### Health Information and Quality Authority Regulation Directorate

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<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-0003008</td>
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<td>Centre county:</td>
<td>Louth</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>St John of God Community Services Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Sharon Balmaine</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Jillian Connolly</td>
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<tr>
<td>Support inspector(s):</td>
<td>Siobhan Kennedy</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>15</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 3 day(s).

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

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>19 May 2015 10:30</td>
<td>19 May 2015 18:30</td>
</tr>
<tr>
<td>20 May 2015 10:30</td>
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</tr>
<tr>
<td>26 May 2015 11:00</td>
<td>26 May 2015 22:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
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<tbody>
<tr>
<td>Outcome 01</td>
<td>Residents Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>Outcome 06</td>
<td>Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07</td>
<td>Health and Safety and Risk Management</td>
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<td>Outcome 08</td>
<td>Safeguarding and Safety</td>
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<td>Outcome 11</td>
<td>Healthcare Needs</td>
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<td>Outcome 12</td>
<td>Medication Management</td>
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<td>Outcome 14</td>
<td>Governance and Management</td>
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<td>Outcome 17</td>
<td>Workforce</td>
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**Summary of findings from this inspection**

The centre is located on a campus alongside seven other designated centres. A monitoring event took place in February 2015 and following the findings an improvement notice was issued to the provider which outlined immediate actions in relation to governance and management, staffing, staff training and development, fire precautions, premises and general welfare and development.

A further inspection was conducted in April 2015.

Inspectors found significant and ongoing levels of non compliance and were not assured that the services provided were safe.

Following on from the inspection in April, the provider submitted an action plan to the Authority which stated the proposed actions to be taken to mitigate the risk. Inspectors reviewed the actions which had been taken and the progress towards achieving the actions in which the time frames had yet to elapse. Eight outcomes were inspected and major non-compliance was identified in seven of the eight outcomes inspected against. Moderate non-compliance was identified in medication management.
Inspectors acknowledged that action had been taken by the provider such as the appointment of a person in charge and the discharge of a resident since the last inspection. The overall findings demonstrated that the governance and management systems remained ineffective as there was:

- The absence of consistent healthcare being provided to residents
- Insufficient staffing
- Absence of staff supervision
- Absence of appropriate management of risk
- Absence of the implementation of positive behaviour support plans
- The number of residents residing in the designated centre considering the size and layout of the designated centre

Thirty breaches of regulation were identified on this inspection. Seventeen of which are the responsibility of the registered provider and thirteen are the responsibility of the person in charge.

As a result the Chief Inspector issued a Notice of Proposal to Cancel the registration of the designated centre under Section 51 of the Health Act 2007. The registered provider submitted a representation in respect of this within 28 days as required by legislation. The provider committed to the closure of the designated centre and outlined the actions that would be taken in the interim to safeguard residents.

The centre ceased operation in December 2015.
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:
There were six failings identified on the inspection conducted in April 2015. The provider had outlined a variety of actions that would be implemented immediately with a final completion date of September 2015. On this inspection, inspectors found that improvements had been made towards ensuring that the dignity of residents was respected and upheld, however there was still areas which required addressing to ensure positive outcomes for residents. The following details the actions that the provider stated would occur and the findings of inspectors on this inspection:

In April 2015, it was identified that the inappropriate placement of residents was impacting on the dignity of other residents. The provider stated that this would be addressed by the discharge of one resident from the designated centre to a more spacious living environment. Inspectors confirmed that this had occurred. This resulted in each resident having their own bedroom, in one house. A twin room remained in one house. Therefore the rights of the two residents sharing this room remained impinged. The unsuitability of the premises also resulted in a resident being temporarily discharged from the designated centre, due to the risk of cross contamination of a communicable infection. This was deemed as the most appropriate intervention as best practice could not be adhered to due to the premises deficits. This is discussed further in Outcome 7, however fundamentally it resulted in a resident having to leave their home to receive appropriate care.

The provider had also conducted a multi disciplinary meeting on the 17 April 2015, as stated in the action plan response. Inspectors reviewed the minutes of the meeting and
confirmed that there were members of each relevant discipline present. Residents were reviewed at this meeting and actions were identified aiming at meeting the individual needs of residents. However there was an absence of dates and persons responsible to ensure that the actions would be met. There was evidence on inspection that some areas had been addressed, however in other instances the outcome of the meeting had not been implemented in an appropriate time frame. An example of a positive outcome was that a resident who had been identified as utilising an inappropriate drinking vessel had an age appropriate aid sourced. However, at the multi-disciplinary meeting it had been agreed that the use of a restrictive intervention which had been authorised by the appropriate committee was to be utilised as a safeguarding measure for one resident. Inspectors found on this inspection, that this had not been implemented. The resident had subsequently been re-admitted to hospital and diagnosed with an acute illness which potentially was as a result of the resident engaging in behaviour that the restrictive intervention aimed to prevent.

All residents had been referred to the positive behaviour support subcommittee following on from the previous inspection. The committee meets on a weekly basis. Residents had been prioritised based on the risk present. Data collection had been initiated for some residents, with the aim of completing a functional analysis to identify the rationale for behaviours exhibited. Other residents were awaiting review. Notwithstanding this, Inspectors found that there had been minimal positive impact for residents in the interim. A review of the accident/incident records evidenced that residents were still engaging in physically assaultive behaviour towards other residents. There had also been a resident admitted to hospital with a condition that could have been as a result of drinking a liquid which had not been modified as recommended by the relevant Allied Health Professional. There was no evidence that actions had been taken to prevent this from occurring.

The registered provider had informed the Chief Inspector of their intention to transition residents from the designated centre following the completion of individual transition plans. The person in charge stated that this was aimed to be completed by the 30 June 2015. The work had yet to commence on this, however resources had been allocated to achieve this. There was also evidence that more suitable accommodation was being sourced within the campus, however as of the day of inspection, the options reviewed were deemed unsuitable by staff. Inspectors were provided with documentation to support the overall closure of the campus, which was aimed at being achieved within eighteen to thirty six months. The strategy identified that a de-congregation committee phase 2 would be established. Inspectors confirmed that this team had been established. However, inspectors found that this did not mitigate the risk to residents' rights and dignity as of the day of inspection. Due to the number of residents residing in the centre and the complex needs of residents, residents were denied the right to reside in an environment which was suitable to meet their needs both physically and psychologically.

