting the meal presented to him. A member of staff prepared an alternative meal in the kitchen area of the unit which was eaten by the resident. Suitable snacks and refreshments were also available in this unit for residents outside of mealtimes.

**Judgment:**
Substantially Compliant

**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

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

**Findings:**
There were systems in place to ensure that residents' medicines were managed appropriately.

Overall inspectors found that residents were protected by safe medication management policies and practices. All residents were supported in the administration of their medication by appropriately qualified and trained staff members. Documentation with regard to the administration and prescription sheets contained the required information to support the safe administration of medicines.
There was a robust medication administration and management policy in place for the centre. This included processes to ensure appropriate procedures were in place for the handling and disposal of unused and/or out of date medicines.

All medication was locked securely in a press in each house that comprised the centre and of a sample of medications viewed, inspectors found they were correctly labelled and in date.

There was also a system in place for reviewing and monitoring safe medication practices. For example, if a drug error occurred it was recorded and reported appropriately.

**Judgment:**
Compliant

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service across the four houses that comprised the centre. Since the previous inspection a new person in charge had been appointed, as well as a clinical nurse manager 1 (CNM 1)

This inspection found that the centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service. From speaking with the person in charge it was evident that he had an in-depth knowledge of each resident's support needs. He was also aware of his statutory obligations and responsibilities with regard to management of the centre. The person in charge was supernumerary and fulltime.
She was also supported by a skilled, qualified and experienced CNM 1. The CNM 1 acted in a management capacity across the entire centre and had adequate protected management hours included in her roster. She had commenced a process of professional development reviews for all staff. Samples of these reviews were observed by inspectors. The CNM 1 was also found to be aware of her statutory obligations and duties with regard to her involvement in the management of the centre. She had an in-depth knowledge of the support needs of each resident. She also informed inspectors that the PIC was very supportive and approachable. The person in charge and CNM 1 meet regularly with the Director of Care to update him on how the centre was progressing.

The CMN I informed inspectors that an on call management system was in place, where staff could make contact with a clinical nurse manager III (CNM III) in the event of an emergency or any unforeseen circumstance occurring.

Inspectors reviewed the results of an unannounced audit of the quality and safety of care and support of the centre, which was conducted in November 2015. This was an in-depth analysis of how the centre was progressing in meeting the requirements of regulation. It also identified the actions required to address any gaps identified. For example, it was identified in the audit that the person in charge was required to commence the process of supervision with the staff in the centre. During the course of the inspection, inspectors observed that this process had commenced.

Both the person in charge and CNM 1 were off duty on the day of inspection. However, the CMN 1 made herself available for the entirety of the process and reported into the centre once she was made aware that an inspection was happening. The person in charge made himself available to the CMN 1 via phone throughout the day and also attended the feedback in the centre at the end of the inspection process. The person in charge also made the findings of an unannounced internal audit available to inspectors. The audit was found to be informative of the progress the centre has made since the last inspection, and identified actions for areas that required further review.

Judgment: Compliant

Outcome 17: Workforce

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

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

Findings:
While improvements had been made in terms of the skill mix, supervision and continuity of staff, inspectors remained concerned regarding the number of staff to ensure the care and safety of residents.

Since the previous inspection an additional staff member had been allocated to the designated centre while the appointment of a new Person in Charge and a Clinical Nurse Manager had improved staff supervision. A core team of agency staff was also in place for the centre to ensure a greater continuity of care for residents. In addition rosters were being reviewed in an attempt to ensure that staff were allocated to provide maximum support for residents at peak times such as during the mornings.

However it was apparent that there was still insufficient numbers of staff. Seven residents were residing in one of the units including one resident who displayed particular behaviours which required close supervision. At the time of inspection one staff member was allocated to this house between 8pm and 8am. An on-call support staff member who covered the entire campus was allocated to this unit during these hours. However, if required in another nearby designated centre the this staff member would have to leave this unit without being replaced.

This was found to be an unreliable arrangement to provide adequate cover in this unit. Some staff members informed inspectors that when on night duty, a lone staff member providing intimate support to one resident could mean leaving six residents unobserved, including the resident who required close supervision.

The need for extra staff in this unit at night had been acknowledged within the designated centre in November however this had not been adequately addressed at the time of inspection. It had also been logged in the complaints records kept in the centre (which was discussed in outcome 1: residents rights, dignity and consultation). Since the previous inspection support intensity scale assessments had been completed for all residents in December 2015, but the information collected had yet to be fully analysed. Hence these assessments had not resulted in additional staff supports being provided.

Training records of all staff members were reviewed. As mentioned under outcome 7: health, safety and risk management, not all staff had undergone required fire training. In addition to this gaps were identified with regard to training for the Therapeutic Management of Aggression and Violence while refresher training in manual handling for some staff had not been updated in line with the providers’ own policies. Eleven staff had received training in positive behavioural support with further training scheduled for
Inspectors reviewed a sample of staff files and found that while most of the required documentation, such as proof of identity and Garda vetting, was maintained some information was omitted. For example in one staff member’s file a yearlong employment gap was not satisfactorily accounted for. There were no volunteers working in the designated centre at the time of inspection.

**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:**

Raymond Lynch
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003015</td>
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<tr>
<td>Date of Inspection:</td>
<td>06 January 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29 February 2016</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 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 did not meet the needs of the residents.

