| Centre name: | A designated centre for people with disabilities operated by St John of God Community Services Limited |
| Centre ID: | OSV-0002878 |
| Centre county: | Wicklow |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | St John of God Community Services Limited |
| Provider Nominee: | Naoise Hughes |
| Lead inspector: | Karina O'Sullivan |
| Support inspector(s): | Conan O'Hara |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 8 |
| 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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 March 2016 10:30</td>
<td>02 March 2016 20:00</td>
</tr>
<tr>
<td>03 March 2016 09:30</td>
<td>03 March 2016 20:00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 02: Communication</td>
</tr>
<tr>
<td>Outcome 03: Family and personal relationships and links with the community</td>
</tr>
<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
</tr>
<tr>
<td>Outcome 10: General Welfare and Development</td>
</tr>
<tr>
<td>Outcome 11: Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12: Medication Management</td>
</tr>
<tr>
<td>Outcome 13: Statement of Purpose</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 15: Absence of the person in charge</td>
</tr>
<tr>
<td>Outcome 16: Use of Resources</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
<tr>
<td>Outcome 18: Records and documentation</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This was the first inspection of this designated centre by the Health Information and Quality Authority (hereafter called HIQA). This designated centre is operated by St John of God Community Services Limited (hereafter called the provider), a company registered as a charity. The organization is governed by a board of directors to whom the CEO (Chief Executive Officer) reports.

A complete application was made to HIQA to register the centre for eight residents. This designated centre aimed to provide a residential service for adults with varied levels of intellectual disabilities. The designated centre consisted of two community
houses with four females and four males residing within.

The purpose of this inspection was to monitor compliance and inform a registration decision under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (hereafter called the regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

The acting person in charge who was a service manager facilitated the inspection with the team leader. Both individuals attended a meeting at the beginning of the inspection and attended a feedback meeting at the end of the inspection with the proposed person in charge also present for feedback.

As part of this inspection, inspectors visited the two houses and met with all of the residents, one family member and staff members and reviewed one questionnaire returned by a relative. Inspectors observed practice and viewed documentation such as personal plans, medical records, recording logs, policies and procedure, minutes of meetings and staff files.

Residents spoken to communicated that they were happy living within this designated centre. Residents had access to social care supports participating in activities appropriate to their interests and preferences.

Over the course of the inspection inspectors found the residents, the acting person in charge and staff to be courteous, supportive and helpful with the inspection process.

Overall inspectors identified that significant improvements were required in order for this designated centre to meet with the regulations and standard. Areas of non compliance related to:

- Residents right dignity and consultation
- Contracts for the provision of services
- Resident's individual assessment and personal plans
- Positive behaviour support and the promotion of a restraint free environment
- Suitability of the premises for the assessed needs of the residents
- Provision of training to staff
- Provision of supervision to staff
- Fire precautions
- Governance and management

All areas of compliance and non compliance are discussed in more detail in the main body of the report and in the accompanying action plan that outlines the failings identified that did not meet the requirements of the regulations and standards.
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):
This was the centre’s first inspection by the Authority.

Findings:
Overall inspectors found that residents were treated with dignity and respect. Good practices were observed regarding the recording of complaints, residents finances and consultation with residents in respect of their routines, choices and daily activities. However, improvements were required to uphold residents’ privacy and dignity and in the oversight of complaints.

Inspectors identified a net curtain in place in a resident’s bedroom was not sufficient to ensure the resident’s privacy and the window faced out on to the road. Inconsistent practices were also identified in relation to the use of disposable aprons during meal times.

The designated centre had a complaints policy and procedure in place. However, inspectors found that the complaint procedures was not on display in a prominent area in both houses: the complaints procedure was on display in the office. The service manager was designated to manage complaints and the complaints procedure outlines the appeals process. Complaints were discussed at quality and service committee every two months. However, it was not clear if there was a designated person to ensure all complaints were handled appropriately and in line with the organization’s procedure. The unannounced six monthly visit by the provider (nominated to the quality team) on 10 December 2015 also identified this as an issue.

Intimate care plans were in place to respect residents dignity. Intimate care plans viewed outlined the support needed and encouraged independence.
Inspectors reviewed the complaints log for the designated centre which reflected that no complaints were currently open, there had been 13 complaints received in the year prior to the inspection. Inspectors found from a review the complaints log that the staff in this service advocated for residents rights in relation to areas such as maintenance, staffing levels and interventions from specialists. The log set out the satisfaction level and actions taken or to be taken in response to the complaints. The log showed that all complaints were responded to, however some complaints were still being addressed – for example the refurbishment plan.

