

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003008
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Louisa Power
Support inspector(s):	Brid McGoldrick;
Type of inspection	Unannounced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 5 day(s).

The inspection took place over the following dates and times

From:	To:
07 April 2015 20:20	08 April 2015 00:40
08 April 2015 10:15	08 April 2015 20:30
10 April 2015 07:15	10 April 2015 12:15
12 April 2015 10:30	12 April 2015 17:10
14 April 2015 07:50	14 April 2015 13:20

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The centre comprised two bungalows situated on a larger campus which accommodated sixteen adult male residents. Residents were assessed with diagnoses of moderate, severe and profound intellectual disability. On the first three days of inspection there were 14 residents; 1 resident was in hospital and another resident was spending time with family. On 12 and 14 April 2015, there were 15 residents residing in the centre.

The campus had originally consisted of two larger designated centres which were inspected on May 2014. Corrective action was required in that the number, qualifications and skill mix of staff was not appropriate to the statement of purpose and the size and layout of the centre. Consequently, the provider restructured the campus to eight separate designated centres. However, due to a continued lack of improvement across the campus, a warning letter was issued to the provider on 24 October 2014.

This was the second inspection of this facility as a centre in its own right. An unannounced inspection was undertaken on 17 and 18 February 2015 following which an improvement notice was issued to the provider on 23 March 2015 requiring corrective action in relation to governance and management, general resident welfare and development, staffing, staff training and development, premises and fire precautions. The actions were required to be completed by 30 March 2015.

At the request of the Authority, a provider-led investigation was initiated following an alleged incident where a resident was physically assaulted by a staff member. The report was submitted to the Authority on 2 April 2015.

The purpose of this inspection was to validate the actions undertaken in the improvement notice in relation to governance and management, fire precautions, premises, staffing and training. The inspection also focused on the safeguarding and protection of residents. Inspectors met with members of the senior management team, key personnel in relation to safeguarding, the clinical practice co-ordinator, medical practitioner, clinical nurse specialist, kitchen staff and staff on the unit. Even though many of the residents were unable to communicate verbally, inspectors communicated with many residents through Lámh and gestures.

Inspectors found that ineffective leadership, governance and management arrangements were leading to consistent, repeated and continual failings. This included poor safeguarding practices, inadequate response to allegations, disclosures or suspected abuse and a lack of support in clinical decision making. Environmental restraint, in the form of locking residents alone in a unit, had occurred on a number of occasions where sufficient staff had not been deployed. Insufficient staffing levels also prevented residents from participating in social and recreational activities in accordance with their rights, interests, capacities and developmental needs.

Management systems did not ensure that residents received continuity of care and support and the premises did not meet the needs of residents due to a lack of space and appropriate equipment, aids and appliances.

The findings of the inspection have identified major non-compliances in nine of the 10 outcomes inspected. The provider nominee and Chief Executive attended a regulatory meeting with the Chief Inspector on 14 April 2015. A plan for compliance was submitted to the Chief Inspector on 23 April 2015 which outlined the immediate corrective actions to be undertaken to meet regulatory requirements.

The action plan of this report identifies the areas requiring to be addressed by the provider nominee and person in charge in order to ensure compliance with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities.

The provider's response to the inspection report was submitted to the Authority on 20 April 2015. The action plan was not satisfactory and a revised action plan was received on 18 May 2015. The information contained within the provider's response and the plan for compliance previously submitted will be verified on inspection by the

end of May 2015 with a view to informing an appropriate regulatory response

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

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

Findings:

Care practices resulted in limited control and choice for residents over their lives in accordance with their preferences. Residents' independence was not actively promoted and maximised. Residents' privacy and dignity was not respected and visitors could not be received in private.

Inspectors observed that age appropriate utensils were not provided to a resident for eating and drinking. Clothes protectors were observed to be routinely worn by residents and not offered as a choice at mealtimes. As a result, mealtimes were undignified and not an enjoyable experience for residents.

Staff with whom inspectors spoke reported that sanitary facilities, especially showers, were inadequate. Practices were inflexible and institutional in nature rather than person centred. There was no bath available for residents in the unit if this was a resident's preference.

Inspectors observed that residents attended activities; some provided within the unit and others provided in a location on the campus. Notice boards and photos were used to display the activities residents would be participating in during the day. Activities facilitated included music, baking, reflexology and yoga. Residents were especially excited about a field trip to a local pond. However, many of the activities took place within the unit and on the campus allowing little opportunity for community integration. For example, instead of facilitating trips to the local cinema, movies were shown in the coffee shop on the campus.

A real and meaningful choice was not offered to residents in relation to meeting their healthcare needs including medical practitioner, pharmacist and allied healthcare professionals. Residents were not offered adequate choice in relation to menu options. Meals were served to residents by staff and additional servings were not available when residents requested same.

Inspectors observed that the premises posed a number of challenges. Limited private accommodation hindered residents' freedom to exercise choice and control when pursuing personal recreational activities. For example, a resident's choice of music was being played loudly in the communal area while other residents were relaxing. This resident shared a bedroom with another resident and his private space to enjoy his music was limited. There was no private space for residents to meet and socialise with their visitors. Visitors were observed in the communal living/dining space which was already limited. Storage space for residents' clothing and belongings was not adequate. Inspectors observed that a resident's clothing was stored in a store room outside their control and access.

Residents' rights and diversity were not respected and promoted. Two residents were unable to attend the religious service of their choice on 12 April 2015. Staff reported and inspectors observed that this was due to inadequate staffing levels. The residents communicated their disappointment at not being able to attend to inspectors.

Residents were not supported to communicate effectively and in accordance with their needs and wishes. Assistive technologies, aids and appliances were not considered or provided for residents to promote their full capabilities. Residents were not supported in independent mobility and to enter and leave their home to enjoy the campus grounds independently. Some residents indicated to inspectors that they would like to go for a walk but inspectors observed that they were not provided with support at the time.

Incident forms, staff interviews and inspectors' observations indicated that inappropriate placement of some residents resulted in negative outcomes for other residents. Residents who had diverse and complex needs including behavioural support requirements were not well supported and were detrimentally impacting on other residents. This included incidents of injury and harm between peers, such as hitting out or biting, occurring on an almost daily basis. Senior staff spoken with by inspectors outlined a long term plan for residents to transition to the community. However, there was a failure to develop suitable goals and timescales for residents to work towards transitioning to community living. Inspectors reviewed a resident's file which outlined his wish to live in his own house, be able to make a cup of tea and to listen to his music. An assessment of housing had not been completed for this resident.

The size of the toilet area was limited and a resident had to use the facilities in an undignified way and had to sit sideways on the toilet. Screens could not be used in shared bedrooms to allow for privacy due to limited space. Inspectors observed that residents' documentation was not consistently stored securely or in a way that respected their privacy. Archived resident files were stored in an unsecured filing cabinet in an unlocked store room.

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:

The design and layout of the centre did not meet residents' assessed needs and did not promote their safety, dignity, independence and wellbeing. This included:

- inadequate private and communal accommodation
- residents were restricted in accessing sanitary facilities in a dignified manner
- space in bedrooms was restrictive and did not allow for free movement of residents, equipment and staff
- inadequate shower facilities
- personal storage was limited.

Residents who required assistive equipment for moving and handling did not have it available to them which had a significant impact on their quality of life. A hoist was not available in the centre and staff reported to inspectors that residents who had fallen were required to be physically lifted from the floor.

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:

The health and safety of residents, visitors and staff was not adequately promoted and protected.

Systems in place for the assessment and mitigation of clinical and environmental risk did not ensure adequate arrangements were in place for investigation of and learning from serious incidents or adverse events involving residents.

There was no hazard/risk log maintained and updated to address new hazards identified and to minimise risks. Staff completed and submitted a form to senior management, called a concern logging form, or sent emails to indicate if there was risk. For example one incident form related to lack of suitable moving and handling equipment for a resident and in another instance related to the management of a resident with a communicable infection. Senior management failed to respond and put in place interventions to mitigate the risks presented. Staff training was required in areas such as hand hygiene, falls prevention/management, infection prevention/control and risk management.

