

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003591
Centre county:	Dublin 8
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Philomena Gray
Lead inspector:	Anna Doyle
Support inspector(s):	Caroline Vahey
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 May 2016 09:30 To: 10 May 2016 20:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
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

Background to the inspection

This was the fourth inspection of this designated centre. The purpose of this inspection was to follow up on actions from the last inspection carried out in the centre in November 2015 and in response to notifications and unsolicited information received by HIQA in relation to safeguarding. However over the course of the inspection other outcomes were reviewed.

Description of the service

This centre is operated by St John of Gods services and is situated on a campus based setting in South Dublin. It comprises of three units: one is a large residential unit that accommodates 13 residents, one is a one bedroom apartment and the other is a five bedroom unit and no residents are currently residing there. The centre provides care to both male and female residents with varying degrees of intellectual disabilities, some of whom have significant medical needs and challenging behaviour.

How we gathered evidence

Over the course of this inspection one resident spoke with inspectors, staff were met, personal plans were reviewed, practices were observed and inspectors observed interactions with staff and residents.

Overall judgment of our findings

Overall inspectors found significant failings in the overall governance and management systems in the centre. For example inspectors found that of the 17 actions identified at the last inspection only one had been completed to a satisfactory level. In addition major non-compliances were found in nine of the outcomes inspected and the other three outcomes were found to be moderately non compliant. Major non-compliances were found in admissions and contracts of provision of services, social care needs, healthcare needs, safe and suitable premises, health and safety, safeguarding, medication management, governance and management and workforce. Moderate non-compliances were found in residents' rights, notification of incidents and the statement of purpose.

At the feedback meeting the provider and person in charge were asked to submit documents to the Authority that were not available on the day of the inspection, however not of all of the documents requested had been submitted at the time of this report.

Inspectors met with the provider nominee after the feedback meeting to outline concerns around governance and management systems in the centre. The action plan at the end of this report outlines the improvements required.

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):

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

Findings:

Overall inspectors found that the actions from the previous inspection had not been implemented effectively in relation to complaints in the centre.

The complaints policy had only been updated on the day of the inspection. The person in charge and the PPIM's involved in the management of the centre were not aware of who the person was that had been nominated to ensure that all complaints in the centre were dealt with and recorded. This had been an action from the previous inspection. The provider nominee informed inspectors in a telephone conversation on the day of the inspection that since the last inspection a new flow chart had been developed to guide staff on the reporting process involved in dealing with a complaint. However there was no evidence of this in the centre.

Inspectors found that a new complaints recording sheet had been implemented since the last inspection. Inspectors reviewed a record of three complaints in the centre and found that practices around the management of complaints were inconsistent. For example one complaint recorded had been dealt with appropriately. However the other two complaints had not been dealt with effectively in that there was no evidence of what actions had been taken in one complaint recorded and there was no evidence that the complainant was satisfied with the outcome of the complaint for both complaints. For example one of the complaints recorded had not been reported in a timely manner and there was no actions identified as to how the concern was to be addressed. Inspectors were informed by the person in charge that they had met with the complainant and inspectors asked for the minutes of these meetings. It was found from

the minutes that there was no evidence of what actions had been taken to address the complaint and that other concerns that had been raised at this meeting had not been followed up on.

While inspectors acknowledge that one of the complaints was still in process and the provider had been responsive in organising an investigation team to deal with this complaint, inspectors found that some of the recommendations from the report formulated by the investigation team dated 11 March 2016 had not been implemented to date. This was discussed at the feedback meeting and inspectors were informed that a meeting had been arranged for next week to discuss the report with the complainant. In addition the provider had sought the support of an independent advocate for this resident who had formulated a report based on their findings. This report was dated 14 March 2016. The recommendations from this report were discussed at the feedback meeting and inspectors were assured that this would be discussed with the complainant at the meeting next week.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Overall inspectors found that the actions from the previous inspection regarding contracts of care were not implemented as contracts of care were not available. In addition residents' transition plans for admission and discharge to the centre were not available.

The inspectors found that residents did not have a written agreement on the terms for which residents resided in the centre, this had been an action from the previous inspection.

There had been one new resident admitted to the centre in December 2015, inspectors found that this resident had no transition plan contained in their personal plan. In addition another resident who was due to transfer to supported living in the community did not have a transition plan in place. This was discussed at the feedback meeting.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

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

Findings:

Overall, the inspectors found there was little or no documentary evidence to confirm the care and support provided to residents was of an acceptable standard, implemented and regularly reviewed. Individual needs were not reflected comprehensively, accurately or timely in personal plans.

One of the three actions from the previous inspection had partially been implemented in that individual goals had been reviewed at six monthly intervals. However, there was no evidence to confirm that keyworkers met with residents on a monthly basis to discuss progress of goals, as outlined on the provider's response to the previous inspection.

Two actions had not been satisfactorily implemented in that personal plans were not comprehensive to guide practice and health care assessments were not in place for a number of residents.

The inspectors reviewed four personal plans. Each resident had an assessment of some needs such as social and personal completed, for example, friendships, hobbies, communication and safety. However, the inspector found some information had not been updated in an assessment of need to reflect a change in circumstances. In addition, an assessment of need for one resident was not subject to an annual review. The inspectors found most health care assessments were not completed at all. In addition, one health care assessment available had incorrect information documented in relation to a diagnosed neurological condition.

