Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003645
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:	Noelene Dowling
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
01 February 2016 17:00	01 February 2016 20:00
02 February 2016 08:30	02 February 2016 18:00

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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was a monitoring inspection and the first full inspection of this centre in its current configuration which had been the subject of a single issue inspection previously in 2014. This centre forms part of an organisation which has a significant number of designed centres nationwide. This centre is designed to provide care for adult residents of moderate to severe intellectual and physical disability, autism and mental health.The inspection was unannounced inspection and took place over 1:5 days.

NIne of the required outcomes were inspected in full with a further three partially reviewed. As part of the inspection inspectors met with residents, a family member and staff members. Inspectors observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, policies, procedures and staff files. Staff were observed to be respectful attentive and very knowledgeable on the residents needs. The residents who could communicate with the inspectors indicated that they were happy with the service, their day care arrangements and comfortable with the staff. The actions identified at the previous

inspection had been addressed by the provider.

This inspection found that the provider was in substantial compliance with the regulations with some improvements required.
Staffing levels and skill mix were satisfactory and had been revised as resident needs changed. Good practice in health care and access to allied health care services including mental health services was evident.
Multidisciplinary services were available and accessed in a timely manner for the residents.

Residents and their representatives had significant involvement in the development of comprehensive personal plans and reviews to ensure their health, social and personal care needs were identified and supported according to their wishes. Care was provided on a one-to-one basis to ensure residents' needs were met.
Some improvements were required in the following areas:
• procedures for the management of allegations or concerns of potential abuse
• risk assessments
• documentation of the decisions and effectiveness of personal plan reviews
• privacy and consultation with residents or their representatives
• signing of tenancy agreements and contracts for services.

There were some gaps in staff training in fire safety and the management of challenging behaviours.

Inspectors found that the person in charge could not satisfactorily carry out the functions of the role due to the number of centres for which she was responsible and the lack of sufficient line management hours within the centre to support such arrangements.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults)

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:
This outcome was not covered in its entirety but it was noted that the residents and their representatives had a considerable level of involvement and consultation in relation to their care needs and how they lived their lives.

Advocates were available externally and had met with the residents who needed this support. This had been an action at the 2014 inspection and had been resolved. Regular meetings were held with the residents at which their views were elicited and acted upon. Staff as key workers were also seen to act as advocates for residents in relation to their accommodation needs and living arrangements.

The manner in which residents were addressed by staff was seen by inspectors to be respectful. Staff were observed respecting the residents' privacy of space. Gender preferences were seen to be respected in the provision of personal care and support. All residents' personal belongings were carefully itemised. The houses, although in different locations, were not in any way distinguishable from their neighbours and all residents had their own bedrooms.

However, it was noted that in one instance a decision to accompany a resident when undertaking a private activity had been made. Inspectors fully acknowledge that this decision was undertaken in the best interests of the resident's safety in order to prevent injury from sudden falls.

However, this decision was not reviewed or overseen by either managers or the rights committee. Alternative strategies which may have been available had not been explored. For example, an occupational therapist review of the bathroom had taken place and the

recommendation had not been acted upon. In addition, the concern regarding the falls had not been made known to the clinician carrying out the review. The actions were unusually intrusive and warranted an alternative option at least being explored.

A review of a sample of the records pertaining to resident's monies indicted that the system were transparent and detailed records and oversight was available. However, while there were consent forms provided to allow nominated staff access to residents' accounts and these had not been signed by the resident or if necessary by their representative to agree to this process.

Inspectors reviewed the complaint policy which contained all of the requirements of the regulations. A review of the complaint log indicated that the provider had responded appropriately and with evidence of good will to complaints. Although a record of complaints was maintained, the outcome of some complaints and the satisfaction levels of complainants were not always recorded as required.

Judgment:
Non Compliant - Moderate

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 observed details in personal plans outlining resident's communication needs and there were very comprehensive communication passports available in the event of a resident requiring care in another service. Staff were observed to be very familiar with the resident's non verbal communication and what it meant and this was further enhanced by the fact that the staff group was consistent.