Residents’ ability to exercise choice and control over their daily life was identified as a failing in the previous inspection. Improvements were recognised in this area. Inspectors confirmed that communication resources such as photographs of meals and activities were being developed as a meaningful method of communication. These pictures were then utilised to support residents to choose the meal they would like or the activity they
would like to take part in. Residents’ meetings had also been initiated as stated in the action plan response. Residents had an assessment of their meaningful day completed and key worker training was scheduled to occur in June 2015, as per the action plan response of the provider. However, inspectors observed deficits in practice whilst on inspection which reduced the effectiveness of the pre-mentioned interventions. For example, residents’ meals were provided from the campus kitchen. There is a system in place in which the residents choose their meals twice per week (as stated in the action plan response from the inspection in April). However on review of the menu planners, in one of the houses the same meal was ordered for all residents. Staff stated that this was because they knew the residents and that the second option was not suitable for residents based on their dietary needs. Therefore whilst theoretically there was a choice available for residents, the choices were not real and appropriate for residents.

It was also stated that an assessment of residents’ rights and the restrictions in place would be completed. Inspectors reviewed the template which was to be utilised, however this had yet to commence as of this inspection. The time frame for completion was the end of June 2015.

The meaningful day assessment and the activities that residents partook in were also indicative of being led by resources as opposed to by the wants of residents. The standard staffing level for each house was three staff up until 18.30 hours. There was an additional staff on duty during the course of the inspection to support a resident in hospital. However due to the supports residents required, inspectors observed residents taking turns in accessing campus based activities as opposed to the day tailored to ensure the individual needs of residents were met. There had been an increase in the activities residents partook in. On review of one resident’s activity schedule in a one week period they had left the campus once to engage in horse therapy. There was no evidence that the resident had left their house for three of the days and the remaining three days consisted of table top activities, reflexology, hand massage, television and resting which all took place in the resident’s home. The resident had partaken in the cinema club, a walk and attending the campus coffee shop once over these three days. Inspectors were informed that this was a work in progress and that it was planned that at the end of each month the residents participation and enjoyment level of the activity would be reviewed and their schedule adapted accordingly. As of the day of inspection a full month had not been completed therefore a review had yet to take place. There were positive outcomes for two residents, who were attending the campus coffee shop independently and inspectors observed this in practice. Inspectors were also informed by the regional director of nursing that the staffing levels in each of the houses would be increased with immediate effect to four staff until 18.30 hours based on the findings of inspectors, in this area and in relation to the healthcare/behavioural needs and manual handling needs of residents.

The absence of suitable storage was also observed as impinging on the privacy of residents in April 2015. Inspectors observed that this was being progressed by the person in charge with documents being re filed and archived. The proposal was that an area on the campus had been identified to store archived documentation, which facilitated residents’ current information to be stored securely in the centre. However due to an absence of administrative support for the person in charge, the time to achieve this was unduly lengthened.
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:
Major non –compliance was identified in April 2015 as the evidence supported that the premises did not promote the safety, dignity, independence and well being of residents. This was as the following were not provided in line with Schedule 6 of the regulations:

• Adequate private and communal space
• Rooms of a suitable size and layout for the needs of residents
• Adequate and suitable storage facilities
• Adequate shower facilities

There was also an absence of appropriate assistive equipment to support residents’ manual handling needs.

As stated previously, the registered provider responded by transitioning one resident to a more spacious environment. A review had also taken place by the Manual Handling Instructor on the 27 April 2015. The recommendations of the Instructor was the sourcing of a piece of equipment which would ensure that residents who fell could be supported from the floor without risk of injury to the resident and staff. In the absence of this equipment, the alternative was for the resident to be transitioned to an alternative residence, due to the risk to staff and residents. This information was communicated to the management on the 29 April 2015. The resident in question had three falls since the information was communicated, once whilst being supported by two staff in the shower room which is not of a size to facilitate same. There was no evidence that the equipment whilst identified had been sanctioned by senior management.

Inspectors also identified hazards (which are discussed further in Outcome 7) which demonstrated that whilst action had been taken in respect of storage of personal information there were still deficits in this area. Inspectors observed the food containers blocked a fire exit. There was also a wheelchair, cleaning equipment and wash basket
blocking access to fire equipment. The weighing scales which were sourced in response to a failing from the previous inspection was stored in the communal living room, with a blanket covering it. Residents’ recreational belongings were blocking exit routes.

As outlined in Outcome 1, whilst there were plans in place to transition residents to more suitable accommodation, there had been no area identified as the day of inspection. Therefore the failings from the previous inspection remain and are repeated in the action plan at the end of this report.

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:
There were four breaches of regulation identified on the previous inspection, in respect of health and safety, risk management and infection control. Fire Safety procedures and precautions were included in the failings and actions required in the improvement notice dated the 23 March 2015.

The findings from the last inspection were that a number of clinical and environmental risks had not been identified or assessed. Subsequently there was an absence of adequate measures and actions in place to control the risks identified for example, suitable staffing, appropriate equipment and training. There was a further absence of systems in place for the assessment, management and ongoing review of risk.

Inspectors found on this inspection that there had been no improvement in this area. Whilst actions had been taken by the registered provider as stated in the action plan response to address the failings, the impact of these actions had not mitigated the overall risk within the centre.

A key factor in the ineffective risk management is the unsuitability of the premises based on insufficient space to accommodate seven/eight residents in each house. Considering each of the individual supports the residents require significantly increased this risk. While the provider had communicated the intention to transition residents to reduce the numbers residing in the house, immediate action was required following on from the last inspection to safeguard residents whilst this was occurring.
The registered provider responded by stating that all staff attended a team meeting on the 21 April 2015 where the Person in Charge reinforced identification and control measures to address clinical risk and environmental risk. Inspectors determined that this was not an effective action as the person in charge commenced their post on the 20 April 2015, which did not facilitate appropriate time for the person in charge to assess the actual risk within the centre. Inspectors reviewed the minutes of this meeting and found that there was no reference to the identification and control measures for clinical and environmental risk recorded. The minutes stated ‘risk assessments to be updated.’ Inspectors determined that this was a disproportionate response by the registered provider.

The registered provider further stated that the risk management policy would be completed by the 8 May 2015 for the designated centre which would include hazard identification and control measures. It was further stated that staff would be inducted into the policy. Inspectors reviewed the risk management policy and found that it had not been reviewed within the required time frame. There was a draft action plan in place which provided a template for the assessment of risks within the designated centre. Inspectors determined that of the risk identified, it was generic and did not account for the actual level of significant risk within the centre. Residents had individual risk assessments in place within their personal plans which aimed at reducing risks to individual residents based on their needs such as epilepsy.

Inspectors found that due to the numerous deficits in the effective management of risk within the designated centre, that risk management was not embedded within the culture of the organisation. Therefore until this core deficit was addressed, a significant level of risk would remain.

Actions had been taken following the last inspection, for example, clean continence wear was no longer stored in the toilets or there were no longer overflowing used laundry bags at the front of the entrance. However this action was taken following identification by inspectors as opposed to recognition of staff.