Resident's meetings were held weekly and residents were consulted about a range of individual preferences. Meetings discussed meals, activities, routines complaints and news in the designated centre. From a review of the minutes of meetings and care plans it was clear that residents influenced their activities, routines and meals in the designated centre. For example, it was evident that residents were given a choice on the menu for the upcoming week and their preferences dictated the menu.

Inspectors observed that practices and routines were centred on the residents and their wishes. Inspectors observed staff respecting resident's personal space and speaking to the residents in a respectful manner. Inspectors reviewed a sample of financial records and found the designated centre had a clear system in place regarding residents' finances.

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):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that residents were supported and assisted to communicate in accordance with residents' needs and preferences.

Residents augmentative and alternative communication needs were identified within their personal planning documentation. Supports needed by residents were put in place such as the use visual displays boards, visual displays for meals and staff rosters and Lámh (manual sign system used by children and adults with intellectual disabilities and communication needs in Ireland). Inspectors observed all of these interventions within the residents' files and also in practice over the two day inspection. Staff were aware of the communication needs of all residents and inspectors observed staff and residents
Communicating freely.

Inspectors viewed a project under way in relation to a visual board. This consisted of pictures of food, meals, places and activities. The resident and staff had taken on this project as they preferred to have actual images relating to the life of the resident instead of generic pictures. A lot of this work had already taken place and inspectors viewed evidence of this within the designated centre. Inspectors spoke with the resident’s key worker who outlined the process and rationale for this project. Evidence was also available within the resident's file and collaboration was occurring between staff, resident and speech and language therapist.

Residents had access to television, radio and wireless internet connection within the designated centre. Some residents also used the aid of devices such as tablets to enhance their communication further, work was being undertaken by staff to maximise the use of these devises for residents.

**Judgment:**
Compliant

**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
From the information available inspectors found that families and friends were encouraged to get involved in the lives of residents.

Staff outlined how they facilitated residents to maintain contact with their families. This included access to telephones, transport home for visits and family invitations to events in the designated centre including significant life events such as birthday parties and special occasions.

Regular contact with family members was evident between staff and their relatives in accordance with residents' wishes. Family communication documentation was evident within the designated centre and clear records were maintained by staff around family involvement.

Staff assisted in the organization of meals out with residents and family members.
Visitors were welcomed within the designated centre. Residents were building relationships among the wider local community though participation in community based activities involving membership in the local gym, yoga classes and swimming.

Residents had pictures of family members in the designated centre. Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community. For example residents going on social outings, visiting the pub, going out for meals and local music and sporting events.

Family members could and did visit the designated centre on a regular basis and were free to do so. Inspectors observed an approachable system whereby families could access the staff and acting person in charge.

**Judgment:**
Compliant

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors found that the residents’ contracts for the provision of services did not outline the information as required within the regulations. Residents’ contracts did not contain sufficient detail in relation to the services to be provided, fees charged and the details of additional charges to residents.

A sample of residents written contracts were viewed and the inspectors noted that these were signed where possible by the resident and the resident's representative and representatives of the designated centre.

On the day of inspection inspectors observed a massage therapist attending the designated centre. This cost of this service was not outlined within the residents contract as an additional fees.

The fee paid by residents was also unclear to inspectors as both houses within the same designated centre had different amounts specified within the resident’s contract of care provisions. Staff spoken to were unsure as to the rationale for this. The contracts also specified a percentage of the light and heat bills were to be paid by the resident. The inspectors found the exact percentage was not outlined within the resident's contract.
Inspectors also noted that some residents purchased items prescribed to them to address assessed needs by clinical professionals. These items included a helmet and massage pads for a chair.

There were policies and procedures in place for the admission, transfer and discharge of residents. The process was also described in the statement of purpose. There were no recent admissions to the designated centre.

Referrals to the designated centre were submitted by families or an agency and following screening and assessments, suitable residential places were then identified. Admissions to the designated centre were planned and residents and families could visit the designated centre prior to admission. The designated centre does not accept emergency admissions.

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):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that there were some measures in place to promote resident's social care needs and quality of life, however this area required further improvements in relation to the review process and the information contained within the plans.

Inspectors found that residents had plans in place however the review of these plans did not take into account the effectiveness of the plans. In some instances the information identified in the personal plans did not reflect actual practice. Inspectors also found the review process in place was not effective for example one goal was set in December 2011 and this was not reviewed until June 2015 while other plans did not have any review of how goals set were being progressed.
Each resident had a personal plan in place incorporating personal and social needs. These plans were personalised and reflected resident’s individual requirements in relation to their social care needs. For example the inclusion of a meaningful day for residents, this provided clear person-centred evidence of what residents enjoyed participating in. Activities sampling was also evident where dancing, yoga and bowling were being trialed for one resident in order to incorporate more activities into the resident’s life.