Pain assessments were seen on records where residents were unable to verbalise. Communication cards were used to help residents and staff communicate and a resident used sign language which staff were familiar with.
There were directions from speech and language therapists to support communication and speech development for the residents and further referrals had been made in relation to this. Aids such as IPads were made available to the residents.
Communication logs were used between the day services and staff to ensure continuity of care and the reside carried these themselves.

The personal plans were synopsised in a suitable pictorial format for the residents. The residents were a significant part of the local community. For example, they did their shopping locally, attended at various facilities including leisure clubs and religious services and were registered and supported to vote.

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:
There was a policy on admissions which outlined the assessment and decision making process and took account of how the admission procedure would ensure that residents were suitable to live together. By virtue of their care needs and assessments it was observed that admissions and care practices were congruent with the statement of purpose. A significant number of changes had been made in the preceding year to reduce the numbers of residents living together and ensure residents needs were compatible. A parent told inspectors that this change had a very beneficial effect for his adult child. Further previews were in process at time of this inspection with a view to making more suitable arrangements for another resident.

There was detailed information on health, medication, social care needs and communication needs available in the event of transfer to acute care.

However, a tenancy agreement and separate care agreement was provided. While both were satisfactory in content they were not signed on behalf of the resident where this was necessary.

Judgment:
Non Compliant - Moderate

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 reviewed the personal plans, medical records and daily records of six residents and found good practice in the systems for assessment and monitoring of residents social health care and psychosocial needs. There was evidence of a range of evidenced based assessment tools being used for health, nutrition, communication, falls and skin integrity. The residents had a diverse and complex range of needs which were seen to be supported. Resident's daily routines were clearly identified and primary care, healthcare needs, social inclusion and development were seen to be well supported.

There was evidence of appropriate multidisciplinary involvement in residents care with very good access to services such as physiotherapy, occupational therapy, speech and language, psychiatric and mental health services.

There was evidence that the residents themselves and their representatives were involved in the planning and review process. The personal plans detailed short, long and medium term goals.

However, the records of the annual reviews were inconsistent in quality and detail as to how they demonstrated that the plans were evaluated for implementation or effectiveness. Some of the review records did not clearly define the timescales or the persons responsible or whether the plans had been implemented as agreed. In the inspectors view this finding was exacerbated by the copious and often duplicated documentation used to asses and plan for the residents. However, there was sufficient information to determine that the plans were adhered to and evaluated.

The individual residents need for staff support and supervision were managed in a person-centred way with one to one supports available to ensure residents health and social care needs were met. A resident lived alone with one-to-one staff as this was found to be the most suitable and enabling arrangement for her.

Inspectors found that the social care needs of the residents were very well supported with interesting and meaningful day-to-day and long term social activities including access to the community, holidays, participating in special Olympics, shopping trips, helping with their own housekeeping with staff support, and taking part in local events.The action regarding access to social and meaningful activities from the previous inspection had been resolved. While there were daily schedules these were flexible to the wishes of the residents on the day and were not influenced by staffing or resourcing

issues.
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Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Improvements were needed in relation to the fire safety systems in place while the management of risk also required some review.

The designated centre comprised five units, three of which were located side by side. While these three units did have wired smoke detectors in place, inspectors found that there was not an integrated fire detection system in place for these units. It was also observed that these three units did not have emergency lighting in place as required by the Regulations. Sufficient fire safety systems were in place in the remaining two units.

However, it was noted in one of these two units that the fire alarm was only receiving maintenance checks at 6 monthly intervals rather than at the required quarterly intervals. Maintenance records of fire extinguishers were seen across all five units within the required timescales. Internal daily and weekly checks were also being carried out.

Inspectors reviewed training records and observed that some staff members were overdue for fire safety training in line with the provider's own policies. Staff members spoken to were aware of what to do in the event of evacuation and the evacuation procedures were on display throughout the centre. Fire drills were carried out at regular intervals at varying times of the day which informed residents' personal evacuation plans, which were available and detailed.