On this inspection, as stated in Outcome 6, inspectors observed hazards which could have been instantly addressed such as items blocking fire equipment or exits which were not identified by staff but were rectified once identified by inspectors. There were numerous clinical risks identified on the previous inspection, which are discussed in Outcome 11. However, inspectors found that whilst individual actions had been taken to address the risks identified by inspectors such as sourcing appropriate weighing scales or post fall investigations were being conducted, there was an absence of evidence to state that staff were independently competent to initiate appropriate preventative or responsive interventions to hazards. This resulted in adverse events re-occurring and significant risk to the healthcare needs of residents being met.

For example, on the previous inspection there was a resident who had a communicable healthcare associated infection. Inspectors identified deficits in practices which presented a risk to the resident and fellow residents. Inspectors found that the provider had responded as stated in the action plan. This included the resident having their own room and individual equipment sourced for the resident. The Clinical Nurse Specialist also attended a staff meeting and instructed staff of the best practice to reduce the risk.
However, parallel to this, another resident was identified as having a communicable infection who was sharing a room. Whilst appropriate action had been taken to reduce the risk of cross infection during the day, there was a delay of three days in reducing the risk at night. The resident was temporarily discharged from the designated centre as it was deemed this was the most suitable means to mitigate the risk. However, the delay demonstrated that there was an absence of learning from the findings of the previous inspection.

The provider responded by stating that cleaning schedules would be developed for medical equipment. This had yet to occur however inspectors observed equipment to appear clean. Inspectors observed staining on shower room floors and cracks in bathrooms. Inspectors reviewed a sample of cleaning schedules and confirmed that they were consistently completed. Food Hygiene training had also yet to occur however the timeframe identified by the provider for this had not passed.

Four actions were required in respect of fire management as identified in the improvement notice of the 23 March 2015. On an inspection conducted on the 17 and 18 February 2015, it was identified that adequate means of escape was not provided as a fire escape route via a garden gate was blocked by a ramp and the garden gate was difficult to open. There was also no signage denoting fire exits from the living and conservatory rooms. The registered provider responded by stating that a Senior Fire Consultant had reviewed the fire escape route and ramp associated with the designated centre and were satisfied that the exits were not blocked and also found no concerns relating to the garden gate. An external consultant was also engaged and was addressing the signage denoting fire exits and is issuing a report for immediate follow up. Inspectors requested confirmation of this in writing, however at the time of writing this report, the report was not available.

Inspectors were not assured that the findings had been clearly communicated to staff as staff stated that they would utilise the external doors in the event of an emergency (which inspectors were informed were not deemed to be fire exits) if necessary. Inspectors determined that further fire safety training was required.

The improvement notice also identified deficits in staff knowledge and the procedures to be followed in the event of an emergency. The registered provider responded by stating that all staff had received training on the 30 March 2015 which would include a fire drill. They further stated that the personal evacuation plans for residents would be reviewed. Inspectors confirmed that the training had occurred as stated however not all staff who were actively rostered to work in the designated centre had attended. Of the sample of personal evacuation plans reviewed, inspectors confirmed that they had been updated. The fire notice located on the wall had been updated as stated in the action plan response.

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:**
The regulations addressed in this outcome identify compliance with the procedures in place to ensure residents are safeguarded and protected from abuse. The regulations further identify if the practices in place to ensure that residents who exhibit behaviours that challenge are supported and their well being promoted. Major non-compliance was identified in April 2015 in both areas.

Inspectors found in April 2015 that the policy and procedures in place for the prevention, detection and response to abuse were not adequate to protect residents from abuse. Staff were also not clear of the reporting procedures for allegations and suspicions of abuse. The registered provider responded by stating that the procedure would be reviewed by 30 June 2015 and staff had completed training in safeguarding.

As of this inspection, the procedure had yet to be reviewed, however the timeframe provided in the action plan response had not elapsed. Staff spoken to were able to identify the processes to be followed in the event of an allegation or suspicion of abuse. There was evidence that incidents such as unexplained bruising were processed in line with national policy.

There had been one incident of residents’ personal funds going missing. Inspectors reviewed the process followed and were assured that the appropriate action had been taken by the person in charge, inclusive of notifying the Gardai. At the time of writing this report, the outcome of the investigation was pending. Inspectors found that the circumstances in which the monies went missing, were not reflective of respecting/safeguarding the personal finances of residents.

The failings identified in April 2015 in respect of positive behaviour support for residents who exhibited behaviours that challenge were that it was not always possible for staff to implement the strategies outline in the positive behaviour support plans of residents. Staff were not familiar with the plans and staff had not been trained in the management of behaviour that challenges. As stated previously the provider responded by referring all residents to the positive behaviour subcommittee. Of the sample of positive behaviour support plans viewed by inspectors it was also evident that staff had signed to state that they had read the plan since the last inspection. Inspectors reviewed the training records of staff and staff had not received training in positive behaviour support.
as stated by the provider. Inspectors were informed that this was in the process of being planned. From a review of training records it was evident that not all staff had received training in de-escalation and breakaway techniques working with residents. This presented a risk to both staff and residents due to the regular recorded incidents occurring.

Inspectors found that whilst staff had signed to state that they had read the plans of residents, in practice there were clear deficits in the actual supports provided to residents. As a result there was significant risk to residents’ health and well being. There were numerous incidents of residents engaging in physically assultive behaviour towards others and engaging in self – injurious behaviour. As stated in Outcome 1, there were two residents who had been admitted to hospital. Each of the residents had a positive behaviour support plan in place which identified the proactive strategies which aimed to prevent residents engaging in behaviours that could affect their health. On review of the progress notes, there was no evidence that the strategies had been implemented prior to admission or post discharge from hospital. In both instances the residents had been re-admitted to hospital in a short period of time. Inspectors also identified instances where the post discharge care provided to residents was inadequate and did not ensure that their health was maintained. This is discussed further in Outcome 11.

In April 2015, it was identified that individual houses were locked to facilitate staff change over. At this time there was one staff on duty in each house from 20.00 hours, a staff nurse and a health care assistant. Inspectors confirmed on this inspection that staffing levels had increased to one staff nurse and two health care assistants as stated by the provider in the action plan response. However due to additional deficits identified, this staffing level was deemed insufficient by inspectors. An additional staff was placed on duty prior to inspectors leaving the centre.

Judgment:
Non Compliant - Major

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:
There were three failings identified in April 2015 regarding the provision of healthcare to residents. There were five failings in respect of the food and nutritional support provided
to residents. Whilst there was evidence that the registered provider had implemented
some of the actions from the previous inspection, there were clear deficits identified in
the care provided to residents and the subsequent risk to the health and well being of
residents.

Inspectors found on this inspection that residents had regular access to their general
practitioner. There had also been referrals and reviews conducted by Allied Health
Professionals. Families who met with inspectors stated that they felt their loved ones
were well cared for.