Clinical risk

Inspectors conducted a review of falls by residents as documented by staff for the period: 01 Jan 2015 to 14 April 2015. There were 59 fall incidents documented as sustained by 11(68%) of the 16 residents living in the centre. The data evidenced that five (37%) of residents each fell more than five times in the period reviewed. Resident injuries as a result of falling included bruising, swelling of various body parts, lacerations and cuts requiring first aid. One resident required treatment in hospital for a wound sustained during a fall on one occasion, which the resident described to inspectors through signs. Four (6%) falls were associated with residents experiencing seizure activity.

Controls stated to mitigate risk of further falls as identified in the incident reports included "needs supervision", "close supervision", "requested not to go into kitchen without frame", "support when mobilising", "bedroom environment cannot accommodate equipment", "need to reduce the number of residents" and "unfamiliar staff". These controls did not include sufficient detail relevant to the specific resident to inform implementation of suitable care.

Inspectors viewed a number of falls assessments, some of which did not accurately inform the level of risk of potential serious injury for some residents. For example, a resident who had fallen nine times was assessed as high risk of fracture but had a 'low risk of falls' documented as an outcome of assessment. This inaccurate assessment of each resident's level of risk of injury did not inform preventative measures and placed vulnerable residents at risk. Procedures in place for post-fall review and learning to mitigate the level of risk to some residents required immediate and sustained review.

Inspectors observed that vulnerable residents in the sitting rooms were unsupervised on a number of occasions on the days of inspection which supported evidence of insufficient staffing resources to meet residents' needs. From observation, discussion with staff and review of falls assessment records and other associated resident

documentation, inspectors found that 2 residents required additional staff supports to ensure their safety and wellbeing.

Two differing resident falls risk assessment tools were in use, one of which was 35 pages long. Staff spoken to, had not received training on completing this assessment tool or were unable to locate the standard operating procedure to refer to. All residents had an initial falls assessment completed. However, revision of the falls assessment was not routinely completed following a recent fall.

Care plan documentation was not updated to inform supervision arrangements. There were gaps in residents' physiological observation records. Respiration rate and oxygen levels (in cases of a seizure) were not consistently recorded. This did not ensure residents were adequately monitored during a seizure when they were at increased risk of breathing difficulties. Inspectors found that there was a lack of suitable emergency monitoring equipment immediately available and staff confirmed that they frequently had to borrow this equipment from other units.

The inspectors cross referenced accident and incident records with medical and nursing documentation to assess residents' care post an incident of fall. From the sample reviewed there was inconsistent evidence of timely medical review of residents.

There was lack of sufficient equipment to monitor each resident's health status. Items of equipment concerned included;

- blood pressure monitoring equipment to suit the needs of residents
- first aid equipment – A Resuscitation Mask was out of date
- weighing scales

Environmental risk

Identification and assessment of areas of environmental risk/hazards to the safety, health and wellbeing of residents was not adequate, including:

- the suitability of a shower chair for use by a number of residents required review to ensure it met their needs.
- unsafe floor covering in some rooms
- ramped area of floor between the hallway, dining and kitchen areas
- ramped access to external garden in one of the units renders it unsuitable for 3 residents living in the unit
- waste bins for the disposal of rubbish had lids open
- unsecure storage for residents personal information
- narrow hallway hindering the passage of a resident using assistive equipment
- storage of clean continence wear in the toilet
- overflowing used laundry bags at the front entrance on 12 April 2015
- storage of personal hygiene items under beds
- no suitable facility to prepare medication
- inadequate provision of suitable alarms to alert staff
- inadequate equipment for monitoring residents weights

Staff advised inspectors that they recognised that the living accommodation was unsuitable and had communicated their findings and concerns to senior management. However, no action was evidenced in response.

Infection control

Procedures consistent with the standards for the prevention and control of health care associated infections and Regulation 27 were not in place. Inspectors observed inadequate cleaning procedures in place. The kitchenettes used for resident food preparation and showers used by residents were unclean. The housekeeper's duties included both cleaning of areas used by residents and distribution of their meals. The housekeeper had responsibility for completion of these duties in two houses over four days each week.

Hand gels were located at strategic points throughout the centre. However, inspectors did not observe staff adhering to adequate hand hygiene procedures. Personal protective equipment was worn by staff when dealing with food.

Inspectors viewed a number of respiratory therapy administration units (nebulisers) which were without appropriate labelling to indicate the resident using the equipment, when tubing required changing or advice on reservoir cleaning procedures to ensure best practice with regard to infection prevention and control.

Evidenced based practice for the prevention, control and management of communicable infection was not adequate. One resident living on the unit had a communicable healthcare associated infection. However,

- this resident shared a room with another resident who had a wound
- the space between their beds was not adequate
- staff were unclear if the resident sharing the room had a swab sent for microbiological analysis to ensure cross infection had not occurred
- management of this resident's laundry was not in line with best practice.

Inspectors observed inappropriate administration of eye drop medication in both eyes for a resident with infection. One eye had a documented ulcer and the other had tested positive for infection with a communicable healthcare associated infection and was noted to be red and inflamed on the days of inspection. The same administration dropper was used for instillation of drops in both eyes which posed a risk of cross-contamination. Furthermore, staff did not carry out appropriate hand hygiene procedures post instillation of eye drops and between residents before moving to the next task.

There was a system in place for the administration of antibiotics directly into the veins. However, measures were not in place to prevent invasive medical device infections such as guidelines and care bundles.

Moving and Handling

Not all staff had attended training on safe moving and handling of residents as required. While risk assessments were available for each resident; adequate assistive equipment was not provided as prescribed. For example, a resident who sustained a number of falls and a fractured limb was assessed as requiring a sit-stand hoist in 2013. However, this was not progressed due to space constraints in the resident's area. Reassessment was not undertaken to identify alternative measures to meet this residents' need. The resident sustained another fall in February 2015 and the incident form stated "serious

need to reassess safety and person needed for night support". While a review occurred post this repeated fall there was no suitable intervention put in place to mitigate the risk of further injury to this resident. In another instance, where a resident was assessed as requiring a hoist for safe transfer, documentation stated that "four attempts were made to assist a resident off the floor."

Fire Safety

Aspects of fire safety management were reviewed. Fire safety procedures and precautions were the subject of an improvement notice issued on 23 March 2015. Staff had attended fire safety training since the last inspection. However, Inspectors were not assured that staff would be able to evacuate residents safely at night time in an emergency if required due to the staffing numbers available and the complexity of the residents needs. The other areas identified in the improvement notice had not been attended to. However the timeframes stated for satisfactory completion have not yet expired.

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:

There were inadequate measures in place to protect residents from being harmed or suffering abuse. Adequate processes were not implemented to ensure that appropriate action was taken in response to allegations, disclosures or suspected incidents of abuse. Residents were not consistently provided with adequate emotional, behavioural and therapeutic support that promoted positive person centered care.

There was a policy and standard operating procedure in place for the prevention, detection and response to abuse. The policy had been implemented in October 2013 and the standard operating procedure had been reviewed most recently in August 2014. Staff confirmed and provided documentary evidence that the Group Chief Executive had written on 26 January 2015 outlining that the policy and procedure was being reviewed

to reflect the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures launched by the Health Service Executive on 9 December 2014. Senior management confirmed that the review process was not complete to date. Furthermore, a key member of staff had submitted feedback in relation to the local policy and procedure in January 2014 to ensure that there was a clear process in place to safeguard residents.

Incidents of injury and harm between residents, including hitting out and biting, occurred on an almost daily basis and was observed by staff. Measures, such as alternative accommodation and analysis of the behaviours, had not been put in place to protect residents.

Staff with whom inspectors spoke demonstrated an adequate knowledge of what constitutes abuse and the measures required to safeguard residents. However staff were not clear on the reporting procedure for allegations, suspicions and disclosures of abuse. Some articulated that the safeguarding forms were to be given directly to key staff and others stated that they could be left in a designated post area. Staff reported that they had not all attended refresher training but were booked onto a course in late April 2015. Inspectors identified that a member of agency staff who worked alone at night had received training in understanding abuse but not as it pertains to adults with a disability.