The risk management policy was satisfactory and inspectors saw evidence that the designated centre was responding to risks identified. A general risk register had recently been developed while individual risk assessments were also in place. An environmental assessment had taken place and any deficits such as thermostatic controls required in one house had been addressed.

However, while comprehensive risk assessment in relation to falls was undertaken there was no corresponding action plan and no risk management plan for residents who

smoked.

Site specific safety statements were in place along with an emergency plan which outlined the steps to be taken in the event of a number of emergencies such as adverse weather or loss of power arising. Each resident had a missing person profile in place with a photo of each resident. It was observed however that a number of the photos on the profile were too small for this purpose.
Infection control systems were evident and satisfactory.

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

Findings:
The inspectors reviewed the policies and procedures for the prevention, detection and response to allegations of adult abuse and the protection of vulnerable adults. Inspectors were informed that the organisation had adopted the Health Service Executive (HSE) and that the procedural aspects would be amended to reflect the structures and positions within the organisation. There was a dedicated social work service in the region to address any incidents or allegation which occur. Training for staff in the protection of vulnerable adults and reporting of allegations was up to date.

Each resident had an individual safeguarding plan which identified specific areas of vulnerability and strategies to support them. There were also pictorial and easy read versions of safeguarding systems for residents. The residents were supported to keep themselves safe by education in social interactions. There was regular access to managers for oversight of their care and safety. Residents who could communicate it the inspectors stated that they felt safe living there. A family member also told inspectors that he had no concerns regarding safety.

Staff were able to articulate their understanding and responsibilities in relation to this and expressed their confidence in both colleagues and management to act responsibly.

Inspectors were informed by the centre manager that there were no allegations of this nature made or being investigated at this time.

However, from a review of the documentation there was a lack of clarity in regard to how allegations or statements made by residents were being managed where they were perceived as being related to incidents of challenging behaviour. While staff were able to articulate the process used and the interventions of the designated officers, the documentation, records, risk assessment and behaviour support plans did not correlate with this information. This presented potential risk to residents as allegations could therefore be assumed to be unfounded.

It was further found that a residents' risk assessment contained information which suggested he posed a risk to other vulnerable persons. The manager or staff could not explain the nature of this risk, the occurrence or time-frame as to when this had emerged and what procedures were used to mitigate this or indeed if any were required. These matters indicate that the systems for identification of risk, transparent responses and follow up actions in the context in which they occur required a review.

There was an up-to-date comprehensive policy on the management of behaviour that was challenging. The behaviour management interventions were guided by detailed plans and analysis of the behaviours. There was a dedicated clinical nurse behaviour specialist available to staff. Inspectors were informed and there was evidence that the reduction in resident numbers ,suitable compatibility decisions, and the provision of one to one staff had made significant reduction in behaviours that challenged. Inspectors found that staff had very good understanding of such behaviours and were supportive of the residents.

There was no policy on the use of restrictive practices. A limited number of these had been implemented such as on some occasions locking the front door and on occasions lacking a resident's wardrobe. These were not consistently applied, however, there was evidence that they were being reduced systematically.

A review of the notifications forwarded to the Authority indicated that there had been a significant reduction in the of PRN (as required) medication for incidents of challenging behaviour. However, the lack of a robust policy may increase the risk of procedures being implemented without due oversight.

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:
A review of the accident and incident logs, resident's records and notifications forwarded to the Authority demonstrated that the person in charge was in compliance with the requirement to forward this information to the Chief Inspector. Incidents were reviewed by the team and remedial actions put in place.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found evidence that resident's healthcare needs were very well supported. A local general practitioner (GP) service was primarily responsible for the health care of residents and records and interviews indicated that there was frequent and prompt access to this service. Where residents could attend themselves or with family at the GP clinic they did so.

Residents had choice in attending medical and allied care services and there was evidence that staff made efforts to ensure they understood the reason for the appointments and the outcomes. Supportive strategies were devised to ensure residents could participate, for example, in relation to the taking of bloods.