In April 2015, Inspectors identified that there was an absence of clear guidance to staff
to ensure that the appropriate level of healthcare was provided to residents and that if a
discharge was required to an acute setting that it was safe and planned. Inspectors
found on this inspection, that there had been no improvement in this. In April 2015,
there had been a resident admitted to hospital. On this inspection, inspectors found that
the resident had been re admitted to hospital. As with the findings of the previous
inspection, this admission occurred during the night. From a review of the progress
notes, there was evidence that four days prior to the resident being re admitted to the
hospital there was a deterioration in how the resident was presenting. As stated in
Outcome 8, there was an absence of evidence to support that the safeguarding
measures authorised to prevent the resident in engaging in a behaviour was
implemented, which could be a contributing factor to their clinical needs. There was also
an absence of monitoring of clinical observations to ensure that the resident was well
and a relapse would not occur. The resident returned to the designated centre on the
final day of inspection. Inspectors reviewed the acute care plan in place for the resident
and were assured that it provided information on how to meet the short term needs of
the resident. However there remained an absence of clinical parameters agreed in the
event of the resident becoming unwell. When inspectors queried staff on the actions
that would be taken in the event of the resident's health deteriorating again, conflicting
responses were provided.

On the final day of this inspection, inspectors were informed of another resident who
had been re-admitted to hospital. They had been discharged from an acute setting, five
days prior. Inspectors queried whether there were any clinical indicators that the
resident’s health was deteriorating. Inspectors were informed and confirmed that no
clinical observations had been conducted since the day following the initial discharge
from the acute setting. When inspectors queried the rationale for this decision, staff
stated that the resident was presenting as "fine" and therefore it was deemed
unnecessary. In view of the evidence in respect of lack of clinical observation and the
failure to implement the resident’s behaviour support plan, the cumulative evidence is
indicative that the health care needs of residents were not being met. There was also an
absence of care plans created or reviewed post the initial discharge for both residents.

The person in charge informed inspectors prior to the close of inspection, that a new
procedure had been implemented. As of immediate effect, all residents who were
prescribed a short term medication such as an antibiotic or residents who were
discharged from hospital would have clinical observations conducted. The practice could
only cease once consultation and approval was received by the person in charge or the
director of care.
Inspectors were also informed of a resident whose needs were changing. They had recently been assessed as requiring the support of two staff for all manual handling needs. This meant that from 20.00 hours, the remaining residents would be unsupervised when this resident was being supported. There were only two staff on duty. As stated previously, an additional staff member was allocated to the designated centre prior to inspectors leaving the centre.

Of the actions stated by the provider in respect of the provision of food and nutritional support, inspectors determined that improvements had been made in this area. Inspectors observed that nutritional supplements which had been prescribed for residents were readily available. There was also an improvement in the food and snacks available for residents in the designated centre. Inspectors reviewed the system in place for sourcing food and snacks for residents. The designated centre, has no individual unit funds that staff can utilise to purchase items in local supermarkets. All food and snacks are sourced through the campus kitchen via a requisition system. Therefore a limitation remained in place for the choice available to residents based on the institutional care practices and systems in place. For example, inspectors reviewed a requisition form completed on a Wednesday which was required for Friday indicating the absence of spontaneity. As stated in Outcome 1, there was also evidence to support that the choice of food available for residents was not a meaningful choice. Inspectors were informed that there was ongoing engagement with external parties regarding increasing the options of residents being supported to prepare their own meals and snacks. The timeframe for this action to be achieved had not yet elapsed.

The provider had further stated that a meeting would take place on the 30 April 2015 relating to the fortification of food and the menu choices available to residents. Inspectors confirmed that the meeting had occurred and that actions were planned to address the deficits identified. This included staff training (as stated in the action plan response by the provider) and plans to review the menus. Inspectors confirmed that staff training in the area of Dysphasia had commenced and was ongoing. Staff training was planned for food hygiene and food choice.

Inspectors observed a mealtime experience for residents and found that signs were in place indicating that meal times were in progress. In the main the mealtimes were a relaxed experience with sufficient staff present for the number of residents. However inspectors were not assured that this was standard practice, as there was a resident in hospital. Therefore there was inadequate room at the dining table for all residents if the centre had full capacity. The person in charge had recognised this and inspectors were informed a new dining room table was being sourced. Inspectors observed residents being offered additional portions of food.

As stated previously a new weighing scales had been sourced for both houses in the designated centre. Inspectors were not able to ensure that the weights of residents were being consistently monitored as the new procedure had only been implemented. There was evidence that the residents’ food intake was recorded daily. However there was an absence of parameters to identify the portion size to begin with. For example it was documented that residents had eaten 75 – 100% of their meal. However it was not clear what 100% equated to. There were also more detailed food records maintained for
residents who required this such as experiencing weight loss. However inspectors were not assured of the effectiveness of this system, as when asked to view the record of one resident, inspectors were informed only fluid intake was maintained. However the person in charge and the care plan for the resident both stated that a record was maintained. Therefore staff were not aware of this monitoring intervention. For other residents, there was clear evidence that residents were exhibiting behaviours that challenge as a result of a digestive need. However, the records of their dietary intake to evidence that efforts were being made to alleviate this need were insufficient. The Eating and Drinking Care Plans of residents had been updated following the findings of the previous inspection. However, there was evidence that they had not been reviewed post discharge from hospital for a resident. Evidence found indicated that this was a requirement. All residents had been referred to the Speech and Language Therapist and had been assessed.

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

**Findings:**
There were three failings identified in respect of medication management in April 2015. Inspectors identified that residents did not have a meaningful choice of pharmacist. This action had not been addressed as of this inspection. The time frame for completion was the 31 August 2015. Inspectors reviewed the management plans for the treatment of status epilepticus and confirmed that they had been reviewed and updated as stated in the action plan submitted by the provider. Residents with a diagnosis of epilepsy have also been referred to the appropriate specialist.

However, inspectors identified additional failings on this inspection in the medication management systems. Residents who were diagnosed as at high-risk of aspiration and as a result had modified diets, did not have an assessment to see if they needed their medications crushed. Inspectors also observed staff disposing of medication that was refused by a resident, however not documenting the disposal of same. Therefore inspectors were not assured that the systems were safe.

**Judgment:**
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:
Governance and management arrangements of the designated centre remained ineffective. Inspectors reviewed the actions taken by the provider and confirmed that they had occurred as stated:

- A person in charge had been appointed as of the 20 April 2015
- The person in charge is supernumary
- The person in charge facilitated a meeting with the staff team on the 21 April 2015
- Weekly meetings were occurring with the Director of Care, the Person in Charge and a member of the staff team
- Weekly meetings are taking place with the regional director, provider nominee, person in charge and the director of care

Inspectors met with the person in charge who facilitated the inspection. Inspectors confirmed that the person in charge had the necessary qualifications, skill and expertise to be employed as the person in charge of the designated centre. They also demonstrated a clear understanding of the regulations and their statutory responsibility. All of the information as required was submitted to the Chief Inspector within an appropriate time frame.