Inspectors met with key members of staff who are responsible for screening safeguarding reports and acted as a liaison with external agencies in relation to safeguarding. Resources had not been adequately deployed to ensure that these key members of staff could meet their legal obligations and allegations were not always followed up in a timely way. This included an incident of alleged physical assault of a resident by a non-permanent staff member. A provider led investigation received by the Authority on 2 April 2015 outlined a number of failings which included:

- immediate safeguarding measures were not put in place
- delay in reporting by witnesses
- delay in obtaining witness statements
- delay in preliminary screening
- external agencies not contacted promptly
- gaps identified in staff training; 59% of staff required safeguarding training
- lack of adherence to local policy and procedures.

Following this investigation, an external review of safeguarding procedures was commissioned on 9 April 2015 by the provider. A schedule of weekly meetings commenced on 16 April 2015 where all adverse incidents, including safeguarding, were discussed and additional training was to be provided for staff.

A policy for the provision of behavioural support for residents was in place but had not been reviewed since May 2011. Inspectors examined a selection of positive behaviour support plans, which had been reviewed in the previous six months. There were clear strategies in place to support residents. However; inspectors noted that it was not possible for staff to implement all of the strategies outlined in the plans. For example, a trigger identified in many of the plans reviewed was new/unfamiliar staff. Based on review of rosters and observations during inspection it was evident that new/unfamiliar staff were continuously on duty to fill unplanned absences. An inspector observed an

incident of challenging behaviour at mealtimes where residents were supported by one familiar staff member and a staff member who had commenced work in the unit in the previous two weeks. This incident impacted on four residents.

There was evidence that regular staff supporting residents had read, and were familiar with, the positive behaviour plans. However, there was no evidence that agency staff who may work alone with residents at night had read and were familiar with residents' behavioural support plans in order to provide consistent and prescribed support. As part of the provider led investigation previously mentioned, the provider had identified that none of the regular staff in this centre had completed training in positive behaviour support. Training had not been provided for staff at the time of this inspection.

Policies and procedures in relation to restraint were comprehensive and evidence based. Staff with whom inspectors spoke demonstrated an adequate knowledge of these documents. Inspectors saw that there had been a reduction in the use of chemical restraint. Where physical and chemical restraint was used, inspectors saw records that demonstrated that episodes of restraint were considered only if the risk involved outweighed the possible negative effects on the resident subject to restraint. There was also evidence that alternative interventions were considered prior to the use of physical and chemical restraint. A full assessment of the resident prior to each episode, monitoring of each resident during any episode, adverse events resulting from restraint and a detailed record of each episode of restraint were documented.

However, inspectors noted at least three episodes where environmental restraint was used to facilitate a changeover of staff. A unit was locked and residents were left alone while a staff nurse went to the other unit to administer medicines. These episodes occurred over a period of two weeks.

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:

Overall, inspectors found that all residents were not supported on an individual basis to achieve and enjoy the best possible health.

The centre catered for 16 adult men with a moderate, severe and profound intellectual

disability. Inspectors noted that residents were diagnosed with a range of complex physical and mental health issues.

Inspectors reviewed a sample of care plans. Four of the residents were actively experiencing regular epileptic seizure activity. Care plans in relation to epilepsy management lacked sufficient information to guide staff to effectively care for and support residents. Seizure recording sheets did not accurately reflect the number and type of seizure experienced which could lead to staff not recognising an increase or change in seizure activity or pattern and not accessing specialist advice.

Seizure management plans did not sufficiently guide staff in the administration of rescue medication to reduce the length of a seizure and to prevent the development of status epilepticus. The emergency management of seizures was also compromised by unsafe medication practices.

Inspectors noted that residents' neurological observations were not routinely recorded after seizures. Where observations were recorded, documentation was poorly maintained and not dated. Inspectors identified a recent incident where a resident went home following a seizure during which the resident hit his head. There was no documented communication with his family to outline the recent seizure and how it was managed. Staff with whom inspectors spoke also reported that this resident's family would not be able to manage seizures effectively.

A meaningful choice was not provided for residents in relation to a medical practitioner. Two doctors were employed by the provider and were contracted to work on a sessional basis. Based on interviews and observations, inspectors found that one doctor focussed on psychiatric and neurological conditions while the other ran a more general practice. Residents attended a medical clinic which was located on the campus. Inspectors spoke with one of the doctors who described a number of health promotion initiatives that had been implemented and a specialised admission policy to allow for a planned transfer of residents to the acute hospital to prevent undue distress. An epilepsy outreach team from a specialist neurological unit visited the centre four times per year. A service that allowed for residents to receive antibiotic therapy into the vein had been implemented successfully reducing the amount of time residents spent in hospital. However, the doctor outlined significant and ongoing gaps in the medical cover provided for residents.

Inspectors identified an incident where staff were unaware of what the 'on call' arrangements were for seeking medical advice. This led to a delay in accessing appropriate medical care and advice. Staff with whom inspectors spoke reported that residents could not always access a timely appointment at the medical centre due to an over-subscribed service.

Three residents had been transferred to hospital in the previous six months and these residents were at an advanced stage of illness before transfer to hospital. All of these transfers occurred out of hours and directly to the local emergency department. One of these residents showed initial signs of clinical deterioration at 01:20 before his condition gradually worsened overnight. When the 'out of hours' doctor service was contacted at 08:30, the staff were informed that the service did not cover the campus. The resident was subsequently transferred to the acute hospital via ambulance at 10:45 and spent

four days in the emergency department receiving antibiotic therapy.

Appropriate action such as referral to the medical clinic or increased monitoring was not implemented in a case where observations and other clinical indicators highlighted a possible clinical deterioration in another resident's condition in the seven days preceding a transfer to hospital. On transfer to hospital, the resident required a number of investigations and antibiotic treatment. Procedures did not ensure residents who experienced sudden collapse had observations of physiological condition carried out immediately. A third resident's condition deteriorated and resulted in a transfer to the emergency department via ambulance. This resident spent his hospital stay in the emergency department undergoing investigations and tests.

Nursing staff with whom inspectors spoke were not aware of any tool or clinical decision making policy in use at the centre to guide staff in the early detection of deteriorating health. Furthermore, equipment for the recording of observations was not calibrated and as such was not fit for purpose.

There were care plans in place to guide staff in relation to the management of constipation. However, care plans were not always implemented in practice. Intake charts were not consistently completed to ensure that residents were adequately hydrated to prevent constipation. Many care plans outlined the need for a high fibre diet as a preventative measure. Inspectors did not observe high fibre options being made available at meal times such as whole grains and prune juice, even though recommended by the dietician and included in residents' care plan. These foods were not observed to be stocked in the unit. Medication prescribed for constipation was not ordered in a timely way; doses were missed and resulted in the 'out of hours' doctor service prescribing an alternative rectal preparation to promote bowel emptying.

Based on observations of meals and meal preparation, interviews with catering staff and review of documentation, inspectors concluded that monitoring systems for food preparation, nutritional value of resident's intake and inadequate staffing resources to assist residents required an immediate and sustained response to ensure residents' nutritional needs were met.

Residents were at risk of negative nutritional outcomes due to inadequate provision of resources to meet their needs, including monitoring equipment, adequate and suitable quantities of food and drink, appropriate staff assistance and sufficient monitoring procedures. Records of food provided or amount eaten by residents was not documented accurately and sufficiently. These records did not facilitate the accurate calculation of the nutritional value of food provided, food eaten and fluids consumed.

Food was predominantly prepared in a central kitchen on campus which was staffed from 08:00 to 17:00. This included all dishes for lunch and tea and porridge in the morning. The meals are delivered in a van to the units and served by unit staff. Breakfast cereals, hot drinks and a light supper were prepared in the kitchenette at unit level.