Personal plans were in place and incorporated areas such as individual goals, intimate care guidelines and individual risk assessments. However, the inspectors found the detail contained within most of these plans was not sufficiently detailed to guide

practice. For example, intimate care plans stated the number of staff required to provide the care but did not outline what the care required was.

Most healthcare plans for identified healthcare needs were not in place. Of those available, the inspectors found plans were either out of date or not updated to reflect the current practice. In addition, these plans contained basic information and the guidance required to support residents with complex medical conditions was not available. In addition some medication management plans which formed part of the personal plans were not completed.

There was some evidence that plans were implemented however, this was not consistent. For example, there were no records of a sensory programme being carried out regularly throughout the day as recommended. In addition, the clinical nurse manager (CNM2) informed the inspector that the staff had discontinued this programme, however, there was no documentary evidence to confirm this had been reviewed or updated by the relevant allied health professional.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Overall inspectors found that areas of the centre were unclean and poorly maintained. One area in the centre required major renovation work. In addition two actions from previous inspections carried out in the centre had not been implemented effectively.

Not all of aspects of this outcome were reviewed as part of this inspection. At the last inspection, inspectors were not able to visit all areas in the centre due to residents needs. These two areas were inspected as part of this inspection and inspectors found that significant improvements were required.

The five bedroom unit in the centre was not in use and was being used for administration purposes. At a meeting held with the person in charge inspectors were informed that this centre was not currently being used but that the intention may be to

use it for emergency admissions. Inspectors found that this area of the centre was not suitable for this purpose until major renovation works had been completed. These findings were discussed at the feedback meeting and the provider was in agreement with these findings.

Inspectors found that the one bedroom apartment required redecoration work that had formed part of the action plan from the inspection carried out in March 2015, had not been completed. Areas of this unit were unclean, there was a musty smell evident in the en-suite area and tiles in another shower room were broken. The resident informed inspectors that the water in one shower was too hot and staff also confirmed this. No action had been taken up to the date of the inspection to rectify this matter. There was outside space available to the front of the building and inspectors found that this area was covered in moss and the outdoor furniture available needed to be replaced. In addition there was no access to laundry facilities for this resident to do their own laundry. This and other areas of concern were discussed at the feedback meeting.

Inspectors found that the large residential unit in the centre was generally well maintained. Some residents' bedrooms were viewed by inspectors and found to be spacious and personalised. Some configurations had taken in place in the centre to address findings at the last inspection in that the dining room was now located in a larger room and had a large dining table that was more homely. In addition the visitors room in the centre had been redecorated. However inspectors found that the accessibility to this area of the centre was compromising one resident's right to privacy as the resident had to go through the visitors room in order to access their bedroom. This was discussed at the feedback meeting.

Inspectors also found that since the last inspection window blinds had been put in place on a doorway that was used to access the outside of the building to protect residents' rights to privacy. This had been an action from the previous inspection, however one of the blinds was missing from the door on the day of the inspection.

There was no evidence to confirm whether all equipment in the centre had been properly maintained on the day of inspection. Inspectors asked for these records to be submitted to HIQA after the inspection. The records submitted showed that only some of the equipment had been properly maintained. For example there was no records for the maintenance of clinical equipment used in the centre.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

Overall inspectors found that some of the actions from the previous inspection had not been implemented in that there were no arrangements in place for the review of incidents in the centre. In addition improvements were required in fire safety and evacuation procedures in the centre.

Since the last inspection, inspectors found that a new incident report form had been implemented. There was a significant amount of incident reports on file in the centre. Inspectors viewed a sample from the most recent reports and found that the forms were not been completed in full. For example staff names and resident names were not completed. In addition there were no reporting systems in place for staff in relation to when and who they should report incidents to. The CNM2 was not aware of what the process was. The person in charge was asked about this and informed inspectors that staff were guided by the incident reporting procedures. Inspectors were given a copy of two of these procedures and found that there were no reporting structures in place for staff.

Inspectors found that there was no review of incidents occurring in the centre. The incidents were not collated and reviewed to identify trends and inform future practice. This had been an action from the previous inspection. At the feedback meeting the provider and the person in charge were asked to submit a synopsis of the incidents that had occurred in the centre since the last inspection to HIQA. This had not been submitted at the time of this report.

Suitable fire equipment was provided in the centre and this had been appropriately maintained. There were systems in place to check fire equipment daily, however the records were not consistently completed. A fire drill had been completed in March 2016, however in recent months, the staffing levels at night had been reduced and no night time fire drill had taken place to reflect this. Given the complexity of residents needs in the centre, the CNM2 was asked to seek advice from a qualified persons regarding the simulation of a fire evacuation of residents at night time in order to ensure a safe evacuation of the centre.