Residents personal interests were also reflected within their plans including pet therapy and music interests. These interests were also evident within the designated centre, where staff would play a musical instrument such as the guitar for residents.

Inspectors viewed clear evidence of collaboration between the day service and the designated centre in relation to skill training pertaining to the use of transport however, no other example was evident within the plans viewed.

**Judgment:**
Non Compliant - Moderate

**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors found the designated centre required significant improvements to ensure it was suitable and safe for the number and needs of residents.

The designated centre consisted of two community houses within a two mile radius of each other. One house consisted of a two story detached house while the second house was a bungalow. All residents had their own bedroom and these were individualised in accordance with the preference of the resident.

Inspectors were not satisfied with the progress pertaining to maintenance across the designated centre. For example inspectors viewed a maintenance requisitions in relation to a broken shower logged in November 2014. On May 2015 maintenance repaired the shower resulting in a six months period for the resident concerned. The log did not identify a date for the bathroom reconstruction. Inspectors queried this process and staff identified that no further update was available and explained that the resident had
the use of a bath within the designated centre. However when inspectors viewed other
documents such as the complaints log the resident had made a complaint pertaining to
this area of care provision, identifying that the shower in the swimming pool was being
utilised as an interim measure. Within the complaints log a record of this shower being
fixed was dated 29 February 2016; two days prior to this announced inspection.
Therefore it took 15 months to rectify this issue. Other areas of concern pertained to the
identification of a radiator making a loud noise in 24 February 2015 this was fixed in
December 2015; nine months later.

One of the houses within the designated centre was in significant need of renovation,
this had also been identified by staff and management within the organization. Issues of
concern related to the size of kitchen area to accommodate residents and staff to
participate in meal times together. The grounds outside the designated centre required
upgrading and resurfacing to the front and back of the house to ensure residents
requiring the use of a wheelchair could be safely evacuated. Painting was required in
areas such as the kitchen, this had also been identified by residents on the 24 February
2015 however this remained outstanding on the days of inspection.

Inspectors found the redevelopment plans presented to inspectors dated February 2016
had no timeframes specified. While an action plan was evident this did not outline who
was responsible for carrying out the actions and the agreed timeframe for actions to be
completed. Inspectors did acknowledge the work completed in the designated centre
since December 2015 including the installation of new radiators and boiler and attic
insulation.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors were not satisfied that the health and safety of residents, visitors and staff
was promoted in relation to fire containment.

Steps were in place to manage the risk of fire as evidence of routine checks and
servicing of the fire detection, alarm system and emergency lighting were completed by
a fire professional. There were provisions for weekly checks to be conducted within the
designated centre. There were no fire doors in place.
Personal evacuation plans were completed for residents. There was also evidence of review post fire drills to reflect learning. For example the use of a wheelchair for a resident to assist their safe evacuation. Other preventative measures were in place including a vibrating pillow for a resident with hearing difficulties.

Inspectors viewed the emergency plan and found that it contained sufficient detail to guide staff in the procedure to follow in the event of possible emergencies such as flood or power outage.

Inspectors found that there were appropriate policy and procedures regarding health and safety. There was a health and safety statement in place within the designated centre this was dated April 2015.

From speaking with staff and viewing documentation inspectors determined that there was a system in place to monitor accidents, incidents and near misses in the designated centre. Inspectors found that appropriate corrective actions were not implemented when required as there was no evidence of auditing of accidents or incidents to bring about learning this was discussed with staff on the day of inspection.

Inspectors reviewed the risk management policies and procedures and found them to meet the requirements of the regulations. There was a clear system in place to identify, examine and manage potential hazards within the designated centre. This was evident through the risk register viewed within the designated centre. Inspectors also observed control measures in place to alleviate identified risks prevalent in the designated centre. Individual risk assessments and plans were evident in personal plans, these were reviewed and updated accordingly to reflect any changes, for example the ingestion of chemicals.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.
Findings:
Inspectors found measures were in place to protect residents being harmed or suffering abuse. However, improvements were required in relation to behavioural support as plans did not reflect current practice.