Healthcare related treatments and interventions were detailed and staff were aware of these. Inspectors saw evidence of health promotion with regular blood tests, vaccinations, medication reviews and other clinical investigations. Gender and age related health care needs were identified and supported. Specific vulnerabilities were noted and acted on, for example, falls, epilepsy, diabetic or cardiac risks. There were very detailed individualised protocols in place for the management of epilepsy and staff were clear on these protocols.

Nutrition and weights were monitored. There was documentary evidence of advice from dieticians and speech and language therapists available and staff were knowledgeable on the residents' dietary and or specialised meal requirements. They were able to tell

the inspector what to do in the event of,for example, a choking incident and had had training in this. They were also aware of resident's preferences for food. One resident brought lunch to his workshop as he did not like the meals available and staff the cooked his evening meal in the unit. All of the kitchens were suitably equipped, domestic in style and residents had full access at all times in a homely and relaxed environment.

There was evidence that families were closely involved with all health care related interventions and decision. Inspectors were informed that if a resident was admitted to acute services staff were made available to remain with them to ensure their needs were understood.

There was a policy on end of life care. While this had not as yet been required for this service staff were aware that due to age and currently changing needs this may become necessary. Staff outlined that it would be their wish to maintain the resident in their own home. As this is a nurse led service the capacity was there to facilitate this.

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

Findings:
There was a policy on the management of medication which was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration and storage of medication were satisfactory. No controlled medications were being administered at the time of this inspection but there were satisfactory systems in a place should this be required.

Inspectors saw evidence that medication was reviewed regularly by both the resident's GP and the prescribing psychiatric service. The only medication audit available had been undertaken in 2013. Inspectors were informed that the pharmacist had arranged to come and undertake audits of medication management systems to ensure practices were robust. This would include a system for the receipt of dispensed medication.

There were procedures for the management of PRN (as required) medication and this had been an action at the previous inspection. However, the maximum dosage of PRN medication was not clearly defined in some instances although staff were aware of this. Social care staff administered medication on occasions and inspectors found that they

had received appropriate training and assessment in doing so. Additional food supplements were used only if prescribed.

At the time of the inspection no residents were assessed as being able to self administer medication.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose was reviewed and found to be in compliance with some minor amendments required. These were the inclusion of room sizes. The person in charge agreed to remedy this in preparation for the registration inspection. The statement was found to be centre-specific and detailed the care needs and service to be provided. Admissions to the centre and care practices implemented were congruent with the statement of purpose.

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):

No actions were required from the previous inspection.

Findings:
Inspectors were not assured that the current governance arrangements were satisfactory to ensure the safe and effective delivery of care. The person in charge who had significant experience and training was the person in charge for six designated centres. She was very knowledgeable on the regulations and legal requirements. An arrangement had been made whereby a centre manager was appointed with day-to-day operational management responsibility. Inspectors found this was not satisfactory and some of the deficits identified in safeguarding and health and safety may be attributable to this lack of ability to direct and monitor the care delivered.

The nominee of the provider has visited the centre and had also commissioned two unannounced audits in 2015. The findings were based on pertinent aspects of the standards and regulations. Some recommendations were in the process of being addressed. The audits found that a reduction in the number of centres in the remit of the person in charge was required. To this end inspectors saw evidence that recruitment procedures had commenced.

Local governance arrangements included the director of nursing for the organisation and community services. There were defined reporting and communication structures evident and regular meetings took place with the person in charge. The director of nursing also attended team meetings in the centre.

The changes in the configuration of the centre, allocation of smaller residences and the increased staffing demonstrated that the provider has committed to responding proactively to the needs of the residents.
The annual report was not yet compiled but inspectors were informed that a template and procedure for undertaking this was in development.Systems for auditing required review as while useful information was collated there was no process for learning or evaluating the information.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

No actions were required from the previous inspection.

Findings:
Inspectors found that there were suitable numbers of staff with appropriate skills to meet the needs of residents. It is a medical model based on the assessed needs of the residents and therefore a nurse led service. However it is not required that a nurse is on duty at all times. Such decisions are made based on the level of nursing care required and they are satisfactory.