Residents had personal evacuation plans contained in their personal plans, however from a sample viewed, three had not been completed at all. In addition there were three fire evacuation procedures in place and not all of the residents were considered as part of the evacuation of the centre. For example there was no system in place to ensure that the resident who stayed in the apartment on their own was included in the evacuation of the centre. Inspectors were reassured haven spoken to this resident that there were aware of what to do in the event of a fire in their area. In addition the emergency evacuation procedure did not outline where residents were to be evacuated to in the event of a full evacuation of the centre.

Residents had individual risk assessments on file, however they did not identify all hazards and as such control measures in place did not ensure the protection of

residents. For example one resident had a risk assessment completed for showering. This stated that the resident would seek staff assistance if required. However inspectors were informed that this resident requires full assistance when showering due to mobility issues. The environmental risk assessments for the centre were not reviewed as part of this inspection.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

Overall inspectors found that the actions from the previous inspection had not been fully implemented in that interventions which formed part of therapeutic support plans were not consistently implemented. In addition improvements were required in relation to restrictive practices in the centre and the documentation and review of behaviour support plans.

The action from the previous inspection had not been satisfactorily implemented, and there was no documentary evidence to confirm that an intervention which formed part of the use of restrictive practice was implemented.

Inspectors found that the appropriate procedures were not followed in relation to a safeguarding issue for one resident that had been recorded in the minutes of a meeting.

The inspectors reviewed records in relation to three residents presenting with behaviour that challenges. There was no plan or guidance in place for a resident with whom the use of restrictive practices was required. The use of this practice had not been notified to the Authority.

Detailed guidance was available for another resident on the use of restrictive practice however, the conditions for use of this practice required that it be reviewed by the multidisciplinary team on a monthly basis. In addition the protocol for use of this

practice had not been signed by any multidisciplinary team member. The last review of this practice had taken place in January 2016 with no plan in place for an additional review. There was no risk assessment in place for the use of this restrictive practice. Documentation was maintained on each occasion the restrictive practice was implemented.

There were two plans in place to support a resident with behaviours that challenge however, one plan had been implemented in 2013 with no documented review since then. In addition a specific risk assessment for this resident outlined a control measure to refer to the behaviour support plan however, the behaviour support plan did not outline how to support the resident with the specific behaviour in order to minimise the risk.

Not all of the areas under this Outcome were inspected.

Judgment:
Non Compliant - Major

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

Findings:
Overall inspectors found that the actions from the previous inspection had not been effectively implemented as inspectors found evidence of some incidents relating to restraint used in the centre did not match the information submitted to the Authority. In addition inspectors noted that one complaint made that was currently being investigated by the provider had been recorded in the reports as concerns around safeguarding issues for one resident. This had not been notified to the Authority. This was discussed at the feedback meeting.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Overall the inspectors found improvement was required to ensure health care needs were met and to ensure the care provided was safe and in line with best practice.

The action from the previous inspection had not been implemented. Health care plans were either not developed, did not contain the appropriate information to guide safe practice, or were not updated to reflect changes in circumstances. In the absence of documentary evidence, the inspectors could not ascertain the care and support in place, or required, to meet identified healthcare issues. In addition, the inspectors were not assured the care provided was consistent, monitored effectively and in line with best practice.

The inspectors also found that fluid intake monitoring required as part of a nutritional requirement was not consistently recorded.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that significant improvements were required in medication management systems in the centre.

Inspectors did not inspect all areas under this outcome. However over the course of the inspection issues arose that required attention in this area.

Inspectors viewed four residents' prescription sheets and found a number of areas required improvements. Two of which required immediate attention as it was found that they may compromise residents safety. The CNM2 contacted the prescribing physician who attended the centre before the end of the inspection to rectify these discrepancies.

Most PRN prescriptions did not have the maximum dosage in 24 hours stated.

In addition inspectors found that in one area of the centre the medication policy was not been implemented and significant improvements were required in this area in relation to the administration, storage and disposal of unused medications. This was discussed at the feedback meeting.

Judgment:
Non Compliant - Major

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:
Overall inspectors found that there was a Statement of Purpose in place in the centre but it had not been kept under review and the services outlined in it were not implemented into practice.

The Statement of purpose had been reviewed in December 2015; however since then a number of changes had occurred in the centre. Examples included:
Changes to the management structures in the centre.
Changes to the provision of services in the centre as one unit was not in use.
Changes to the reconfiguration of the centre.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Overall inspectors found that an action from the previous inspection had not been implemented and significant improvements were required in the governance and management structures in place in the centre so as to ensure a safe quality service.

Inspectors met with the person in charge and found that they were the person in charge for two other designated centres belonging to this service. They were also employed as a programme manager with responsibility for another four designated centres belonging to this service. Inspectors found that the person in charge could not ensure the effective governance, operational management and administration of the designated centre concerned given the areas of responsibility they were assigned. While the provider had taken some remedial actions to address the governance and management structures, inspectors found that the management systems in place were ineffective as there were no clear lines of accountability for decision making and responsibility for the delivery of services to residents.

A number of audits had taken place in the centre since the last inspection, this included and unannounced quality review of services and an external auditor had conducted a review of the designated centre. However while action plans had been formulated from these audits, inspectors found that a large number of the actions did not clearly indicate who was responsible to oversee that the actions were completed and that the majority of actions had not been completed effectively at the time of this inspection. Examples include contracts of care for residents, a review of all personal plans and supervision meetings for staff.