However, inspectors determined that although the provider had completed the actions as stated, the governance and management systems remained weak with insufficient resources allocated to ensure that the areas of risk as identified within the previous inspection was addressed.

As evidenced throughout the report, this was an inconsistent response to the findings of the inspection in April 2015. Whilst some areas were addressed or in the process of being addressed fundamental risk remained in the designated centre due to:

- The absence of consistent health care being provided to residents
• Insufficient staffing
• Absence of staff supervision
• Absence of appropriate management of risk
• Absence of the implementation of positive behaviour support plans
• The number of residents residing in the designated centre considering the size and layout of the designated centre

Due to the significant failings and the requirement to achieve compliance and positive outcomes for residents, insufficient resources had been allocated to support the person in charge in their role. All actions were being allocated to the person in charge to address. However, inspectors determined this was inappropriate as healthcare provided to residents was not being addressed due to other tasks such as sourcing a new dining room table, amending the risk management policy, completing rosters and sourcing staff.

There had been an internal review of the centre completed by a quality team, however whilst this was a positive step it was not addressing the immediate risk within the centre.

The findings of this inspection, demonstrated that while the registered provider is responsive to the findings of inspectors, such as increasing staffing, there have been no improvements in outcomes for residents as described in outcome 1 and there was evidence of continued poor care provision as outlined in outcome 11. Despite a number of regulatory actions including a warning letter, improvement notice and communications with the Chief Inspector the provision of care is not safe.

**Judgment:**
Non Compliant - Major

<table>
<thead>
<tr>
<th>Outcome 17: Workforce</th>
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<tbody>
<tr>
<td>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.</td>
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**Theme:**
Responsive Workforce

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

**Findings:**
As stated previously inspectors were not assured that the staffing levels within the designated centre were sufficient. There had been an increase of one staff member
from 20.00 hours to 8.00 hours since April 2015. However, this was insufficient to meet the needs of the residents. The registered provider responded by increasing the staffing levels in the centre. Inspectors however were not assured that this would mitigate all areas of risk, as increasing the number of people within the designated centre at any one time could also increase residents exhibiting behaviours that challenge. Numerous residents were documented as requiring a quiet environment. Inspectors determined that the only effective measure was to reduce the numbers of residents residing in the centre.

There was an absence of supervision of staff in the centre. For example, there was numerous incidences identified by inspectors (evidenced throughout the report) were the needs of residents were not met. This resulted in negative outcomes for residents and a risk present to the well being of residents. However, there was no evidence that these deficits had been identified prior to the inspection and therefore no clear actions were identified to ascertain the level of support/supervision staff required.

Continuity of staff was also identified as an area requiring improvement in April 2015. The provider stated that there is a recruitment campaign in progress to address this issue. However, in the interim, the current rostering system often resulted in permanent member of staff only being present for 78 hours (50% of their working time) in a one month period during the day. Based on the system in place, this resulted in permanent staff not being present during the day for a minimum of two weeks every month. The deficits were being filled by non – permanent staff and whilst it was aimed to ring fence the staff, this did not always occur in practice. For example, over the course of the inspection, inspectors observed a staff member from another designated centre within the campus working in the centre who was not familiar with the needs of residents. There was also agency staff who had been in the centre once before. Inspectors determined that until a consistent staff base could be secured, it would be challenging to reduce the risk in the centre.

Inspectors reviewed the training of staff and confirmed that deficits remained. As stated previously, training was planned for staff in the centre. The time frame for completion of this training had not elapsed. However in the interim, a risk remained to the quality and safety of care provided to residents. As stated in Outcome 7 and 8, there was mandatory training required in fire management and de-escalation and breakaway techniques for some staff.

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:*

Jillian Connolly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by St John of God Community Services Limited

Centre ID: OSV-0003008

Date of Inspection: 19, 20 and 26 May 2015

Date of response: 17 June 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents remained inappropriately placed.

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

1. Three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31/07/2015

2. The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015

3. Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

4. Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment.

**Proposed Timescale:** 31/07/2015

**Theme:** Individualised Supports and Care

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

Residents did not have the opportunity for meaningful choice and control:

- menu options
- activities
- healthcare

**2. Action Required:**

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

1. Menu Options;
   a. Menu Planning is in place twice weekly for residents to promote each residents involvement in meal choices.

   b. A meeting relating to the availability of greater menu choice and snack choice took place on 30/04/15 with Dietician, Speech and Language Therapist, Chef, Director Care and Support and General Manager. Monthly meetings will take place and a full review of menus choices is being undertaken.

   c. A follow up meeting to progress menu options and fortification of food at source is scheduled to take place on the 18th June 2015.
d. Additional and adequate supplies of food and snacks will continue to be provided for all residents including residents with modified consistency diets, however we are progressing greater level of choice. The Person In Charge following consultation with the Dietician is on contact with the Catering Department progressing new menu plans for residents.

2. Activities;
   a. Meaningful Day Schedules have been reviewed for the months of April and May, which will inform each resident’s Social Assessment and in turn promotes residents preferences and access to experience new activities. 21st June 2015

   b. Keyworkers are currently identifying dates for Circle of Support meetings for their key residents to ensure individual specific goals for each resident will be met.

   c. The Person In Charge has met with and is working closely with the Day Service Programme Manager/Day Activities Co-ordinator with regards to accessing activities which take place every day both in the residential setting and in the community. This has included proposals for activities for residents who are older persons and would benefit from pre-retirement type activities.

   d. Additional access to transport to facilitate these activities is being progressed.

   e. Staffing levels have increased as from 26/5/15.
      • 1 residential home, roster plan is as follows:
        08.00-20.00hrs x 3 staff member, 1 staff nurse, 2 Residential programme assistants
        08.00-22.00hrs x 1 staff member, residential programme assistant
        20.00-08.00hrs x 2 staff members, 1 staff nurse and 1 residential programme assistant

      • The second residential home roster plan is as follows:
        08.00-20.00hrs x 4 staff members, I staff nurse and 3 residential programme assistant
        08.00hrs -22.00hrs x1 staff member, 1 residential programme assistant
        20.00- 08.00hrs x 2 staff members, 2 residential programme assistant

   e. The increase in staff and change in roster will facilities a more person centred approach to meaningful activity and resident’s access to external activities in their community.

3. Healthcare:
   • Systems analysis review is in progress in relation to the resident that could have ingested unmodified fluids. This review will be complete by 18th June 2015
   • All findings and recommendations from this review will be prioritised and actioned.