1. **Action Required:**
   Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The management of Bliain Orga Designated Centre and St. John of God North East are committed to ensuring that residents within this Designated Centre are prioritised for de-congregation. This will include the provision of appropriate living accommodation to meet residents individualised assessed needs. St. John of God North East Management are sourcing 2 x 4 bedded houses for Bliain Orga which will reduce the numbers in the Designated centre to 12. Each of the two houses will accommodate 4 residents; each Residents needs will be established based on the Supports Intensity Scale assessment and compatibility given the profile of the residents. These moves will afford the remaining residents of Bliain Orga with a more spacious environment until they ultimately decongregate to the Community also.  

Proposed Timescale: 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There were bedrooms which were inner rooms and therefore could impede the safe evacuation of the occupants.

2. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
1. All residents have Personal Emergency Evacuation Plans in place and are up to date. They reflect the resident’s current needs in the event of an emergency to ensure their safe evacuation from this Designated Centre.
2. The Critical Information Sheet also details what the specific residents needs are in the event of an emergency.
3. Fire Drills take place to ensure safe evacuation of residents and all action are prioritised for implementation. A night fire drill will be carried out by 17th of Feb 2016
4. Eight residents from this Designated Centre have been identified and are being prioritised for transitioning to two new houses within the community as part of the National De – congregation Reform Funding. These moves will provide appropriate living and bedroom facilities to residents.

Proposed Timescale:
1. Completed
2. Completed
4. 30/9/16
**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 all staff had adequate training to support the individual needs of the residents.

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

Please state the actions you have taken or are planning to take:
1. A schedule of training for all staff within this Designated Centre is and will continue to roll out. Each new member of staff will receive a one day Positive Behaviour Support Programme which embraces the principles of corporate Positive Behaviour Support Policy and fosters the principles of a Person Centred Culture.
2. 11 staff have completed a 1 day positive behaviour support training and by 4th May, 22 staff will have completed the one day Positive behaviour support training.
3. All staff have received safeguarding training.
4. All staff are inducted into the current Behaviour Support Plans and revised plans.
5. All new staff are inducted on commencement of employment into each resident's critical information sheet and behaviour support plan and this is managed by the Manager/Shift Leader.
6. Therapeutic Management of Aggression and Violence training has been recognised as a priority for this Designated Centre. Therapeutic Management of Aggression and Violence training will be the priority module to be delivered in the overall training programme scheduled. A Clinical Nurse Manager 1, 1 Staff Nurse and 1 Care staff are trained in Positive Behaviour Support following completion of the Longitudinal Multi Element Positive Behaviour Support Management Programme. The Clinical Nurse Manager 1 has twelve supernummary hours providing supervision.
7. Staff Nurse in the Designated Centre has a diploma in Management of Challenging Behaviour.
8. All recommendations from Positive Behaviour Support Sub Committee relating to immediate strategies to support residents who present with behaviours that challenge is implemented.
9. Fire training is taking place on the March 10th and April 13th and any outstanding staff will be allocated to these dates.

**Proposed Timescale:** 30/06/2016

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A vaccine for one resident had not been followed up on.

4. **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:**
This resident was reviewed by his GP on 08/01/2016. The GP has advised Nursing Staff that the resident does not require this specific vaccination for 12 years.

**Proposed Timescale:** 08/01/2016

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a sufficient number of staff in place to ensure the care and safety of all residents in one part of the centre.

5. **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:**
The Management of this Designated Centre in collaboration with the Staff team have re-engineered the duty roster to meet the Resident’s needs. The new roster which will be in operation by the 15th of Feb 2016, provides for additional staff during each night duty shift. Additional Staff member has been allocated every night from 21:00 to 06:00.

**Proposed Timescale:** 15/02/2016

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all of the required information was maintained in staff files.

6. **Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.
Please state the actions you have taken or are planning to take:
The Clinical Nurse Manager has met with the Human Recourse Officer and the staff Files for the Designated Centre which were not compliant with Schedule 2 are being reviewed and updated to ensure full compliance.

**Proposed Timescale:** 30/04/2016  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Gaps were identified with regard to the required training for some staff. Some staff had not attended the required training in positive behavioural support to meet the needs of residents.

**7. Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
1. A schedule of training for all staff within this Designated is and will continue to roll out. Each new member of staff will receive a one day Positive Behaviour Support Programme which embraces the principles of corporate Positive Behaviour Support Policy and fosters the principles of a Person Centred Culture.
2. 11 staff have completed a 1 day positive behaviour support training and by 4th may, 22 staff will have completed the one day Positive Behaviour Support training.
3. All staff have received safeguarding training.
4. All staff have been inducted into the current Behaviour Support Plans and revised plans.
5. All new staff are inducted on commencement of employment into each residents, critical information sheet and behaviour support plan and this is managed by the Manager/Shift Leader.
6. Therapeutic Management of Aggression and Violence (TMAV) training has been recognised as a priority for this Designated Centre. TMAV training will be the priority module to be delivered in the overall training programme scheduled.
7. A Clinical Nurse Manager 1, 1 staff Nurse and 1 Care staff are trained in Positive Behaviour Support following completion of the Longitudinal Multi Element Positive Behaviour Support Management Programme. The Clinical Nurse Manager 1 has twelve supernummary hours providing supervision.
8. Staff Nurse in the Designated Centre has a diploma in Management of Challenging Behaviour.
9. All recommendations from Positive Behaviour Support Sub Committee relating to immediate strategies to support residents who present with behaviours that challenge is implemented.
10. The Chairperson of the Positive Behaviour Support Sub Committee / Behaviour Specialist spends time in this Designated Centre on a weekly basis to review data of behaviour and provide advice and guidance to the staff team.
Proposed Timescale: 30/06/2016