An annual review had not been completed for the centre. This had been an action from the last two inspections carried out in this centre.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Overall inspectors found that some of the actions from the previous inspection had not been fully implemented and improvements were required in the supervision of staff in the centre and staffing numbers in the centre.

Inspectors reviewed training records submitted to the Authority after the inspection and found that the actions from the previous inspection had not been implemented, in that the records reflected that staff had not been provided with training in relation to some of the assessed needs of residents. For example training on the use PEG tube feeding. In addition not all staff had received refresher training. For example it was found that since the last inspection seven staff had received refresher training in fire safety.

Inspectors also found that some staff had not been trained in the use of restrictive practices used in the centre. In addition as part of the action from the last inspection the provider had undertaken to complete training needs analysis. This was not available to inspectors.

Inspectors were informed from speaking to staff that there was no formal supervision in place for staff. Staff reported that they felt concerns that had been raised with management were not addressed. One staff member who inspectors were informed was being mentored by another staff member had received no formal mentoring since the process was due to commence a number of months ago. In addition staff meetings were held infrequently in the centre. The last one recorded had taken place in March 2016.

There were large numbers of agency and relief employed in the centre. This was verified by staff, the CNM2 and the service coordinator. Staff spoken to stated that the use of agency staff made as it difficult to provide consistency of care to residents given their complex needs and the requirement for specific staff training to support some residents. Inspectors requested that a sample of rosters should be submitted to the Authority after the inspection. On reviewing these inspectors found that the actual roster was incomplete in that not all staff names who had actually worked in the centre had been included on the roster. In addition there were times of the day where there was insufficient staffing levels to meet the assessed needs of residents. For example in the late morning mid afternoon time, five staff were on duty; however three of these staff

were supporting residents who required intensive supervision. However there were times during this period where four staff were required to meet the residents' needs as per their personal plans.

In addition staff that supported the resident who resided in the apartment in the centre, was not always available at certain times during the day and it was not clear to inspectors who supported the resident at these times. For example this resident's risk assessment stated that the resident was supported at night by staff from the unit that was currently closed. Inspectors found from speaking to the CNM2 and the service coordinator that there were unsure of who was responsible for supporting this resident when their support worker was not available. In addition a staff member who appeared to be supporting the resident on the day of the inspection informed inspectors that she had not being assigned to support this resident but was on her morning break from the other centre. Inspectors observed this staff supporting the resident to take their eight o clock morning medications at midday.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003591
Date of Inspection:	10 May 2016
Date of response:	03 June 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-compliance s 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: One complaint had not been reported in a timely manner.
There was no evidence to support what actions had been taken address a complaint made.

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

Some concerns raised at a meeting had not been recorded as a complaint and there was no evidence to support what actions had been taken to address the concerns raised.

1. Action Required:

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

The Registered provider will ensure that:

- The revised complaints procedure and staff understanding of it will be discussed at team meeting on 07/06/2016 and staff will be reminded of the agreed timescales for reporting complaints
- All complaints will be reported and addressed within the timescales within the procedure. In exceptional cases where timescales will not be met, this will be communicated to complaint originators as per the procedure. Effective from 11/05/2016
- The newly revised complaint records and log require actions to be detailed and recorded. 13/05/2016
- The PIC will review all complaints and meeting minutes from Q4 2015/Q1 2016 to date to ensure all complaints are captured, all actions are recorded/implemented and will follow up on any gaps with staff concerned. 01/07/2016

Proposed Timescale: 01/07/2016

Theme: Individualised Supports and Care

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

Some of the recommendations from the investigations team report had not been implemented.

2. Action Required:

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

The Registered provider will ensure that:

- The investigation report is not finalised as the complaint originator is not satisfied with the outcome, report and some recommendations. The director is currently awaiting a written submission regarding the report and has written to request same in the absence of it being forthcoming.
- The record identified in recommendations was introduced on 31/05/2016 to meet safeguarding requirements.
- A crisis management protocol is being extended regarding roles/responsibilities of staff which will be reviewed at team meeting on 7/06/2016 and will be implemented on 08/06/2016
- Recommendations regarding visiting procedures are under review and changes will be introduced by 31/07/2016.

Proposed Timescale: 31/07/2016

Theme: Individualised Supports and Care

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

It was not evident who the nominated person was to ensure that all complaints were dealt with and recorded.

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:

The Registered provider will ensure that:

- A newly revised complaints procedure was introduced on 11/05/2016 which identifies a nominated person.
- All staff were provided with copies of the complaints flow chart process on 23/05/2016
- All staff requested to read & sign to indicate understanding of specifically this procedure on 23/05/16 and approximately 50% of staff have done this on 31/05/2016
- The procedure and staff understanding of it will be discussed at team meeting on 07/06/2016.
- CNM I and CNM II will monitor policy signature sheet to ensure all staff have read the procedure by 14/06/2016

Proposed Timescale: 14/06/2016

Theme: Individualised Supports and Care

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

There was no evidence to support whether complainants were informed of the outcome of their complaint.

4. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

The Registered provider will ensure that:

- The newly revised complaint records and log require feedback to the complaint originator and satisfaction/further steps to be detailed and recorded. 13/05/2016
- All outcomes and un-captured complaints will be included in these records and communicated to complaint originators. This will be updated by 01/07/2016

Proposed Timescale: 01/07/2016

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:

Residents did not have a written agreement of the terms on which the residents reside in the centre.

5. 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:

The Registered provider will ensure that:

- Letters to families/representatives and contracts of care have been drawn up on 31/05/2016
- Schedule of charges will be completed and all documents sent to families/representatives by 08 /07/2016
- The PIC/CNM II will follow up on the written agreements with residents and families by 22/07/2016

Proposed Timescale: 22/07/2016

Theme: Effective Services

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

There was no evidence of transition plans for two residents contained within their personal plans.

6. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

The Registered provider has ensured that:

- One outstanding transition plan had been completed but missing from records on the date of inspection and this was replaced on 23/05/2016.
- All staff were directed on 23/05/2016 to re-familiarise themselves with this plan and the supporting documents to ensure they are aware of all information shared at the time of transition
- The remaining " My transition journey" was drawn up with the resident and their representatives, and was commenced on 30/05/2016
- The resident concerned will transition according to their plan by 31/08/2016
- All staff have been provided with the "my transition journey" format on 31/05/2016 for future transitions

• All future discharges/admissions/transitions will use a "my transition journey" format, informed by all relevant members of the MDT, the person and their representative, prior to any move.

Proposed Timescale: 31/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Comprehensive health care assessments were not in place for a number of residents.

A health care assessment contained incorrect information relating to a diagnosed neurological condition.

Assessments of need were not updated to reflect a change in circumstance.

An assessment of need had not been subject to an annual review.

7. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The PIC and CNM's will ensure that:

- Comprehensive health care assessments are being drawn up for all residents. These have commenced on 16/05/2016 and are in various stages of progress. Seven will be completed by 08/07/2016. The remaining six will be completed by 31/07/2016 and their progress is being monitored by the CNM's.
- The healthcare assessment containing incorrect information was reviewed and corrected on 12/05/2016.
- Assessments of need are under review currently and all changes in circumstances and identified needs will be reviewed for all residents by 31/07/2016.

Proposed Timescale: 31/07/2016

Theme: Effective Services

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

Personal plans did not consistently outline the support required to meet assessed needs. Personal plans were basic and did not comprehensively guide practice.

Healthcare plans were not available for a number of residents.

Medication management plans were not completed for a number of residents.

8. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

The PIC and CNM's will ensure that:

- All personal plans have been reviewed by clinical nurse managers and it has been determined that the formats are not adequately accessible, and require review and development.
- A Personal Directed Planning (PDP) coordinator met with PIC/CNM's on 01/06/16 to identify a style of personal plan most appropriate to resident's needs.
- A PDP coordinator will provide training to keyworkers in goal setting and monitoring progress by 15/07/2016
- New personal plans which will clearly outline goals, steps to achievement and provide guidance will be drawn up with residents and their representatives. Seven personal plans will be completed by 29/07/2016; Six plans will be completed by 02/09/2016
- The progress of plans will be monitored on a monthly basis by keyworkers and CNM's from 29/07/2016
- The PDP coordinator will provide ongoing mentoring and oversight regarding the quality of individual plans from 01/06/2016 to 02/09/2016. The PDP coordinator is visiting the service weekly to support the progress of the plans.

- Healthcare plans are in place for eight residents on 31/05/2016 and the remaining five plans are in progress and will be completed by 13/06/2016. Any additional plans arising from new health assessments will be updated by 31/07/2016.
- A CNS and CNM I is supporting staff to develop medication management plans for all residents. These will be completed by 08/07/2016

Proposed Timescale: 02/09/2016

Theme: Effective Services

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

Personal plans were not consistently subject to an annual review.

Individual goals were not reviewed in a timely manner.

9. Action Required:

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.

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

The PIC and CNM's will ensure that:

- New personal plans will be introduced 29/07/2016 to 02/09/2016 and these will be subject to annual review.
- Individual goals will be revised and incorporated into the newly revised plans. Goals will be reviewed monthly and progress tracked and recorded. 29/07/2016 to 02/09/2016

Proposed Timescale: 02/09/2016

Theme: Effective Services

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

Documentary evidence was not in place to confirm the implementation of a sensory programme as recommended by an allied health professional.

10. Action Required:

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

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

The Registered provider has ensured that:

- The PIC and CNM's arranged for the review of the sensory programme by the CNS and has been reconfigured with supporting documentation to guide staff. 20/05/2016

Proposed Timescale: 20/05/2016

Theme: Effective Services

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

A sensory programme had not been reviewed or updated to reflect a change in circumstance.

11. Action Required:

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

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

The PIC and CNM's ensured that:

- The PIC and CNM's arranged for the review of the sensory programme by the CNS and has been reconfigured with supporting documentation to guide staff. 20/05/2016

Proposed Timescale: 20/05/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

One unit in the centre was unclean and poorly maintained and required major renovations to bring it up to an acceptable living standard.

The outside area in one part of the centre was covered in moss and the garden furniture needed to be replaced.