Inspectors reviewed a sample of staff files and found that most of the required information such as references and Garda vetting were present. Some of the required information was not present in the files but these were provided to inspectors before the close of inspection. It was noted however that one staff member's file did not have a satisfactory explanation of a 14 month employment gap. The person in charge agreed to make enquiries and rectify this.

Inspectors reviewed staff rosters and found there were sufficient numbers of staff to cater for residents' needs. During the course of inspection interactions between staff members and residents were seen to be warm, comfortable and respectful. The staff members spoken to appeared committed to the residents and were aware of their preferences and needs. The staff and the person in charge informed inspectors that they make every effort not to use agency or unfamiliar staff as it has a negative impact on the residents behaviours and wellbeing.

Staff training records were reviewed. As mentioned under Outcome 7 there were some gaps in fire safety training while records also showed that some staff had not undergone training in the therapeutic management of aggression or violence (TMAV). Additional training had been provided for some staff in areas such as food hygiene and key worker roles and dementia. A schedule of training was also in place for 2016. A sample of professional development records were also read and it was noted that any training needs identified were followed up on.

There was evidence of formal supervision of staff undertaken by the person in charge and the staff nurses.

Judgment:
Non Compliant - Moderate

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:

Noelene Dowling
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Regulation Directorate
Health Information and Quality Authority

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003645
Date of Inspection:	01 and 02 February 2016
Date of response:	22 February 2016

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:
Resident or their representatives had not had an opportunity to agree the systems for the management of resident's finances.

1. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in

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

accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
1.All residents to sign support agreements and financial passports or their advocate will sign on their behalf.
2.Information Sessions will take place for all residents with regard to supporting them with management of their own finances.
3.Contact will be made with the External National Advocacy Service to engage their support for residents who request this.

Proposed Timescale:
1.22/02/2016
2.30/05/2016

Proposed Timescale: 30/05/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The strategy adopted to prevent falls in one instance was unusually intrusive on the resident's privacy and no alternative had been adequately explored.

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.The risk assessment for the resident will be reviewed in its totality with Multi-disciplinary input to ensure that the least intrusive measure is in place to promote the residents privacy.
2.The Clinical Nurse Specialist in Behaviour Management has obtained an epilepsy Helmet for the resident who has refused to wear it. A shaping programme will be tried.
3.Referral made to Occupational therapist, objective to include risk assessment of bathroom area.
4.Contact to be made with Epilepsy Consultant to seek their advice regarding measures in place.

Proposed Timescale:
1.08/02/2016
2.08/02/2016
3.12/02/2016
4.15/02/2016

Proposed Timescale: 15/02/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The satisfaction or views of the complainant were ot consistently recorded in the complaint record.

3. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
1.A Review has taken place of the complaints log in each house/Designated Centre to ensure compliance .
2.All complaints will be signed off, to ensure the complainant is satisfied with the outcome.

Proposed Timescale:
1.19/02/2016
2.18/03/2016

Proposed Timescale: 18/03/2016

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:
Contracts and tenancy agreements were not signed by representatives of the resident where this was necessary.

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.All residents to sign contracts and tenancy agreements or advocate will sign on their behalf.

Proposed Timescale: 22/02/2016

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:
Some identified risks to residents did not have control measures implemented.

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

Please state the actions you have taken or are planning to take:
1.All fall's assessments for residents to be reviewed and actions fully implemented.
2.A Risk assessment to be completed for residents who smoke and actions fully implemented.

Proposed Timescale:

1. 12/02/2016
2. 16/02/2016

Proposed Timescale: 16/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire alarm in one unit was not undergoing quarterly servicing as required.

6. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
1.The fire alarm service schedule in house is to be amended and will be serviced on a quarterly basis as per the approved requirement.

Proposed Timescale: 30/03/2016

Theme: Effective Services

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

Three of units did not have emergency lighting in place.