Inspectors viewed behavioural support plans. Elements of the plan were very informative and provided clear guidance for staff when communicating with the resident. If staff observed any identified triggers, clear verbal phrases were outlined to assist staff members to engage in a consistent approach to behavioural management. Behavioural management plans referred to the use of placebo medication. This plan was only recently in place since February 2016. The inspectors viewed this plan and discussed it with staff members and found the plan did not guide staff effectively in this aspect of care provision. Inspectors asked to view policy guidance in relation to the use of placebos however, this was not available. There was also a lack of evidence of clinical input into the decision to prescribe placebo medication as part of behavioural management.

Inspectors were not satisfied that a restraint free environment was promoted within the designated centre. Inspectors were informed that in one house the outside door was locked only at specified time and at all other times residents were able to open the door from the inside. However, inspectors observed this not to be the case on the second day of inspection. On arrival to the designated centre the door was locked despite three staff members being present within the designated centre. Inspectors were informed that the practice of locking the door had been in place for a long time. Inspectors asked to see a review of this practice which was not made available. A door chain had also been installed which restricted all residents within one house. No evidence of skill teaching to residents in relation to the use of the door chain was provided.

Inspectors found there was policy in place regarding the prevention, detection and response to abuse. Staff members were familiar with the types of abuse and reporting mechanisms to report allegations, disclosures or concerns to clearly identified designated persons should an allegation of abuse arise.

Inspectors found residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. From speaking with residents they were knowledgeable in relation to who to speak to should concerns arise.

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):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that the acting person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, during the course of inspection environmental and physical restraints were identified which had not been notified to the Chief inspector.

Environmental restraint in the form of locking of external doors was evident in both houses. One house was locked at all times and this was notified to the Chief inspector while the second house was also locked at specified times and this was not notified to the Chief inspector.

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development
Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that the general welfare and development needs of residents were promoted. Residents were afforded opportunities for new experiences, social participation, education, training and employment in accordance with the needs and preferences of residents.

Inspectors spoke with and observed residents, staff and viewed documentation and found that the residents were provided with suitable activation in line with their own goals and preferences and relevant to their needs. The team leader and support workers outlined how support was provided to residents to pursue a variety of interests including gym activities, swimming, food preparation and computers.

Inspectors found that some residents attended day services while others were supported from their homes depending on the needs and preferences of the residents. Residents were also facilitated to have a day off from day services if the resident wished. Inspectors viewed residents’ profiles and these contained relevant information in relation to activities residents participated in.
Staff members present were aware of residents' individual needs and preferences. Some residents used community transport and visited and socialised within their community for example the local pub and shops.

**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):**
This was the centre's first inspection by the Authority.

**Findings:**
Inspectors were not satisfied that the overall health needs of residents were appropriately supported. Improvements were required in relation to the monitoring of the effectiveness of interventions in place for residents.

Residents had documented healthcare plans in place however, inspectors were unable to identify within the sample viewed how these plans demonstrated residents were being supported in their healthcare needs in accordance with their care planning.

Inspectors were unable to see evidences of how interventions were monitored for example the risk of urinary tract infections. Interventions included "recording of daily fluid intake and encourage extra fluids". Inspectors were unable to see what the base line fluid intake was and staff members spoken to were also unable to specify this. While a record of fluid intake was present this did not specify the volume of fluid intake.

Monthly weight recording was identified as an intervention for another resident however, no record was present for April, May, July, August and September therefore, inspectors were unable to see the purpose of this intervention.

Inspectors were also concerned in relation to the practice in place within one house where hourly checks operated at night-time to assist the elimination needs of residents. Inspectors found that alternative interventions were not implemented in relation to this. However the practice of entering into a resident's bedroom resulted in waking the resident on some occasions. Inspectors found that this aspect of care provision was not clearly identified as a need, health or choice perspective.
Inspectors identified that residents had opportunities to access allied health professionals such as general practitioner, occupational therapist, speech and language therapy, psychiatry and nursing care. Residents had access to specialist services and hospital appointments when required. Inspectors observed the implementation of speech and language interventions as a result of feeding, eating, drinking and swallowing (FEDS) assessment. Residents requiring modification to the texture of their food was clearly outlined in the residents file and staff were knowledgeable in relation to the implementation of individual food requirements.

Residents were observed to be provided with healthy meals and choice. Inspectors found residents participating in meal times within the designated centre. Residents assisted staff in meal preparation and participated in menu planning. Inspectors viewed user-friendly menu selection (in pictorial format), and weekly shopping lists. Refreshments and snacks were available for the residents outside mealtimes within the designated centre.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors found the oversight of the medication management system within the designated centre required improvement. Inspectors were concerned as there was no system in place for reviewing and monitoring safe medication management practices within the designated centre.