There was little formal communication evidenced between the kitchen and staff/residents on the unit. Kitchen staff reported that they had little or no autonomy

when ordering food and preparing menus. As a result, there were no appropriate provisions available to the kitchen staff in order to fortify food as recommended for residents at risk of unintentional weight loss or low body weight.

Inspectors observed a total of six dining experiences throughout the days, evenings and nights of the inspection. Inadequate staffing levels at mealtimes resulted in residents not receiving appropriate assistance with eating or drinking. Mealtimes were rushed and institutional in nature. Some residents were required to wait for meals served at a second sitting. These residents sat and watched their peers eating while they waited. Meal ordering was completed twice weekly and did not allow residents to change their meal order on a daily basis. Inspectors reviewed a sample of meal order sheets and saw that even though two options were offered for each meal, only one option was consistently ordered for the unit which resulted in residents not receiving a meaningful choice for meals. Residents were offered a limited choice of drinks and had limited opportunity to independently prepare meals and snacks.

Additional servings of food were not available on request and there was observed to be a lack of fresh, healthy snacks on the unit. Snacks and drinks were not stored in a way to ensure they were accessible to residents. The central kitchen on campus was not staffed after 5pm each day. There was limited choice of food and provisions available at unit level to residents should they choose to have a meal or hot snack. Supper, which was observed to be a light meal before bed-time, included a serving of cereal or yogurt. There was limited choice of snacks at unit level for residents requiring modified consistency diets to meet their needs.

Inspectors also found that a number of residents had documented low body weights. However, the weights documented were not reliable or accurate for the following reasons:

- records did not indicate if clothing/hip protectors/orthotic shoes were worn when residents were weighed
- no calculation of weight of clothing/hip protectors/orthotic shoes if worn to facilitate calculation of net (actual) weight
- weights were done when convenient for staff to use the scales in another unit
- weights were not consistently recorded in the same units of measurement
- no documentary evidence that equipment used was appropriately calibrated.

Due to these findings, residents' weights as documented could not be relied on as accurate. Inspectors also observed that, where residents refused to be weighed, an alternative method for calculation of weights was not considered or used. There was a failure to increase the frequency of monitoring in response to findings of weight loss by residents with low body weights.

There was little evidence that staff working in the kitchen on the unit (known as housekeepers) was aware of specific individual resident requirements as outlined in care plans or as recommended by allied health professionals. A number of residents were receiving prescribed nutritional supplements. However, inspectors could not determine if residents consistently received their prescribed supplements due to the inconsistent completion of medication administration records. There was also evidence that prescribed nutritional supplements were out of stock on the unit for a period of days

even though the pharmacy provided a delivery service on a daily basis.

An evidence based screening tool was in use to monitor risk of malnutrition but was not consistently completed in line with local policy. Staff with whom inspectors spoke were unable to demonstrate an adequate working knowledge of the screening tool and the relevance of the weight loss score. A resident who was found to have experienced an unplanned total body weight loss of greater than 5% did not have appropriate interventions implemented.

Access to specialist health and allied health services, such as speech and language and dietetics, was provided on a referral basis at unit level. However, inspectors identified a resident who had a diagnosis of recurrent gastric reflux. His care plan outlined that he was at risk of losing weight. An exacerbation of this condition was recorded on three occasions since January 2015. There was documentary evidence from 2012 stating that the resident should be referred back to the gastroenterologist if condition recurs. However, records made available to inspectors did not indicate that a referral had been made as advised. An inspector observed the resident experiencing unpleasant symptoms associated with this condition during the inspection.

An external review which included food and nutrition was commissioned by the provider on foot of a concern raised to the Authority in June 2014. The review outlined a number of failings in relation to food and nutrition including:

- inadequate food supplies on the unit
- menu choices not made available to residents
- menu options ordered long in advance
- fresh fruit not ordered on a daily basis
- limited opportunities for residents to prepare meals
- desserts not provided each day
- inadequate amount of food supplied by kitchen
- records in relation to residents' weights and food/fluid not consistently completed
- lack of healthy snacks.

Based on observation and review of records, inspectors noted that adequate corrective action had not been taken to address these failings in the intervening 10 month period.

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):

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

Findings:

A policy in relation to medication management was in place, had been reviewed in March 2014, was comprehensive and evidence based. Guidance was included in the policy relating to the ordering, receipt, prescribing, storage, administration and disposal of medicines. The policies were made available to staff who demonstrated adequate knowledge of this document and the policy was implemented in practice.

A person-centred plan in relation to medication had been developed for each resident which outlined the medicines prescribed, the reason for use, dose, frequency and side effects. This plan was reviewed at least annually and in line with residents' changing needs.

Medicines were supplied by a community pharmacy. Staff with whom inspectors spoke confirmed that the pharmacist was facilitated to meet his/her obligations to residents under relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Staff with whom the inspectors spoke outlined that a delivery of regular medication was made on a monthly basis, emergency medications could be ordered on any day and would be delivered promptly. However, as outlined in outcome 11, medicines were not always ordered in a timely fashion to facilitate treatment.

Medications were stored securely. Medication refrigerators were provided and medications requiring refrigeration were stored appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Staff confirmed and inspectors saw that medications requiring additional storage requirements were not in use at time of the inspection.

Medication management training was facilitated and nursing staff with whom the inspectors spoke demonstrated knowledge and understanding of professional guidance in medication management. Staff reported and the inspectors saw that it was not practice for staff to transcribe medication.

The medication management policy outlined that residents were encouraged to take responsibility for their own medication, in line with their wishes and preferences. A tool was available to guide staff in the risk assessment and assessment of capacity of residents who wish to take responsibility for their own medicines. Staff confirmed that no residents were self-administering medication at the time of inspection.

Inspectors noted that medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, medication administration records were not consistently completed.

Some residents required their medications to be crushed prior to administration and each individual prescription contained an authorisation from the prescriber to crush medications.

Resident-specific management plans were in place for the management of status

epilepticus. However, these plans did not always contain sufficient information to guide staff including the appropriate time to wait before administering rescue medication.

Pouched compliance aids were used by nursing staff to administer medications to residents. Staff with whom the inspector spoke confirmed that training had been provided regarding these systems. References to identify a specific medication among several medications in the pouch were available to aid nursing staff to confirm the prescribed medication in the pouch.

Staff with whom inspectors spoke outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. However, an inspector observed an outer container of a rescue medicine for epilepsy which indicated the medication contained within had expired. The inspector brought this to the attention of staff who identified that the medication contained in the outer container had been repackaged in this container and had not expired. This posed the risk that medication may not be administered in an emergency situation.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspectors found ineffective leadership, governance and management arrangements in place to protect residents and promote their care and welfare.

The structure of the local management team was complex and multi-layered leading to deficiencies in the overall governance, operational management and administration of the designated centre as evidenced throughout the inspection. The Statement of Purpose states the CNM3 (Clinical Nurse Manager 3) is responsible for four designated centres and the assistant director of care and support is responsible for another four designated centres. There is a CNM1 or CNM2 in the designated centre and that the

staff nurses and attendants report to the CNM.

However, inspectors found that this governance structure was not evident on the days of the inspection. There had been a number of changes to the structure with a person in charge being appointed for each unit or over more than designated centre. A new chief executive officer (CEO) had been appointed at the end of February 2015. There was a temporary person in charge who had ceased as person in charge on 31 March 2015. The Director of Care and Support was identified as the Person in Charge of this designated centre. Feedback given to inspectors from staff working in the designated centre did not provide for assurances that there was effective and clearly defined governance arrangements in the centre. Staff told inspectors that they were supported by the CNM1 but not by senior management.

On 7 April 2015, inspectors were verbally informed that the Director of Care and Support was the person responsible for the designated centre. On 14 April 2015, the Regional Director of Care and Support verbally informed inspectors that a new person in charge had been appointed for this designated centre and would commence on 20 April 2015. The turnover of managers since November 2013 did not provide stability and led to poor delivery of care for residents. The Statement of Purpose states that the centre is governed by a corporate team in Hospitallier Ministries Headquarters in Stillorgan, Dublin and local management team in Co. Louth.