12. 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 Registered provider will ensure that:

- The building will be emptied of all unused or broken equipment by 30/06/2016.
- A referral will be made to the Capital Development Committee to determine the suitability of works and the future plan for the building in June 2016
- Unused outdoor furniture will be removed
- Outside areas to be power hosed and treated with moss deterrent by 30/06/2016

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

One resident had no access to laundry facilities in the centre.

One resident only had access to their bedroom through the visitors room in the centre.

13. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

The Registered provider will ensure that the PIC will review and action:

- The resident's capability of operating laundry equipment will be reviewed and risk assessed by 31/07/2016.
- A washing machine and drier within centre will be installed if appropriate based on risk assessment by 31/08/2016
- All staff supporting the resident have been reminded of the need to provide full support and access to laundry facilities to the resident on 13/05/2016.
- The access to an area for visitors is currently under review. In the interim an

alternative room will be set up to provide visitors with the option of using that area. Bathroom and refreshment facilities will be in place. 30/06/2016

Proposed Timescale: 31/08/2016

Theme: Effective Services

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

One area of the centre was unclean and required updating.

14. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

The Registered provider will ensure that:

- Centre to undergo renovation works in regards to paintwork and appliances by 31/08/2016.
- A full clean and further maintenance cleaning was carried out on 14/05/2016, 21/05/2016 and 23,24,25/05/2016.
- Cleaning schedule has been reviewed and is now integrated into the resident's schedule from 23/05/2016.
- The residential Coordinator is checking the area in the centre every other day to ensure it is maintained appropriately. 23/05/2016

Proposed Timescale: 31/08/2016

Theme: Effective Services

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

There was no evidence to confirm whether all equipment in the centre had been properly maintained.

15. 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 Registered provider has ensured that:

- Copies of all equipment maintenance records held by maintenance services (hoists/beds/mattresses) were placed in the centre on 13/05/2016.
- Two overdue suctioning equipment apparatus were serviced on 16/05/2016.
- Servicing details for O2 equipment and other apparatus received on 17/05/2016 and

retained in the centre.

- Servicing of Nebulisers and PEGs followed up with state agency responsible for these medical devices and written confirmation received of replacement of those two years and older and the arrangements for specific make of equipment that does not require servicing but is replaced if not working. Record maintained of this information 30/05/2016.

Proposed Timescale: 31/05/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There was no systems in place for the review of incidents in the centre.

There were no systems in place for the reporting of incidents in the centre.

16. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The Registered provider has ensured that:

- All incidents are required to be sent to the CNM II and then to the PIC for the DC for review and further action 23/05/2016.
- The reports are entered onto an electronic system and a report is generated which is issued to the line managers of the DC.
- The PIC and CNM's will review on a monthly basis of incidents at a staff meeting. The PIC and CNM's will submit a Quality data report (including incidents), to the Quality and safety Committee. The learning from incidents at the team meeting will be shared & implemented in the DC. 01/07/2016.
- All reports are reviewed monthly by the quality and safety committee to identify trends, learning and actions.
- The reports described above will be maintained in the DC and where appropriate, required actions fed back to the PIC and CNM's for implementation. 01/07/2016.

Proposed Timescale: 01/07/2016

Theme: Effective Services

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

Individual risk assessments in place did not guide practice and did not reflect the needs of residents.

17. 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:

The Registered provider will ensure that:

- The PIC and CNM's will schedule reviews of all risk assessments in the centre and replace those required to ensure they guide practice and reflect individual needs by 19/08/2016

Proposed Timescale: 19/08/2016

Theme: Effective Services

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

The fire evacuation procedures for a night time evacuation had not been updated to reflect a reduction in staffing levels at night.

18. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

The Registered provider will ensure that

- The fire evacuation procedure is currently under review by the PIC/CNM II and will reflect current staffing levels. 08/06/2016
- Additional staff training in evacuation sleds is scheduled for 27/06/2016 and 29/06/2016 and the description of the equipment will be updated in the procedure.

Proposed Timescale: 29/06/2016

Theme: Effective Services

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

Residents personal evacuation plans had not been completed.

There were three fire evacuation plans in place in the centre.

The evacuation procedures did not outline where residents should be moved to in the event of a full evacuation of the centre.

19. Action Required:

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

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

The Registered provider will ensure that:

- All residents have a Personal Evacuation Plan in place that is located in both their file and in the emergency grab bag that is in place to be removed from the centre in an emergency. 16/05/2016
- One evacuation procedure was removed on 11/05/2016. Two remain in place. One is the full text of the procedure and the other is a summary of the full text evacuation procedures which both accurately reflect the procedure.
- The correct alternative location was added to the evacuation procedure and this will be discussed at the team meeting on 07/06/2016.

Proposed Timescale: 07/07/2016

Theme: Effective Services

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

Records for daily checks on fire equipment were not consistently maintained.

20. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

The Registered provider will ensure that:

- All staff have received direction regarding the importance of completing daily checks and incorporating this into handover. 23/05/2016
- CNM's will monitor these records to ensure compliance. 23/05/2016
- The completion of fire checks have been incorporated into daily visual audits carried out by CNM's/PIC from 30/05/2016

Proposed Timescale: 30/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Documentary evidence was not available to confirm a recommended intervention was implemented.