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

Please state the actions you have taken or are planning to take:
1.Review of Alarm and emergency lighting system carried out by Fire alarm company.

2.Alarm system & Emergency lighting to be installed in three houses of the Designated Centre.

Proposed Timescale:
1.11/02/16
2.30/03/2016

Proposed Timescale: 30/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An integrated fire detection system was not in place for three units.

8. 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.Review of Alarm and emergency lighting system carried out by Fire alarm company.

2.An Integrated fire panel to be installed within one part of the Designated Centre where there are three houses.

Proposed Timescale:
1.11/02/16
2.30/03/2016

Proposed Timescale: 30/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A small number of staff had not received refresher fire safety training.

9. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
1.All staff who had not got up to date fire training received this on 11th February 2016

Proposed Timescale: 11/02/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no policy in line with evidence based practice on the use of any restrictive procedures.

10. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
1.The Local Restrictive Policy to be reviewed to include environmental restraint.
2.All staff team will be inducted into this revised policy

Proposed Timescale:
1.30/04/2016
2.31/05/2016

Proposed Timescale: 31/05/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Documents available did not sufficiently demonstrate that the systems for managing and response to risk including allegations were sufficient to safeguard the residents, where such concerns related to challenging behaviours or historical information which was not substantiated.

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

Please state the actions you have taken or are planning to take:
1.Meetings took place on 5/02/2016, 17/02/2016 and 22/03/2016 to review the system for managing and responding to risks including safeguarding allegations relating to a resident. This review was conducted by the Designated Officer and members of the Multi disciplinary team/ Person In Charge and members of the Senior Management Team.
2.All actions arising from this review have been prioritised and are being implemented in line with the National Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures.
3.The Designated Officer has completed a review of all safeguarding allegations .
4.A Review relating to one resident where there was a risk assessment relating to historical concerns has confirmed that there are no safeguarding risk to be addressed all documentation amended as required.
5.A comprehensive review of the resident's Individual Programme Plan including Positive Behaviour Support Plan will be completed and actioned.
6.All safeguarding incidents and Positive Behaviour Support Plans will be reviewed at each house meeting.
7.All safeguarding concerns relating to this resident were reviewed with the Regional Safeguarding Team at a meeting on the 16/02/2016 and actions implemented.

Proposed Timescale:
1.05/02/2016, 17/02/2016 22/02/2016
2.22/02/2016
3.05/02/2016
4.04/02/2016
5.30/03/2016
6.29/02/2016
7.16/02/2016

Proposed Timescale: 30/03/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The maximum dose of PRN medication was not entered on the prescriptions.

12. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
1.PRN protocol to be amended to reflect the max dose in 24hr period

2.A Review of all prescription in relation to PRN to be undertaken by GP

Proposed Timescale:
1.22/02/2016
2.30/03/2016

Proposed Timescale: 30/03/2016

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 could not carry out the function effectively due to the number of centres for which she was responsible and lack of adequate operational management supports.

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

Please state the actions you have taken or are planning to take:
•Advertisements for the post of Person in Charge took place on 28th Aug 2015, 21st Oct 2015, 17th Nov 2015 & 8th January 2016 with no successful candidate to date.
•A more robust governance structure will be in place for this Designated Centre with additional resources being made available to the Person In Charge.

Proposed Timescale:
1.28/08/15, 21/10/15, 17/11/15, & 8/01/16
2.30/03/2016

Proposed Timescale: 30/03/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The required annual review of the safety and quality of care had not taken place.

14. 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:
•The required annual review of the safety and quality of care will be untaken for this Designated Centre.
•All actions arising from this review will be implemented

Proposed Timescale: 30/03/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were unexplained gaps in the documentation available for the safe recruitment of staff.

15. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
•The unexplained gaps in the documentation available for the safe recruitment have been addressed and all documents pertaining to employment gaps have been received.

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:
A small number of staff did not have up to date training in a system for managing behaviours that challenge.

16. 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:
•All staff will have up to date training in the area of Positive Behaviour Support in accordance with the Service providers policies.

Proposed Timescale: 30/03/2016