Deputising arrangements were inadequate. The deputising arrangements as notified to the Chief Inspector on 27 January 2015 had ceased on 31 March 2015. These arrangements were not suitable as this person was employed to work 30 hours per week but was deployed to answer the on-call emergency telephone for at least 12 hours per week. A written notification had not been made to the Chief Inspector as required under Regulation 33(1) of the procedures and arrangements that would be in place for the management of the designated centre during the absence of the person in charge on or after 31 March 2015. The person in charge was observed not working in the Designated Centre on the days of inspection and on the first day of the inspection staff were not able to tell the inspectors who was in charge on that day.

It was not clear who had responsibility for the day to day management of the campus. There was a Director of Care, and Assistant Director of Care who both worked in the Campus Monday to Friday, however, neither of these people had direct responsibility on a day to day basis for contact with or supervision of the designated centre.

There was a separate system in place whereby a senior manager was an 'on the clip' system where by persons in charge from other designated centres and the community were responsible for answering the on-call emergency telephone. On discussion with staff and the Regional Director this was not adhered to in all cases and multiple calls were made.

There was a separate manager assigned to allocations, whose responsibility was to plan rosters and replace staff to the units. This manager had no direct accountability to evaluate if the allocation they assigned was sufficient or appropriate to meet the needs of residents. Inspectors inquired from one of the persons assigned to allocations when they had last attended the designated centre and were informed that it was 15 years and

that they were unfamiliar with the needs of the current residents living there. The person in charge indicated on the planned roster what shifts and grades of staff were required to be filled.

The corporate management structure did not assure itself that risks to residents were being managed appropriately by local management. Local Management had set up a number of committees and projects for improvement including policies and programmes to transition residents to the community. However, the timeframes and availability of staff to engage in these committees was questionable and therefore unlikely to achieve their stated goals and objectives given the current challenges in the operation of day to day services in the unit and on the campus. It was not clear who had overall responsibility and accountability for the committees and projects and what responsibility corporate management would undertake in the process.

The inspectors found that the premises were not suitable for the assessed needs of some residents living in the centre. Some residents were identified who could transition to living in the community but there were no transition plans in place. If others wished to remain on campus, no proposal to facilitate an upgrade to current premises or a construction of new accommodation was explored.

There was poor oversight of safety arrangements, operational management and administration of the designated centre evidenced throughout the inspection. Governance and management systems did not support staff to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. Staff with whom inspectors spoke to were committed to providing good, safe care and to improving the services that the unit provides. However, inspectors found that staff were not aware of who was in charge of the centre and who they would report concerns about resident welfare, accidents and incidents. Where concerns were raised, inspectors saw evidence of an unacceptable delay in senior management putting controls in place to meet residents' needs. Staff were unaware of what the on call arrangements for doctors to the centre. This was recognised when a resident clinically deteriorated out of hours and there was a delay in accessing appropriate medical care resulting in a transfer to the acute hospital.

There was insufficient staff provided to ensure a high quality, safe and reliable care and support for residents living in the centre. There was not an organised and planned approach to training. Training records available outlined deficits to staff access to appropriate training, including refresher training as part of a continuous professional programme. There was a lack of oversight by senior staff to ensure that evidence based tools for the recording, screening and monitoring of pertinent measurements such as weight, seizure frequency, neurological observations, respiration rate and behavioural incidents. Senior staff did not ensure that clinical documentation was in place and audited for accuracy and completeness.

Inspectors were not satisfied that the actions and timeframes outlined in the provider's response would mitigate the risk and improve outcomes and quality of life for residents.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The Chief Inspector was not appropriately notified in writing of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during such absence.

Inspectors identified that the person in charge of the centre had been absent since 27 January 2015. The deputising arrangements as notified to the Chief Inspector on 29 January 2015 had ceased on 31 March 2015. A written notification had not been made to the Chief Inspector of the procedures and arrangements that would be in place for the management of the designated centre during the absence of the person in charge on or after 31 March 2015. On 7 April 2015, inspectors were verbally informed that the Director of Care and Support was the person responsible for the designated centre. As outlined in outcome 14, inspectors found that the deputising arrangements were not suitable.

On 14 April 2015, the Regional Director of Care and Support verbally informed inspectors that a new person in charge had been appointed for this designated centre and would commence on 20 April 2015.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Based on observation, review of relevant documentation and interviews, inspectors concluded that there were inadequate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Due to a reliance on agency and bank staff (a panel of St. John of Gods staff who do not normally work in the specific unit) residents did not receive person centred continuity of care.

Records reviewed by inspectors found that there were gaps in the planned roster for the week commencing 13 April 2015 including a number of night shifts. However, Inspectors were informed that permanent, bank and agency staff would fill these gaps. Agency and bank staff could work alone at night-time even though risk assessments and behaviour support plans stated that residents should receive support from familiar staff.

Staff nurses with whom inspectors spoke outlined that they would have to contact a central allocations office when they came on duty to report that they required additional staff to facilitate activities. Inspectors observed delays in deploying staff where unexpected absences occurred. On 12 April 2015, the replacement staff member was not deployed for the 08:00 shift until 12:20. On 14 April 2015, senior management was not aware that agency housekeeping staff had not arrived for duty and there was a subsequent delay in their deployment. This led to some residents becoming visibly upset and distressed as they waited to receive their breakfast.

The rostered hours of kitchen staff did not meet residents' needs. For example, the rosters indicated that kitchen staff did not start work until 08:00 which meant that residents who wished to have porridge could not choose to take an early breakfast.

A training programme was in place for staff but, as previously outlined, records made available to inspectors indicated that some staff had not received mandatory training in the areas of safeguarding, positive behaviour support, fire safety and manual handling. Training records indicated that relevant staff had not received appropriate and adequate training to provide support for residents with specialist care needs.

All staff were not supervised appropriately to their role. On the days of the inspection staff were not aware of the change in the deputising arrangements for the person in charge. There was evidence of some formal supervision but it did not focus on improving practice and accountability.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in

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

Theme:

Use of Information

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

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

Findings:

As outlined in outcome 8, the policy for the provision of behavioural support, including the use of restrictive practices, had not been reviewed in the previous three years. As previously outlined, policies in relation to health and safety, food and nutrition and safeguarding were not implemented which had resulted in residents not being appropriately safeguarded and receiving care that is in line with evidence based practice.

As outlined in outcome 12, inspectors observed that medication administration sheets were left blank at a number of times where medication was due to be administered. Therefore, there was not a complete and accurate record of each medicine administered signed and dated by the nurse administering the medicines.

As outlined in outcome 11, records in relation to resident observations, oral intake and weight were not consistently and accurately completed. Records of food provided for residents did not contain sufficient detail to determine if the diet was satisfactory and if special or modified diets were adhered to.

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:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003008
Date of Inspection:	07, 08, 10, 12 and 14 April 2015
Date of response:	18 May 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 were placed inappropriately with residents who had diverse and complex needs including behavioural support living alongside residents whose activities of daily living and being could detrimentally impact on others.

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

Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is 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. One resident has transitioned from this Designated Centre to another Designated Centre on 14/04/15 to support a more spacious living environment.
2. As a Interim measure it is proposed to relocate a number of residents from this Designated Centre following the completion of their Individual Transitional Plans. These plans will be completed by the 18/06/2015
3. 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. It is envisaged that Phase 2 will identify temporary arrangements while the individual's transitioning plans can be completed. (31/07/2015)
4. A plan is in place on a daily basis to support residents engage in meaningful day activities.
5. All residents have been referred to the Positive Behaviour Support Sub Committee for the completion of a full Behaviour Support plan with a functional analysis of behaviours that challenge. A meeting to progress these referrals is taking place on 6/04/15.
6. A multi disciplinary review meeting took place for all residents within this Designated Centre on 17/04/15 with actions agreed.

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 were afforded little meaningful choice and control over their daily lives, including provision of healthcare, menu options and activities.