There was an organizational medication management policy and local procedures in place.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received and a stock check was carried out once a week. However, there was not a clear system for PRN (as required) medication as while this was counted when received no regular checks were taking place thereafter. The pharmacy also carried out a review of the medication for each resident.
Inspectors observed that all medication was stored in a secure, locked cabinet in a locked area and the keys to access the medication cabinet were held securely by staff. Inspectors noted that the opening date was not recorded for all required medications, for example creams and drops. There were no controlled drugs in use in the designated centre at the time of the inspection.

Administration sheets were in place for each resident and a number of these were viewed by inspectors. These were found to be up to date and showed that staff administered and signed for medication, and the exact times of administration were in place on each administration sheet. However, there was insufficient space to record comments.

PRN protocols were in place for as needed medication however the maximum dosage to be administrated to the resident in a 24 hour period was not recorded. PRN prescriptions were reviewed every 6 months.

A sample of training records examined in the designated centre showed that competency assessments had been carried out as part of staff training in the safe administration of medication.

There was a system in place for recording, reporting errors and reviewing medication, however, this required improvement. The team leader and the acting person in charge of the designated centre informed inspectors that medication errors were reviewed and addressed in isolation and that long term audits of medication errors were not in place.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors were satisfied the statement of purpose met the requirement of the regulations.

**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):  
This was the centre’s first inspection by the Authority.

### Findings:

Inspectors found that improvements were required in the overall governance and management of the designated centre.

The provider had nominated a person to conduct visits to the designated centre at least once every six months and produce a report. However, while this was being completed no time frames for completion was evident in relation to actions identified. Inspectors discussed this with the acting person in charge and established that while some actions had been completed, others were not.

Inspectors found that there was a clear governance and management structure in place. All staff spoken to by inspectors clearly outlined the systems and process in place within the organization.

While there was a temporary person in charge was in place, recruitment had been completed for a permanent person in charge to take up the post. On the second day of inspection inspectors met with the proposed person in charge for this designated centre.

A clinical nurse manager (team leader) oversaw the day-to-day management of the two houses however, this individual had only recently moved in to post. Therefore, inspectors were unable to see evidence of clear collaboration between levels of management. For example inspectors were informed that the acting person in charge met with the team leader every week and the team lead met with staff weekly/fortnightly. However, on viewing the minutes of these meetings, this was not evident. Weekly or fortnightly staff meetings minutes were not present and in some cases monthly meetings did not take place. Inspectors identified this to both the acting person in charge and the team leader as this was also identified as an area of concern within the last unannounced visit in December 2015 by the quality and safety department. The organization also held additional meetings on a two monthly basis with the acting person in charge, supervisors and team leaders throughout the organization to bring about shared learning. However inspectors were unable to see any shared learning among the staff team in the designated centre as topics identified were not discussed within staff meetings minutes presented to inspectors.
Judgment:  
Non Compliant - Moderate

Outcome 15: Absence of the person in charge  
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:  
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):  
This was the centre’s first inspection by the Authority.

Findings:  
Inspectors found that the person in charge was aware of the requirement to notify HIQA of any emergency absence or proposed absence over 28 days. However, inspectors were satisfied in relation to the upkeep and maintenance of the designated centre as outlined in outcome 6.

Judgment:  
Compliant

Outcome 16: Use of Resources  
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:  
Use of Resources

Outstanding requirement(s) from previous inspection(s):  
This was the centre’s first inspection by the Authority.

Findings:  
Inspectors found that the designated centre was resourced to ensure the delivery of care and support in accordance with the statement of purpose. However, inspectors were not satisfied in relation to the upkeep and maintenance of the designated centre as outlined in outcome 6.

Judgment:  
Substantially 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):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that there were appropriate staff numbers and skill mix within the designated centre. Improvements were required in relation to the provision of training and supervision.

Mandatory training had not been completed by some members of staff in relation to fire safety and manual handling.

Inspectors viewed a sample of staff files including training records and gaps were identified. The acting person in charge was able to account for these gaps on the second day of inspection.

Inspectors viewed rotas within the designated centre, however it was unclear in relation to the actual rota within one house. As the rota was not reflective of a member of staff working in the house completing an extra shift. The rotas also required a coding system to identify what the various letters referred to. Inspectors also acknowledge the change to the rota in recent times in relation to night duty. The team leader outlined the process of change in relation to this due to a high turnover of staff in the previous months which had more recently changed resulting in a stable staff team.

Supervision of frontline staff had commenced however this was not being completed regularly. For example one staff member had supervision on the 30 July 2015 with a date identified for a subsequent meeting on the 20 September 2015. No subsequent meeting was recorded. Another staff member had supervision on the 26 May 2015 with no other meeting evident.