   • Safeguarding investigation has been completed in relation to this incident. The recommendations from the investigation were to review protocols in place regarding resident’s plan of care post discharge from hospital and this has been addressed and prioritised.

   • A risk assessment has also been completed in relation to this resident ingestion of unmodified fluids and control measures are in place.
• All staff supporting this residents have read and signed the protocol to support this residents needs and to mitigate against this potential risk re-occurring.

• An assessment has been carried out to reflect the changes in need of this resident and a Completion of Care Plan/ Vital Observations post Hospitalisation of a resident. 27th May 2015

• A Procedure has been implemented for clinical observations of residents within this Designated Centre post discharge from hospital. 27th May 2015

• All staff has read and signed off that they are fully aware and understand this procedure. 26th May 2015

• All residents on discharge from hospital will have an immediate review of their Care Plan which commenced on 26th May 2015

• The Resident who was discharged from hospital on 26/05/15 had his Care Plan completed on 26/05/15 and updated on 27/05/15.

• All recommendations following Multi-disciplinary team meetings will be have a realistic timeframe and will have a recognised person responsible for implementing actions.

• All authorised restrictive interventions will be reviewed with the Governance of Restrictive Practice Committee in line with the appropriate recommendations.

4. Rights Awareness Assessment:
• Rights Awareness Checklist will be reviewed for all residents within the Designated Centre by the 15th May 2015

5. Training:
• The Person in Charge is currently progressing a training schedule for all staff within this Designated Centre in the areas of Key working, Meaningful Day, Mealtime Experience, Food Hygiene and Rights and Complaints.
• Dates for this training schedule are agreed and will be implemented.

**Proposed Timescale:** 15/07/2015

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident’s privacy and dignity was not respected in due to the number of residents residing in the designated centre.

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

Please state the actions you have taken or are planning to take:
1. One resident has already been transitioned from this Designated Centre to another Designated Centre on 14th April 2015 to support a more spacious living environment.

2. Three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31/07/2015. As a result all residents remaining in the two houses will have single bedrooms, ensuring their privacy and dignity will be maintained within their own personal intimate space.

3. The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015.

4. Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

5. Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment.

6. Training for staff, in relation to ensuring residents privacy and dignity is respected will commenced by the end of June 2015.

7. A De-congregation Planning Committee Phase 2 has been established. The scope of this committee will be to put in place action plans for the transitioning of residents based on priorities identified by Admission, Discharge, Transfer Committee due to addressing lack of space and unsuitable premises to meet resident’s needs. The Development Planning Committee Phase 2 will highlight the risks and barriers to transitioning.

Proposed Timescale: 31/07/2015
Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Whilst action had been taken to address the storage of personal files. The space remained limited for storage of residents' personal belongings.

4. Action Required:
Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and
possessions.

**Please state the actions you have taken or are planning to take:**
1. The relocation of existing files to create more space within this Designated Centre has been undertaken and completed.

2. Additional storage space for resident’s personal belongings is being sourced within the Designated Centre.

3. To provide greater space for residents, three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31/07/2015. As a result all residents remaining in the two houses will have single bedrooms, ensuring their privacy and dignity will be maintained within their own personal intimate space.

4. The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015

5. Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

6. Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment.

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**Proposed Timescale:** 31/07/2015

**Theme:** Individualised Supports and Care

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

Residents’ access to external activities remained inadequate.

**5. Action Required:**

Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

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

1. Social Assessments/Social Goals are being reviewed and will be completed by the 30th June 2015.

2. Meaningful Day Schedules have been reviewed for the months of April and May, which will inform each resident’s Social Assessment and in turn promotes residents preferences and access to experience new activities.
3. Keyworkers are currently identifying dates for Circle of Support meetings for their key residents to ensure individual specific goals for each resident will be met.

4. The Person In Charge has met with and is working closely with the Day Service Programme Manager/Day Activities Co-ordinator with regards to accessing activities which take place every day both in the residential setting and in the community. This has included proposals for activities for residents who are ageing and would benefit from pre-retirement type activities.

5. Additional transport is being progressed for residents which will enhance residents opportunity to integrate with the wider community

**Proposed Timescale:** 30/06/2015

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The premises were not fit for purpose due to the number of residents residing in the centre.

**6. 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:**
1. To provide greater space for residents and to better meet their needs, three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31/07/2015. As a result all residents remaining in the two houses will have single bedrooms, ensuring their privacy and dignity will be maintained within their own personal intimate space.

2. The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015

3. Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

4. Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment.
5. One resident has already been transitioned from this Designated Centre to another Designated Centre on 14th April 2015 to support a more spacious living environment for him.

6. A De-congregation Planning Committee Phase 2 has been established. The scope of this committee will be to put in place action plans for the transitioning of residents based on priorities identified by Admission, Discharge, Transfer Committee due to addressing lack of space and unsuitable premises to meet resident’s needs. The Development Planning Committee Phase 2 will highlight the risks and barriers to transitioning.

7. All fire exits and fire equipment are being kept clear.

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**Proposed Timescale:** 31/07/2015

**Theme:** Effective Services

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

Assistive equipment was not available to support residents post fall.

**7. Action Required:**

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

- A Multi-Disciplinary Meeting took place on 29th May 2015 to discuss the resident who required assistive equipment.

- The assistive equipment identified in the Multi-Disciplinary Meeting on the 29th May 2015 has been ordered on 16/06/2015

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**Proposed Timescale:** 16/07/2015

**Theme:** Effective Services

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

The following were not provided for:
- adequate private and communal space
- rooms of a suitable size and layout to meet the needs of residents
- adequate and suitable storage
- adequate shower facilities

**8. Action Required:**

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6
Please state the actions you have taken or are planning to take:

1. To provide greater space for residents and meet their needs, three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31/07/2015. As a result all residents remaining in the two houses will have single bedrooms, ensuring their privacy and dignity will be maintained within their own personal intimate space.

2. The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015.

3. Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

4. Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment.

5. Additional storage space for resident’s personal belongings is being sourced within the Designated Centre and greater storage space will be available to residents once transitioning for residents to other Designated Centres has taken place.

Proposed Timescale: 31/07/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors identified numerous hazards throughout the designated centre which had not been assessed. Therefore there were no subsequent control measures in place. There was also an absence of review following adverse incidents.

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

Please state the actions you have taken or are planning to take:
1. The Risk Management Policy is currently under review by the Person in Charge to ensure all hazards within the designated centre have been identified and control measure put in place.
2. A designated centre risk register is currently under development and will be approved at the next Quality and Safety Executive Committee by 30th June 2015.

3. The Person in Charge / Clinical Nurse Manager 1 will review on a daily the Adverse Incident Forms for the Designated Centre. Any recommendations or review required is followed up before the Person in Charge is satisfied to close out the incident.