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. Circle Time has been introduced each morning to promote resident's choice in the context of their meaningful day activities.
2. Resident's House Meetings have commenced per house to promote greater involvement of residents in their living environment and to promote personal choice and greater control.
3. The Person In Charge is introducing Menu Planning twice weekly for residents to promote each residents involvement in meal choices.

4. Staff are using a number of mediums to convey communication supports to promote greater decision making and choice for residents. Each resident has a pocket of pictures showing activities on offer.
5. Key worker training will be provided for all staff (30/06/2015)

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

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

Residents were not afforded the opportunity to exercise their rights, including religious, communication and personal mobility.

Action Required:

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

1. Resident's House Meetings have commenced for each House to promote greater involvement of residents in their living environment and to promote personal choice and greater control and exercise rights.
2. Key Worker Training for all staff will be in place which will provide awareness to staff on their role in promote residents rights.
3. A rights assessment form will completed for each resident within this Designated Centre with the completion of a rights restrictions action plan which will be addressed through the Residents House Meetings and Staff Team Meetings.
4. Circle Time to be introduced at breakfast table utilising pictures relating to the events of the day and these are placed behind the breakfast table.
5. Staff are using a number of mediums to convey communication supports to promote greater decision making and choice for residents. Each resident has a pocket of pictures showing activities on offer

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

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

Residents' privacy and dignity was not respected in relation to personal living space and personal care.

Action Required:

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

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

1. The Person In Charge is exploring a range of options to address the identified need for additional space and the need to afford individual greater space.
2. One resident has transitioned from this Designated Centre to another Designated Centre on 14/04/15 to support a more spacious living environment.
3. As a Interim measure it is proposed to relocate a number of resident's from this Designated Centre following the completion of their Individual Transitional Plans, these plans will be completed by the 18/06/2015
4. 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. It is envisaged that Phase 2 will identify temporary arrangements while the individual's transitioning plans can be completed.
5. A review is taking place to relocate existing files to create more space within this Designated Centre by 30/05/2015

Proposed Timescale: 18/06/2015

Theme: Individualised Supports and Care

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

Limited storage space was provided for residents to store clothing and belongings.

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. One resident has transitioned from this Designated Centre to another Designated Centre on 14/04/15 to support a more spacious living environment.
2. On a short term basis it is proposed to relocate a number of residents from this Designated Centre following the completion of their Individual Transitional Plans these plans will be completed by 18/06/2015
3. A review of the safe storage of files in a different location to create additional space will be completed with actions agreed.

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 have opportunities to participate in activities external to the campus.

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. Weekly Meaningful Day Schedules are developed to maximise community participation for each residents in accordance with their choice and this is supported by the Quality Team in terms of practice development.
2. These schedules are reviewed at the end of each month which inform each resident's Social Assessment and in turn promote residents preferences and access to experience new activities.
3. Key Worker Training for all staff will be in place which will provide awareness to staff on their role in promoting meaningful day activities to include mainstream activities.

Proposed Timescale: 30/06/15 and ongoing

Proposed Timescale: 30/06/2015

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 layout and design of the premises did not promote residents' safety, dignity, independence and wellbeing.

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. One resident has transitioned from this Designated Centre to another Designated Centre on 14/04/15 to support a more spacious living environment.
2. On a short term basis it is proposed to relocate a number of resident's from this Designated Centre following the completion of their Individual Transitional Plans.
3. 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. It is envisaged that Phase 2 will identify temporary arrangements. The individual's transitioning plans will be completed by 18/06/2015
4. A multi - disciplinary review meeting took place for all residents within this Designated Centre and actioned accordingly.

5. A review of the safe storage of files in a different location to create additional space will be completed with actions agreed by 30/05/2015

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

Residents who required assistive equipment for moving and handling did not have it available to them which had a significant impact on their safety and quality of life

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:

1. Following this inspection a resident who required assistive equipment transitioned to a more spacious environment within another Designated Centre which addresses his mobility needs.
2. The Manual Handling Instructor has carried out a review and recommended assistive equipment for supporting residents who are at Risk of Falls and this will equipment is being sourced for purchase.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

The following were not provided in line with Schedule 6:

- adequate private and communal accommodation
- rooms of suitable size and layout for the needs of the residents
- adequate and suitable storage facilities
- adequate shower facilities.

Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

1. One resident has transitioned from this Designated Centre to another Designated Centre on 14/04/15 to support a more spacious living environment.
2. On a short term basis it is proposed to relocate a number of resident's from this Designated Centre following the completion of their Individual Transitional Plans.
3. 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. It is envisaged that Phase 2 will identify temporary arrangements. The individual's transitioning plans will be completed by 18/06/2015

4. A multi - disciplinary review meeting took place for all residents within this Designated Centre and actioned accordingly.

5. A review of the safe storage of files in a different location to create additional space will be completed by 30/05/2015

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:

A number of significant clinical risks and environmental risks had not been identified and assessed.

Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

1. A multi-disciplinary committee reviewed clinical and environmental risks for residents at a meeting of 17/04/2015.
2. Follow up reviews by individual clinician is under completion.
3. A risk register is in place for this Designated Centre and will be updated on an on-going basis.
4. The Risk Management Policy with identification of associated hazards will be completed by 8/05/15.
5. Training is taking place for all staff on Dysphagia, Food and Nutrition and risk management, meal time experience 30/06/2015
6. All staff attended a staff team meeting on 21/04/2015 where the Person In Charge reinforced identification and control measures to address clinical risks and environmental risks.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Adequate measures and actions were not in place to control the risks identified for example suitable staffing, appropriate equipment, guidelines and training.

Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

1. The Risk Management Policy for this Designated Centre will be completed by the 8/05/2015 and this include hazards identification with control measures contained within the Action Plan.
2. The Person In Charge will ensure that all staff have been inducted into this policy and action plan.
3. The Person In Charge will incorporate the Risk Management Action Plan within an Audit Schedule -30/06/2015. The outcome of this audit will advise appropriate control measures and these will be escalated as required.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Systems were not in place in the designated centre for the assessment, management and ongoing review of risk, for example after serious incidents or line with residents' changing needs.

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. A multi-disciplinary review for resident within this Designated Centre took place on 17/04/2015 and this meeting reviewed associated risks relating to resident's.
2. A review by appropriate clinician for residents at risk was agreed and is under completion -30/06/2015
3. Following this meeting a number of referrals have been made for Positive Behaviour Support Plans and Psychiatry assessments etc.
4. All high level risks are included in the Risk Management Policy and Action Plans which is reviewed by Person In Charge.
5. All staff will be inducted into the completed Risk Management Policy and local Action Plan by Person In Charge
6. A procedure for Clinical Decision Making relating to residents who require immediate medical follow up will be developed and all staff will be inducted into this to ensure the best possible outcome for the residents.
7. The On Call/Out of Hours system/procedure for medical assessment is being

reviewed to ensure that residents have access to Allied Health Care professionals on an appropriate timely basis. This procedure will be communicated to all staff within this Designated Centre on completion.

8. A Staff team meeting was convened on 21/04/2015 where the Person In Charge promoted consistency in recording keeping and implemented a new communication book. Staff team meetings chaired by the Person IN Charge will take place on a 4—6 weekly basis.

Proposed Timescale: 30/06/2015 and ongoing

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Inadequate measures, consistent with the standards for the prevention and control of healthcare associated infection published by the Authority, were in place to protect residents including:

- effective governance and management systems
- structures, system and process to prevent and control healthcare associated infection
- physical environment, facilities and resources
- hand hygiene
- prevention, management and control of the spread of healthcare associated infection.

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:

1. All staff will be re –orientated into the Saint John of God Infection Control Policies and Procedures which includes effective hand washing techniques to reduce the rates of healthcare associated infections and cross contamination. Staff will sign to state they have received and understood the policy and procedures.
2. An Infection Control audit will be carried out (30/05/2015) and the recommendation will be actioned and implemented by the Person In Charge (20/05/2015)
3. Individual Cleaning schedules has been developed for both Direct Support Staff and Housekeeping staff.
4. Clinical Nurse Specialist in Health Promotion attended staff team meeting on 21/03/15 to highlight the importance of Infection Control practice and re orientation to local Standard Operating Procedures.