A behaviour support plan had not been reviewed in a number of years.

21. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

The Registered provider will ensure that:

- The intervention was inappropriately recorded through daily logs. A new record sheet was implemented on 24/05/2016 and CNM's will monitor it weekly to ensure the correct information is recorded.
- The behaviour support plan referred to was no longer in use and should have been archived. It was removed from the file on 12/05/2016.

Proposed Timescale: 24/05/2016

Theme: Safe Services

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

There was no guidance on the use of a restrictive practice for a resident.

The use of a restrictive practice was not subject to regular review by the multidisciplinary team.

The protocol in place for a restrictive practice had not been signed by any member of the multidisciplinary team.

There was no risk assessment in place for use of a restrictive practice.

22. 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:

The Registered provider will ensure that:

- The supporting documentation relating to the restrictive practice will be reviewed by the residential coordinator and any gaps addressed by 30/06/2016.
- The use of the restrictive practice is reviewed monthly at the PBS committee. Minutes reflecting the review will be maintained on the file of the resident by 10/06/2016.
- An MDT is scheduled for the resident on 14/06/2016.
- The relevant MDT members are currently signing the protocol. This will be fully completed by 17/06/2016.
- A risk assessment will be undertaken regarding the restrictive practice by 17/06/2016.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

A behaviour support plan did not contain guidance on the support required to minimise the impact of a specified behaviour.

23. Action Required:

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

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

The PIC will ensure that:

- The support plan in question has been forwarded to the CNS for behaviour support for review and will be updated to provide guidance on minimising the impact of a specified behaviour by 30/06/2016.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

The appropriate procedures were not followed in relation to a safeguarding issue for one resident that had been recorded in the minutes of a meeting.

24. Action Required:

Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

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

The Registered provider will ensure that:

- The PIC reviews the meeting minutes and will identify any remedial action required by 09/06/2016.
- The procedure will be discussed with staff at the team meeting on 09/06/2016.

Proposed Timescale: 09/06/2016

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:

One incident relating to a safeguarding concern had not been notified to the Authority.

25. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The PIC will ensure that:

- The person in charge will review incidents and make the necessary notification by 09/06/2016.

Proposed Timescale: 09/06/2016

Theme: Safe Services

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

Incidents of restraint used for one resident had not been notified to the Authority.

26. 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:

The PIC will ensure that:

- The PIC/CNM's will review records pertaining to that resident and submit the required information by 17/06/2016.
- All future incidents of restraint will be notified to the Authority in an NF39 quarterly notification.

Proposed Timescale: 17/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Documentary evidence was not available to confirm the care provided ensured healthcare needs were consistently met in line with best practice.

Healthcare plans were not developed for a number of residents.

Healthcare plans available were basic, did not guide practice and were not consistently updated to reflect changes in circumstance.

27. Action Required:

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

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

The Registered provider will ensure that:

- Healthcare plans are in place for eight residents on 31/05/2016 and the remaining five plans are in progress and will be completed by 13/06/2016. Any additional plans arising from new health assessments will be updated.
- A CNS will review these plans, focusing on up-to-date and best practice issues to ensure the quality of the plans by 01/07/2016.

Proposed Timescale: 01/07/2016

Theme: Health and Development

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

Fluid intake records, which formed part of a nutritional requirement for a resident were not consistently maintained.

28. Action Required:

Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

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

The PIC will ensure that:

- All staff have received written reminders regarding completing intake and monitoring. 01/06/2016
- This issue will be monitored by CNM's through visual audits and any deficits addressed with staff. 01/06/2016
- This will be raised at the team meeting on 07/06/2016
- The CNM I commenced review of the charts in use to ensure they are all appropriate to the needs of residents. 17/06/2016

Proposed Timescale: 17/06/2016

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:

In one area of the centre the medication policy was not been implemented and significant improvements were required in this area in relation to the administration, storage and disposal of unused medications.

29. 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 PIC will ensure that:

- The storage and contents of the medicine cabinet referred to was assessed by a registered nurse and unused/out-of-date medication disposed of according to policy. 15/05/2016
- A CNS is working with the residential coordinator responsible for that part of the centre to undertake a self-administration of medication assessment of that resident by 17/06/2016.

Proposed Timescale: 17/06/2016

Theme: Health and Development

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

Two residents prescriptions had significant errors in medications prescribed that may have compromised residents safety.

Most PRN medications did not have the maximum dosage in 24 hours stated.

30. Action Required:

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

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

The PIC will ensure that:

- The prescription errors were corrected on the day of the inspection 10/05/2016.
- All PRN maximum dosages are scheduled to be completed by a medical practitioner and will be completed across three weekly clinics- 03/06/2016; 10/06/2016; 17/06/2016.

Proposed Timescale: 17/06/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The Statement of Purpose had not been reviewed to reflect changes that had occurred in the centre.

31. Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The Registered provider will ensure that:

- The Statement of purpose has been reviewed, amended and a draft copy has been sent to the Provider nominee on 03/06/2016 for approval.
- The statement of purpose will be finalised by 01/07/2016 and a copy will be forwarded to the Authority.