4. All incidents are reviewed at the weekly Designated Centre meetings with Director of Care and Support.

5. All incidents will be reviewed at staff team meetings in conjunction with risk management policy and register.

6. The National Adverse Event Management System monthly report will be discussed at the staff meetings.

**Proposed Timescale:** 14/07/2015

**Theme:** Effective Services

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

There was an inadequate response to a resident being diagnosed with a communicable infection.

10. **Action Required:**

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

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

**Communicable Infection:**

- Appropriate measures and procedures in line with healthcare associated infection were put in place to address the concern raised with regard to a resident who presented with a communicable infection.
- All staff have been inducted into these procedures.
- Residents who present with a communicable infection are not sharing a bedroom.
- Infection Control Audit was completed for this Designated Centre by 30th May 2015 and all recommendations have been prioritised and being implemented on a scheduled basis.

- Cleaning schedules are being developed for all medical equipment.
- To provide greater space for residents and meet their needs and minimise risk of healthcare associated infection, three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31st July 2015. As a result all residents remaining in the two houses will have single bedrooms, ensuring their privacy and dignity will be maintained within their own
personal intimate space.

• The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015

• Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

• Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment

Fire
• A fire consultant has reviewed all fire exits for this Designated Centre and outcome of this review will be forwarded to this Authority by 24th June 2015.
• The Person in Charge has communicated to all staff and it is included in the induction for new staff that an escape route via the garden is not a fire exit on the basis of the recommendation of the fire consultant.

• Fire Drill training with an external Fire Consultancy Company has been completed for all existing staff and is being progressed for all new staff member who hasn’t such training in place.

Proposed Timescale: 22/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that the recommended strategies had been implemented for residents. This resulted in negative outcomes for residents.

11. 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:
• To ensure residents have positive outcomes, the level of staffing within the designated centre has increased as from the 26/4/15:

1 residential home, roster plan is as follows:
08.00-20.00hrs x 3 staff member including 1 staff nurse and 2 residential programme
assistants
08.00.-22.00hrs x 1 staff member , Residential programme assistant
20.00-08.00hrs x 2 staff members , 1 staff nurse and 1 residential programme assistant

The second residential home roster plan is as follows:
08.00-20.00hrs x 4 staff members, 1 staff nurse and 3 residential programme assistant
08.00hrs -22.00hrs x1 staff member , I residential programme assistants
20.00- 08.00hrs x 2 staff members., 2 residential programme assistants.

•All Positive Behaviour Support Plans for residents will be signed off by all new staff to confirm they have read and understood the content and recommended strategies which been implemented for residents.

•Positive Behaviour Support Training has taken place on the 2nd and 16th June 2015.

•The Person In Charge is progressing further Positive Behaviour Support Training for the remainder of staff within the Designated Centre .31st July 2015

•The Person In Charge will discuss resident’s Positive Behaviour Support Plans at team meetings.

Proposed Timescale: 31/07/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not receive the appropriate training to support residents.

12. 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:
•Positive behaviour Support Training took place on the 2nd and 16th June 2015, which staff from the designated centre attended.

•The Person In Charge is progressing further Positive Behaviour Support Training for the remainder of staff within the Designated Centre.

•All staff working in the Designated Ccentre will receive training in de-escalation and breakaway techniques.

Proposed Timescale: 31/07/2015
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practices regarding residents finances did not safeguard residents' finances.

13. **Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
- Local Operational Procedures will be introduced for the management of residents monies by 30th June 2015.
- Investigation has been undertaken with regards to the missing funds and a report has been furnished with recommendations prioritised.
- Garda are undertaking an investigation.
- All residents Financial Passports will be reviewed and updated by 31st July 2015.
- A Committee has been established to progress residents access to individualised monies in line with best practice guidelines.

**Proposed Timescale:** 31/07/2015

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**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All of the appropriate proactive and reactive clinical interventions were not completed to ensure residents well being and health was maintained.

14. **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:**
- An assessment has been carried out to reflect the changes in need of the resident and a Completion of Care Plan/ vital observations post Hospitalisation of a resident. 27th May 2015
- A procedure has been implemented for clinical observations of residents post discharge from hospital. 27th May 2015
- All staff have read and signed off that they are fully aware and understand this procedure. 26th May 2015
- All residents on discharge from hospital will have an immediate review of their Care Plan. 26th May 2015
- The Resident who was discharged from hospital on 26/05/15 had his Care Plan completed on 26/05/15 and updated on 27/05/15.

**Proposed Timescale:** 27/05/2015  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** 
There was no evidence to support that residents were provided with a choice of general practitioner.

**15. Action Required:**  
Under Regulation 06 (2) (a) you are required to: Ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available.

**Please state the actions you have taken or are planning to take:**  
1. Reviews have taken place with regard to progressing resident's access and choice to a general practitioner. 31st May 2014  
2. It has been agreed that this is being further progressed as part of the De-congregation Implementation Committee for all residents within this Designated Centre. 30th September 2015

**Proposed Timescale:** 30/09/2015  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** 
Residents were offered limited opportunity to prepare meals and snacks.

**16. Action Required:**  
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**  
1. Arrangements have been put in place to ensure that funding is available to the Designated Centre on a daily basis to purchase a variety of snack options commencing on 19/6/15. Snack options will be discussed at weekly residents meetings.  
2. Light meals will be prepared within the house with the involvement of

**Proposed Timescale:** 19/06/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The choice at mealtimes was not in line with residents preferences.

17. Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
1. Resident’s choices and dietary needs will be determined through resident’s house meetings and staff knowledge and experience of supporting resident’s at meal times. 21st June 2015

2. The Person in Charge is liaising with the Kitchen staff to ensure greater choice/menu plans and individual preferences for residents. 22nd June 2015

3. The Catering Department are reviewing the menu options on a seasonable basis.

4. The menu for residents is being ordered three times a week.

5. The Person In Charge is progressing the purchasing of appropriate snack for residents.

Proposed Timescale: 31/07/2015

Outcome 12. Medication Management

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no choice of pharmacists for residents.

18. Action Required:
Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

Please state the actions you have taken or are planning to take:
• The Director of Care and Support is meeting with the current Pharmacists on the 18th June 2015 to discuss the service provided and the development of links with local pharmacists.

Proposed Timescale: 18/06/2015
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed practices in respect of medication management which were not in line with policy.

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

**Please state the actions you have taken or are planning to take:**
- The Person In Charge contacted the Pharmacy in relation to crushing medication for residents requiring same to progress this.
- Review of the changes required is been assessed with the services General Practitioner and Psychiatrist by 30th June 2015.
- The Director of Care and Support is meeting with the current Pharmacists on the 18th June 2015 to discuss the service provided and the provision of appropriate disposal of medications systems. All actions will be prioritised and actioned.