5. Hand Hygiene wipes have been ordered to support residents as an alternative for residents who prefer this approach.

6. The Local Standard Operating Procedure on Infection Control will be reviewed and updated to assist in the management and planning of supports required for residents who present with Communicable Infections.

7. Food Hygiene training will be provided for all staff involved in serving of food within this Designated Centre - 30/06/2015

8. Following on from the Inspection residents who presenting with respiratory medical conditions have their own nebulisers which is stored in their own individual room.

9. A Cleaning schedule will be developed for Medical Equipment.

10. The Shift Leader template will be updated to include the completion of the Cleaning Schedule for Medical Equipment.

11. Medication Management Plan will be updated (30/04/2015) and reviewed as required for one resident regarding appropriate use of eye drop medication.

Proposed Timescale: 30/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

It was not always possible for staff to implement the strategies outlined in plans.

There was no evidence that agency staff had read and were familiar with these plans in order to provide consistent support.

Action Required:

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

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

1. The staff team for this Designated Centre is ring fenced to provide greater continuity of care to residents.
2. All staff are inducted into each residents Critical Information Sheet and their overall plan.
3. A shift leader is in place in the absence of Manager to ensure any new staff is fully

inducted into the Designated centre.

4. This Designated Centre will have access to all regular staff following the commencement of new appointments resulting from a recruitment campaign.

Proposed Timescale: 25/05/2015

Theme: Safe Services

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

None of the regular staff had been trained in managing behaviour that is challenging.

Action Required:

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

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

1. All staff will be re-orientated into the Policy on Behaviours that Challenge and staff will sign off that they have read and understood this.
2. Behavioural recording forms which include ABC/scatterplots will be completed for all residents who present with Behaviours that Challenge while being reviewed with the positive behaviour support sub committee.
3. All residents have been referred to the Positive Behaviour Support Sub Committee for a full Behaviour review including functional analysis of behaviour and a Behaviour Intervention Plan.
4. A Meeting to discuss these referrals with the Sub Committee is taking place on 6/05/15.
5. All staff will complete a one day training session on Positive Behaviour Management Supports -31/07/2015
6. All staff are fully inducted in each residents existing Behaviour Support Plan.

Proposed Timescale: 31/07/2015

Theme: Safe Services

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

Environmental restraint, in the form of locking a unit, was used to facilitate staff change-over in periods of short staffing.

Action Required:

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

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

1. Staff levels was reviewed and increased to provide appropriate supports to residents at night time.
2. All restrictive practices for residents are applied in accordance with national policy and reviewed through the Governance of Restrictive Intervention Committee.

Proposed Timescale: 30/04/2015 and ongoing

Proposed Timescale: 30/04/2015

Theme: Safe Services

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

The policy and procedures for the prevention, detection and response to abuse were not adequate to protect residents from abuse.

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:

1. Staff within this Designated Centre have completed Safeguarding Training
2. All staff will be re-orientated into the local Standard Operating Procedure on Safeguarding.
3. A dedicated Deputy Designated Liaison Person has been appointed to support the appropriate management of safeguarding residents within this Designated Centre.
4. A full review of the Safeguarding system, process and procedure is being facilitated by an external consultant expert in the area of Safeguarding. All recommendations will be actioned and prioritised for implementation. Terms of reference for this review has been agreed

Proposed Timescale: 30/06/2015

Theme: Safe Services

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

An alleged incident of physical assault on a resident was not managed and investigated in a timely manner in order to safeguard all residents.

Staff were not clear on the reporting procedure for allegations, suspicions and disclosures of abuse.

Incidents of injury and harm between peers, such as hitting out and biting, were not analysed as to underlying cause

Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or

suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

1. Staff within this Designated Centre have completed Safeguarding Training
2. All staff will be re-orientated into the local Standard Operating Procedure on Safeguarding.
3. A dedicated Deputy Designated Liaison Person has been appointed to support the appropriate management of safeguarding residents within this Designated Centre.
4. A full review of the Safeguarding system, process and procedure is being facilitated by an external consultant expert in the area of Safeguarding. All recommendations will be actioned and prioritised for implementation. Terms of reference for this review has been agreed.
5. The findings from the Provider Investigation Report relating to an allegation of physical assault has been actioned and being implemented.

Proposed Timescale: 30/06/2015

Theme: Safe Services

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

There were gaps in training for staff and agency staff in understanding abuse as it pertains to adults with disability.

Action Required:

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

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

1. Staff within this Designated Centre has completed Safeguarding Training.
2. All staff will be re-orientated into the local Standard Operating Procedure on Safeguarding.
3. A dedicated Deputy Designated Liaison Person has been appointed to support the appropriate management of safeguarding residents within this Designated Centre.
4. A full review of the Safeguarding system, process and procedure is being facilitated by an external consultant expert in the area of Safeguarding. All recommendations will be actioned and prioritised for implementation. Terms of reference for this review has been agreed

Proposed Timescale: 30/06/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Staff did not have clear guidance, for example in the form of a clinical decision making tool, to ensure that an appropriate level of health care is provided and, if required a safe transfer or discharge is arranged, in response to clinical deterioration or changing need.

Residents were not provided with an adequate and appropriate level of health care, in line with their assessed needs as outlined in the personal plan.

Personal plans in relation to epilepsy, constipation and nutrition and falls were not implemented and did not contain sufficient information to guide staff in the provision of appropriate health care for residents.

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:

1. A procedure for Clinical Decision Making relating to residents who require immediate medical follow up will be developed and all staff will be inducted into this to ensure that possible outcome for the residents.
2. The On Call/Out of Hours system/procedure for medical assessment is being reviewed to ensure that residents have access to Allied Health Care professionals on an appropriate timely basis. This procedure will be communicated to all staff within this Designated Centre on completion.
3. The Clinical Nurse Specialist in Health Promotion met with all staff on 21/04/15 within this Designated Centre and introduced a new Epilepsy Template for completion for all residents as appropriate.
4. All residents who presents with Epilepsy will be referred to Dr Norman Delanty, Beaumont Hospital for review.
5. The Clinical Nurse Specialist Health Promotion is introducing a template for management of constipation and nutrition in consultation with the Dietician and Speech and Language Therapist.
6. All residents were reviewed by the Dietician and Speech and Language Therapist as appropriate.
7. A meeting relating to fortifying of food at source and 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.
8. A meeting will be convened to review the service prescribing of laxatives for residents and actions will be prioritised and actioned.
9. A multi-disciplinary meeting took place on 17/04/15 to review all residents within this Designated Centre and actions agreed.
10. All residents as required were reviewed by the Psychotherapist and falls risk assessments were carried and are being actioned. Investigation assessments are carried out for residents post falls and actions completed.
11. All residents who required Occupational Therapist reviews were prioritised for same.

12. Manual Handling Instructors reviewed residents at risk of falls and has made recommendations to support safe practice.
13. All residents Personal Plans will be updated to reflect changes in healthcare needs following on from the multi-disciplinary reviews.
14. A seated weighing scales is in place for the Designated Centre following the Inspection and all residents have been weighed according to best practice.
15. Fluid intake charts have been introduced for residents as appropriate.

Proposed Timescale: 30/06/2015

Theme: Health and Development

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

A meaningful choice in relation to medical practitioner is not provided for residents.

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. A full review of access to medical practitioner of choice for residents will be completed and actioned.

Proposed Timescale: 30/08/2015

Theme: Health and Development

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

Medical treatments, such as medications and prescribed nutritional supplements, were not always ordered in a timely fashion.

Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

1. A review to ensure appropriate access to medications and prescribed nutritional supplements for residents will be completed and actioned.
2. As an interim basis links have been made with local pharmacy to support appropriate access to medication and prescribed nutritional supplements.
3. Communication to all managers and staff by Director of Care and Support has taken place to reinforce the significance of securing medication and nutritional supplements on a timely basis.