Proposed Timescale: 01/07/2016

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:

The person in charge manages more than one designated centre and could not ensure the effective governance, operational management and administration of the designated centre concerned.

32. Action Required:

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

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

The Registered provider will ensure that:

- The Residential Coordinator for the DC will be the person in charge going forward and an application is being prepared which will be forwarded to the Authority by 01/07/2016.

Proposed Timescale: 01/07/2016

Theme: Leadership, Governance and Management

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

There were no clear lines of accountability for decision making and responsibility for the delivery of services to residents.

33. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The Registered provider will ensure that:

- The governance and reporting structure for the DC was reviewed by the regional director and a new reporting structure was introduced on 23/05/2016.
- There are now clear lines of accountability and oversight in place in relation to the DC.
- The Programme manager will visit the DC regularly to meet with managers, staff and residents to progress the actions and address identified deficits. 23/05/2016
- The PIC reports into the Programme manager daily regarding progress of the actions and the wellbeing of residents. 23/05/2016
- A number of external (to the centre) professionals such as clinical nurse specialists, MDT members and personal directed planning coordinator are supporting the team to address specific deficits outlined in the report. 23/05/2016

Proposed Timescale: 23/05/2016

Theme: Leadership, Governance and Management

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

There was no annual review completed for the centre.

34. Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

The Registered provider will ensure that:

- An annual review will be undertaken and completed by 01/10/2016

Proposed Timescale: 01/10/2016

Theme: Leadership, Governance and Management

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

The action plans identified from audits carried out in the centre, did not clearly indicate who was responsible to oversee that the actions were completed and the majority of actions had not been completed effectively at the time of this inspection.

35. Action Required:

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

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

The Registered provider will ensure that:

- The PIC has commenced a review all audit outcomes and ensure that the person responsible is identified and the action plan captures all actions and is updated regarding progress on a weekly basis from 24/06/2016

Proposed Timescale: 24/06/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There were parts of the day where inadequate staffing levels were available in the centre in order to meet the assessed needs of residents.

It was not clear who was responsible for supporting one resident in the centre.

36. Action Required:

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

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

The Registered provider will ensure that:

- Staffing numbers are sufficient to meet the assessed needs of residents at all times of the day.
- A roster has been developed and is located in the DC to account for the exact hours dedicated named staff are working with that resident. Support outside these hours is also allocated for peak times to provide support as it is needed and all staff have been advised that support must be provided when requested for activities of daily living.

16/05/2016

Proposed Timescale: 16/06/2016

Theme: Responsive Workforce

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

Due to the large numbers of agency and relief employed in the centre it difficult to provide consistency of care to residents given their complex needs.

37. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

The Registered provider will ensure that:

- The agency and relief staff in use in the centre are regular and consistently used.
- The WTE of the centre's staffing numbers is currently being reviewed and the use of agency staff will be considered within that review by 31/07/2016
- A roster review involving managers, HR and staff representatives considering staffing numbers, skill mix and deployment is underway since April 2016 and will conclude by 31/08/2016 which should give greater clarity and stability to the staffing of the DC.

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

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

The actual roster was incomplete in that not all staff names who had actually worked in the centre had been included on the roster.

38. 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:

The PIC and CNM's will ensure that:

- The layout of the roster is being reviewed to identify the best way to incorporate names of all staff from 30/06/2016
- A projection sheet is attached to the roster that identifies all leave/vacancies and the named staff allocated to those shifts. 23/05/2016

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

There were no formal supervision meetings taking place in the centre for staff.

39. 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:

The PIC will ensure that:

- The PIC/CNM's will set up a supervision system in the DC and schedules will be drawn up to proceed with a system where all staff will receive supervision in line with the organisational policy. 11/07/2016

Proposed Timescale: 11/07/2016

Theme: Responsive Workforce

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

There was no training provided to staff in relation to some of the specific needs of residents.

Refresher training had not taken place for all staff.

40. Action Required:

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

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

The PIC and CNM's will ensure that:

- A training needs analysis is currently underway; being carried out by the PIC. It will be completed by 30/06/2016
- Results from the needs analysis will be forwarded to HR and a training schedule will be drawn up by 04/07/2016.
- All outstanding refresher training will be scheduled as a priority and other training scheduled to continue until 01/06/2017 when the needs analysis will be reviewed.
- Refresher training sessions in dysphagia, manual handling, first aid, PCP, and heart saver have occurred in May/June 2016 and further courses are scheduled.
- Training in tracheostomy care has also been delivered to two staff and the remaining 3 staff are scheduled to attend the next available external course in September 2016.
- A revised standard operating procedure (local) for enteral feeding will be introduced in the DC by 06/07/16.
- Training in enteral feeding is being sourced via teaching hospitals and service providers in June 2016 and the most relevant (to resident's needs) course will be

selected. A schedule of the selected enteral feeding training will be put in place by 07/07/16.

- The keyworkers of 4 residents affected will be trained first in enteral feeding by 21/11/16.
- The remaining staff who support residents with enteral feeding will be scheduled to attend the selected training across a number of dates up to 01/06/2017.

Proposed Timescale: 01/06/2016