**Proposed Timescale:** 30/06/2015

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**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 cumulative evidence of this inspection demonstrated that the systems in place were in effective.

20. **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:**
Management and Staffing levels:
- A review of the current management structure within the Designated Centre has taken place.
- Staffing levels have increased as from 26/4/15.
1 residential home, roster plan is as follows: 08.00-20.00hrs x 3 staff member
08.00-22.00hrs x 1 staff member
20.00-08.00hrs x 2 staff members.

The second residential home roster plan is as follows:
08.00-20.00hrs x 4 staff members,
08.00hrs -22.00hrs x 1 staff member
20.00- 08.00hrs x 2 staff members.

Absence of staff supervision

• The Person In Charge has commenced formal supervision with staff within the Designated Centre and will continue to provide informal supervision for all staff members.

• The Person In Charge will also commence Preformance Development Review with all staff members within the Designated Centre

Healthcare:
• An assessment will be carried out to reflect the changes in need of the resident and a Completion of Care Plan/ vital observations post Hospitalisation of a resident

• A procedure has been agreed for clinical observations of residents post discharge from hospital.

• All staff has read and signed off that they are fully aware and understand this procedure

• All residents on discharge from hospital will have an immediate review of their Care Plan.

Absence of appropriate management of risk:
• The Risk Management Policy is currently under review by the Person in Charge to ensure all hazards within the designated centre have been identified and control measure put in place.

• A designated centre risk register is currently under development and will be approved at the next Quality and Safety Executive Committee 30th June 2015.

• The Person in Charge will review the Adverse Incident Forms for the designated centre. Any recommendations or review required is followed up before the Person in Charge is satisfied to close out the incident.

• The National Adverse Event Management System monthly report will be discussed at the staff meetings.
Absence of the implementation of positive behaviour supports plans:

- All Positive Behaviour Support Plans for residents will be signed off by all new staff to confirm they have read and understood the content and recommended strategies which been implemented for residents.

- Positive Behaviour Support Training has taken place on the 2nd and 16th June 2015.

- The Person In Charge is progressing further Positive Behaviour Support Training for the remainder of staff within the Designated Centre.

- The Person In Charge will continue to discuss resident’s Positive Behaviour Support Plans at team meetings.

The number of resident’s residing in the Designated Centre considering the size and layout of the designated centre:

1. To provide greater space for residents and meet their needs, three residents are being assessed utilising the Supports Intensity Scale to transition from this designated centre to another designated centre within the campus based residential services on an interim basis by 31/07/2015. As a result all residents remaining in the two houses will have single bedrooms, ensuring their privacy and dignity will be maintained within their own personal intimate space.

2. The three residents that have been identified to transfer to another Designated Centre will have transition plans completed by 18/06/2015

3. Two new unregistered properties within the community have been identified for up to nine residents. Applications will be made to HIQA for registration of these properties as Designated Centres by the 1st September 2015.

4. Transition Plans will be completed for all these residents to support their transition to these and other Designated Centre by 30th June 2015 and will include the findings from the Supports Intensity Scale assessment.

**Proposed Timescale:** 31/07/2015

**Theme:** Leadership, Governance and Management

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

There was inadequate support available to the person in charge.

21. **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:**

- A review of the current management structure within the Designated Centre has taken place.
- Weekly Designated Centre meetings with the Director of Care and Support and Person In Charge have been introduced which review the Designated Centre Quality Enhancement Plan and timescales.
- Weekly Implementation meetings which is chaired by the Director of Care and Support with all Person In Charge and Quality Manager to discuss Quality Enhancement Plans and shared learning have been introduced.
- Quality Team provide support from Monday to Wednesday to this Designated Centre.
- The Person In Charge is supernumerary.
- A line manager, Clinical Nurse Manager is working opposite to the Person In Charge
- The Clinical Nurse Specialist in Health Promotion is supporting the staff team with care plans and infection controls.

Proposed Timescale: 7th May 2015 on going

**Proposed Timescale:** 07/05/2015

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There was insufficient staff to meet the needs of residents.

**22. 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:**

- Staffing levels have increased as from 26/4/15.
  - 1 residential home, roster plan is as follows:
    - 08.00-20.00hrs x 3 staff member
    - 08.00-22.00hrs x 1 staff member
    - 20.00-08.00hrs x 2 staff members.
The second residential home roster plan is as follows:
08.00-20.00hrs x 4 staff members,
08.00hrs -22.00hrs x1 staff member
20.00- 08.00hrs x 2 staff members.

• The Person in Charge is currently reviewing the roster to ensure that new staff work closely with familiar staff and Social Care Worker will be introduced to the skill mix of this Designated Centre

• A Supports Intensity Scale Assessment is commencing for all residents within this Designated Centre which will inform skill mix and appropriate staffing level. Commencing on 22nd June 2015

Proposed Timescale: 22/06/2015
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of care plans completed. Clinical observations were not completed for residents which were acutely unwell.

23. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
• An assessment will be carried out to reflect the changes in need of the resident and a Completion of Care Plan/ vital observations post Hospitalisation of a resident – 27/05/2015

• A procedure has been agreed for clinical observations of residents post discharge from hospital – 27/05/2015

• All staff have read and signed off that they are fully aware and understand this procedure 27/05/2015

• All residents on discharge from hospital will have an immediate review of their Care Plan - ongoing

• A new Care Plan has been devised and will be implemented on a phased bases.

Proposed Timescale: 30/09/2015
Theme: Responsive Workforce
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistent care provided to residents.

24. **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 Person in Charge is currently reviewing the roster to ensure that new staff work closely with familiar staff.
- The Person in Charge has reviewed the induction checklist and made it Designated Centred Specific.
- A shift leader is in place and a template to support their role.
- The staff team for this Designated Centre has been ringfenced to provide greater continuity of care for residents.

Proposed Timescale: 17/06/2015 on going

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**Proposed Timescale:** 17/06/2015

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have the appropriate training.

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

**Please state the actions you have taken or are planning to take:**
- The Person in Charge is progressing a training schedule for staff in the areas of Key working, Meaningful Day, Mealtime Experience, Food Hygiene and Rights and Complaints and this is being supported by the Quality Advisors.
- The Person In Charge is progressing the schedule for the mandatory training of staff members within the Designated Centre.

**Proposed Timescale:** 30/06/2015

**Theme:** Responsive Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate staff supervision.

26. **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 Person In Charge has commenced formal supervision with staff within the Designated Centre and will continue to provide informal supervision for all staff members.

• The Person In Charge will also commence Performance Development Review with all staff members within the Designated Centre

• The Person In Charge will work opposite her Clinical Nurse Manager 1 to ensure adequate staff supervision.

**Proposed Timescale:** 16/06/2015