Judgment:
Substantially Compliant
**Outcome 18: Records and documentation**

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors found the documentation required by the regulations to be maintained in the designated centre required improvements in relation to Schedule 3, 4 and 5 of the regulations.

Written operational policies as listed in schedule 5 of the regulations were in place to inform practice and provide guidance to staff. However some of the required policies as outlined in schedule 5 were not maintained in accordance with the regulations. These included the following:

- Provision of intimate care - the document present within the designated centre was devised in April 2009 and reviewed in April 2011.
- Two versions of the same policy were in circulation pertaining to recruitment, selection and the Garda Síochána vetting of staff. One document did not have a date specified while the second document was dated 2015.
- There was also two versions of the staff training and development policy in place, with no date on one while the second was dated November 2015.
- Retrieval of policies was difficult as two folders were present in the designated centre containing the same policies and differences existed between documents within each folder.
- Records and documents that were viewed were in accordance with Schedules 3 as listed in the regulations were in place. However records relating to restrictive practice were not available within the designated centre in relation to both physical and environmental restraint. The reason for use, the nature of the restrictive procedure and the duration of the restraint was not available within the designated centre.
Records and documents that were viewed were in accordance with Schedules 4 as listed in the regulations were also viewed. The directory of residents did not identify the dates that residents did not reside within the centre.

Inspectors found systems were in place to ensure that medical records and other records, relating to residents and staff, were maintained in a secure manner.

Inspectors read the residents guide and found that it provided detail in relation to all of the required areas. This document included a summary of the services and facilities to be provided, arrangements for resident involvement in the designated centre and a summary of the complaints procedure.

Inspectors reviewed documentation submitted as part of the application to register, and determined that there was an up-to-date insurance policy in place for this proposed designated centre valid up until the 31st of December 2016.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
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>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002878</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>02 March 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>24 June 2016</td>
</tr>
</tbody>
</table>

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:
Inspectors found areas and practices whereby residents' right to privacy and dignity were compromised as detailed within the body of the outcome.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **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:**
A tinted screen which allows for visibility only from the side of the resident was applied to the resident’s bedroom window. This will ensure that there is privacy from potential passers-by on the adjoining road.

Disposable aprons are no longer used in the Designated Centre.

**Proposed Timescale:** 24/06/2016
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaint procedure was not on display in a prominent area in both houses: the complaints procedure was on display in the office.

2. **Action Required:**
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
The accessible complaints procedure has been moved into the hallway for residents or visitors to clearly see in both locations.

**Proposed Timescale:** 24/06/2016
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear if there was a designated person to ensure all complaints were handled appropriately and in line with the organisation's procedure.

3. **Action Required:**
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Please state the actions you have taken or are planning to take:**
A designated person, Administrative Officer, monitors all complaints.
The complaints officer, and the Person in Charge also monitor complaints, ensuring all are appropriately responded to in a timely manner and satisfaction levels of the complainant recorded.

Staff will be informed of this information at their next team meeting to ensure they are aware of the process.

**Proposed Timescale: 15/07/2016**

<table>
<thead>
<tr>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The</strong> is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>Contracts did not adequately set out the services to be provided, the fees to be charged and the details of additional charges.</td>
</tr>
<tr>
<td><strong>4. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The Contracts of Care will be reviewed and updated for each resident to include the exact services to be provided, fees to be charged, additional fees and the exact percentage of bills to be paid.</td>
</tr>
<tr>
<td><strong>Proposed Timescale: 31/10/2016</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Some of the personal plans of residents were not reviewed annually.</td>
</tr>
<tr>
<td><strong>5. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All personal plans will be audited yearly by Person In Charge. Additionally, residents personal plans will be audited twice yearly by the supervisor. Audits will identify actions, person responsible for same and timelines for completion.</td>
</tr>
</tbody>
</table>
Proposed Timescale: 31/10/2016  
Theme: Effective Services  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Some of the changes in relation to the personal and social care needs of residents were not reflected in the residents' plans.

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

Please state the actions you have taken or are planning to take:
Staff in the Designated Centre will receive Practice Development Session in the Area of Personal Planning from the Quality and Safety Department.

Each residents personal plan will be reviewed by the key-worker in consultation with the wider staff team, assessing the need for any new care plans, and removing any plans that are no longer necessary.

Staff will also link in with day service for general update and will advise wider staff team of areas of focus.

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Proposed Timescale: 31/10/2016  
Theme: Effective Services  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Some of the personal plan reviews did not assess the effectiveness of each goal as one example continued for four years.

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

Please state the actions you have taken or are planning to take:
Staff in the Designated Centre will receive Practice Development Sessions in the Area of Personal Planning from the Quality and Safety Department.

New Person Directed Planning Guidelines will guide practice in the area of goal setting, review and implementation.

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Proposed Timescale: 31/10/2016
# 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 external surface of one of the houses was uneven and not conducive for residents to escape safely especially when one resident required the use of a wheelchair.

**8. Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The uneven pavement will be levelled in order to allow for safer egress of residents. This will form part of the proposed works which will address the back garden and front garden areas of the location.

**Proposed Timescale:** 30/09/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of the kitchen dining area in one house was not sufficient for the number of residents and staff within the house.

**9. Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
Taking into consideration the recommendations of the inspection, the house will be assessed by an architect and quantity surveyor. Plans will be drawn up in consultation with the residents and their representatives for renovation, extension and upgrade of the premises.

The plans will be put out to tender and a builder sought to complete the works in line with Procurement Policy.

The Provider Nominee will link with Estates Department, and Administrative Department to secure the funding to complete the proposed works.

**Proposed Timescale:** 30/09/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre was not maintained in a good state of repair externally and internally.

10. **Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
As noted above, plans will be drawn up to improve the conditions of the premises internally and externally.

**Proposed Timescale:** 30/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Repairs within the designated centre were not being conducted in a timely manner in order to minimise disruption and inconvenience to residents.

11. **Action Required:**
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
The Maintenance Log within the Designated Centre will be reviewed.

The log will contain evidence of progress made on repairs.

The Person In Charge will liaise with the Maintenance Manager in order to ensure that repairs are carried out in a time manager.

Maintenance will form part of the weekly Team Meeting Agenda. Maintenance Repairs and delays in same will be raised at the Quality and Safety Committee meeting attended quarterly by the Person In Charge.

**Proposed Timescale:** 31/07/2016
<table>
<thead>
<tr>
<th><strong>Outcome 07: Health and Safety and Risk Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> Fire doors were not present within the designated centre.</td>
</tr>
<tr>
<td><strong>12. Action Required:</strong> Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Fire doors will be installed in one location in the coming months. (30/9/16). Fire doors will be installed as part of the proposed works in the second location.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 30/09/2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcome 08: Safeguarding and Safety</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> Restrictive procedures in place within the designated centre were not applied in accordance to national policy and regulations.</td>
</tr>
<tr>
<td><strong>13. Action Required:</strong> 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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Locked doors will be referred to the Human Rights Committee for review. The Person in charge will report all restrictions on the quarterly notifications. A Local Protocol will be drawn up in the Designated Centre to evidence the rationale for use of the locked door and procedure for same.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 30/06/2016</td>
</tr>
</tbody>
</table>
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received training in relation to behavioural support.

14. **Action Required:**
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

**Please state the actions you have taken or are planning to take:**
All staff will be trained in one day MEBS (Multi Element Behaviour Support) and MAPA (Management of Actual or Potential Aggression).

Furthermore, staff will receive training in the Positive Behaviour Support Policy and Completion of Behaviour Report Forms.

**Proposed Timescale:** 31/12/2016

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Interventions within a behavioural support plan did not guide staff effectively.

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

**Please state the actions you have taken or are planning to take:**
The use of a placebo medication as a behaviour management strategy has been removed from the behaviour support plan.

The behaviour support plan is to be reviewed and updated by the 15.09.16.

The updated Behaviours Support Plan will be discussed at the monthly team meeting following its review.

**Proposed Timescale:** 30/09/2016
### Outcome 09: Notification of Incidents

**Theme:** Safe Services

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

All of the restrictive practices were not notified to the Chief Inspector at the end of each quarter including environmental restraint in relation to the external door locking of one of the houses during specified periods during the day.

Physical restraint in relation to the use of transportation vest.

**16. Action Required:**

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

- A Local Protocol will be drawn up in relation to the Locking of External Doors within the Designated Centre.
- Additionally this restrictive practice will be referred to the Human Rights Committee. The resident is using a transport vest in order to support with safe positioning of the seat belt.
- This restriction will be documented with a Risk Assessment, Tracking of the use of the equipment, Skills Teaching and Protocol.
- All restrictions will be notified to the regulator on the quarterly notifications.

**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:**

The effectiveness of healthcare interventions was not evident as interventions were not specific and in some cases monitoring did not take place.

**17. Action Required:**

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

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

A review of all health care plans will take place for all residents.
Rationale for all interventions will be clearly stated on the care plan and staff will follow and document the plans effectively.

This will be monitored by Supervisor and Person In Charge as part of the personal plan audits.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate healthcare in relation to elimination and sleep hygiene was not evident.

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

Please state the actions you have taken or are planning to take:
The elimination at night procedures for one resident will be reviewed.
Consultation will be sought from the G.P, Occupational Therapy and Psychology.
A Care Plan will be drawn up to support the resident in relation to elimination at night.

Proposed Timescale: 30/09/2016

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:
Medication administration recording charts did not contain space for staff to record comments if required.

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

Please state the actions you have taken or are planning to take:
The pharmacist has been consulted and he will amend the recording charts to include a comments section.
**Proposed Timescale:** 31/07/2016  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Topical medications were not labelled with the date of opening.

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

**Please state the actions you have taken or are planning to take:**  
Staff will ensure that the date of opening is recorded on all Topical Medications.

**Proposed Timescale:** 24/06/2016  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Prescriptions did not specify the maximum dosage of PRN medication to be administered to a resident within a 24 hour period.

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

**Please state the actions you have taken or are planning to take:**  
PRN medication prescription will include maximum dosage and criteria for use. This will be written on Kardex for all residents.

**Proposed Timescale:** 31/07/2016

**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:**  
Effective monitoring of the designated centre was not evident as audits were not taking place within the designated centre with the exception of the quality and safety department.
22. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
A new Person In Charge will be in place from 11th July 2016.

An audit schedule will be drawn up by the Person In Charge.

Audits will take place to ensure oversight is maintained and to assess the standard of care and supports in the Designated Centre.

**Proposed Timescale:** 30/09/2016  
**Theme:** Leadership, Governance and Management  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Evidence of regular staff collaboration was not present within the designated centre.

23. **Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**
Monthly staff meetings will take place in the Designated Centre.

A revised minute template will be used for staff meetings. This will record accidents, incidents, learning, and quality improvement. Items to be escalated to Person In Charge will be clearly noted on the minutes.

Staff will receive regular supervision and guidance from the supervisor.

**Proposed Timescale:** 30/06/2016  
**Theme:** Leadership, Governance and Management  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Action plan developed from the providers visits did not identify a specific a time-frame for competition, therefore it was not possible to monitor progress within the designated centre.
24. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
The actions identified in the Quality and Safety Departments Inspection will be incorporated into the Quality Enhancement Plan for the Designated Centre.

Each action will have an identified Person responsible and timeline for completion.

**Proposed Timescale:** 31/07/2016

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### Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The designated centre was not effectively resourced with effective maintenance.

**Action Required:**
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
The Maintenance Log within the Designated Centre will be reviewed.

The log will contain evidence of progress made on repairs.

The Person In Charge will liaise with the Maintenance Manager in order to ensure that repairs are carried out in a time manager.

Maintenance will form part of the weekly Team Meeting Agenda. Maintenance Repairs and delays in same will be raised at the Quality and Safety Committee meeting attended quarterly by the Person In Charge.

**Proposed Timescale:** 31/07/2016

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### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The actual staff rota was not evident within the designated centre.
26. **Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
Staff rotas will be kept up to date to reflect changes.

Rotas for week previous, current week and coming week will be kept on site in the staff office.

**Proposed Timescale:** 24/06/2016  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Mandatory training was not up to date for some staff.

27. **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 receive up to date training in relation to Fire Safety.

**Proposed Timescale:** 24/06/2016  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff supervision was not consistent within the designated centre.

28. **Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
Staff will receive Supervision from the Supervisor at least every three months. The Supervisor will develop a Supervision Schedule which will be available for staff reference in the staff office.

Records of Supervision will be kept by the Supervisor of the Designated Centre.
Proposed Timescale: 31/07/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Duplicate versions of policies with the same title and different implementation dates were available within the designated centre this could lead to confusion among staff.

29. **Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

Please state the actions you have taken or are planning to take:
Duplicate policies have been removed from the locations.

Proposed Timescale: 24/06/2016

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Physical and environmental restraint records were not present within the designated centre in relation to the rationale for use and the duration of the restrictive procedure.

30. **Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
A Protocol for the locking of the External door will be drawn up along with Protocol for use of a transport support for one resident.

Proposed Timescale: 30/06/2016

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Dates during which residents did not reside within the designated centre were not available within the designated centre.
31. **Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
Where a resident attends another Service overnight this will be reflected on the Directory of Residents.

Where a resident is away from the Designated Centre overnight (with family) this will be reflected in the PCP (Family Contact Log).

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