Proposed Timescale: 05/05/2015

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 independently prepare meals and snacks.

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. Discussions are taking place with Senior Environmental Health Officer to review the protocols which would support residents cooking and preparing their own meals and all actions will be prioritised.

Proposed Timescale: 30/06/2015

Theme: Health and Development

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

Adequate, additional and accessible supplies of food and snacks were not provided at unit level and there were limited options of snacks for residents who required modified consistency diets.

Action Required:

Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

1. Additional and adequate supplies of food and snacks will be provided for all residents including residents with modified consistency diets. New menu plans will be drawn up and offered to residents.

2. A meeting relating to fortifying of food at source and 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 menu choices is being undertaken and will be actioned.

3. The Person In Charge will complete audits to ensure that adequate supplies of food and snacks are in place within this Designated Centre.

Proposed Timescale: 30/06/2015

Theme: Health and Development

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

A meaningful choice at mealtimes was not provided to residents.

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. The Person In Charge in consultation with the Clinical Nurse Specialist in Health Promotion is setting up a menu planner in the Kitchens within the Designated Centre which will promote greater individual choice for residents.
2. An educational session for staff on meal time experience which will include food choice at meal times will be completed by a member of the Quality Team – 30/06/2015

Proposed Timescale: 30/06/2015

Theme: Health and Development

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

Recommendations from allied healthcare professionals in relation to food and drink options were not implemented in line with each resident's individual dietary needs.

Action Required:

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

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

1. Each residents Eating and Drinking Plans will be reviewed and all staff will sign off to confirm that they understand each plan.
2. Staff will complete training in Dysphagia and Food and Nutrition and Meal Time experience.
3. The Person In Charge will supervise meal time experience as part of an audit to ensure meal are consistent with resident's individual dietary needs and preferences.

Proposed Timescale: 30/06/2015

Theme: Health and Development

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

Inadequate staffing levels at mealtimes resulted in residents not receiving appropriate assistance with eating or drinking.

Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

1. Protected time will be introduced to support a good quality person centred meal time experience.
2. Training will take place for staff on creating a meal time experience and on food and nutrition.
3. As part of the Pilot Project for this Designated Centre all rostering arrangements will be reviewed in the context of identifying residents assessed needs/skill mix of staff to support these needs and promotion of an appropriate model of service 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:

A meaningful choice of pharmacist was not provided to residents.

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:

A full review of access to Individual pharmacy of choice for residents will be completed and actioned.

Proposed Timescale: 31/05/2015

Theme: Health and Development

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

Resident-specific management plans for the treatment of status epilepticus did not always contain sufficient information to effectively guide staff.

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:

1. The Clinical Nurse Specialist in Health Promotion met with all staff on 21/04/15 within this Designated Centre and introduced a new Epilepsy Template for completion for all residents as appropriate. Within this template there is specific reference to the emergency management of the seizure, e.g. rescue medication, oxygen administration and contact with emergency services.
2. All residents who presents with Epilepsy will be referred to Dr Norman Delanty, Beaumont Hospital for review.
3. All staff will be re-orientated into the Person Centred Medication Management Policy.

Proposed Timescale: 13/05/2015

Theme: Health and Development

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

Medications were repackaged into outer containers which indicated that the medicine contained within had expired.

Action Required:

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

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

1. Re-orientation has taken place and will continue to place for all staff on Medication Policy and procedure to ensure practices are safe and in line with the overall Corporate Medication Policy.
2. Medication audit will take place for this Designated Centre and the actions will be prioritised – 30/06/2015
3. Medication plans for each resident will be reviewed and actioned accordingly.

Proposed Timescale: 30/06/2015

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 deputising arrangements for the person in charge were not suitable.

Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

1. A new Person In Charge has been appointed on 20/04/2015 who is supernumary and she is supported by the Clinical Nurse Manager.

Proposed Timescale: 20/04/2015

Theme: Leadership, Governance and Management

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

Inspectors found that staff were not aware of who was in charge of the centre and who they would report concerns about resident welfare, accidents and incidents

Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

1. A newly appointed Person In Charge commenced on 20/04/15 and this has been communicated to all staff within this Designated Centre.

Proposed Timescale: 30/04/2015

Theme: Leadership, Governance and Management

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

Governance and management systems did not support staff to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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:

1. A newly appointed Person In Charge commenced on 20/04/2015 and this has been communicated to all staff.

2. The Person In Charge facilitated a meeting with the staff team on the 21/04/2015.
3. A Governance arrangement has been put in place which includes a weekly meeting of the Person In Charge with the Director of Care and Support, member of Staff team focussing on progressing the Quality Improvement Plan for the Designated Centre.
4. Along side this, a weekly meeting of all Person In Charge and Director of Care and Support takes place which reports to Strategic Management Team which includes the Provider Nominee and Regional Director.
5. A review is taking place of decision making process and structures

Proposed Timescale: 13/05/2015

Theme: Leadership, Governance and Management

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

The complex and multilayered structure of the local management team did not allow for effective governance, operational management and administration of the designated centre.

The lines of accountability for decision making and responsibility for the delivery of services to residents were unclear.

Action Required:

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

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

1. A newly appointed Person In Charge commenced on 20/04/2015 and this has been communicated to all staff.
2. The Person In Charge facilitated a meeting with the staff team on the 21/04/2015.
3. A Governance arrangement has been put in place which includes a weekly meeting of the Person In Charge with the Director of Care and Support, member of Staff team focussing on progressing the Quality Improvement Plan for the Designated Centre.
4. Along side this, a weekly meeting of all Person In Charge and Director of Care and Support takes place which reports to Strategic Management Team which includes the Provider Nominee and Regional Director.
5. A review is taking place of decision making process and structures with clear lines of communication to be agreed.

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Proposed Timescale: 13/05/2015

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

A written notification had not been made to the Chief Inspector of the procedures and arrangements that would be in place for the management of the designated centre during the absence of the person in charge on or after 31 March 2015.

Action Required:

Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

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

1. A newly appointed Person In Charge commenced on 20/04/15 and this has been communicated to the Authority.
2. A NF30 was completed and forwarded to the Authority.

Proposed Timescale: 30/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was inadequate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services which resulted in negative outcomes for residents.

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:

1. The staff team for this Designated Centre has been ring fenced to provide greater continuity of care.
2. A review of staffing for this Designated Centre is underway to identify the Individual staffing needs, skill mix for each Individual house which will form part of a Pilot Project with Terms of Reference finalised on 27/03/2015.
3. A recruitment campaign is underway to introduce regular staff with full Induction for all new appointments taking place on week commencing 18/05/15 and week commencing 25/05/15.
4. This Designated Centre has reduced its residents numbers with one resident moving to another Designated Centre on 14/04/15.
5. A full time Person In Charge has been appointed to this Designated Centre who is supernunnary to provide appropriate support and supervision.

6. The Clinical Nurse Manager has twelve hours supernumary time to support the staff team.

Proposed Timescale: 25/05/2015

Theme: Responsive Workforce

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

Due to a reliance on agency and bank staff, residents did not receive continuity of care and this had led to negative outcomes for residents.

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:

1. The staff team for this Designated Centre has been ring fenced to provide greater continuity of care.
2. A review of staffing for this Designated Centre is underway to identify the Individual staffing needs of each Individual house 30/06/2015
3. A recruitment campaign is underway to introduce regular staff with full Induction for all new appointments taking place on week commencing 18/05/15 and week commencing 25/05/15.
4. A regular full time permanent nurse has been appointed since the Inspection visit.

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:

Staff had not received mandatory training and received appropriate and adequate training to provide support for residents with specialist care needs.

Action Required:

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

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

1. A schedule is in place to ensure all staff from this Designated Centre will have completed their mandatory training .
2. Staff have received Fire Training, Epilepsy Management Training, Safeguarding Training.

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

A number of policies were not implemented including health and safety, risk management, food and nutrition and safeguarding.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. A staff meeting took place on 21/04/15 and the Person In Charge reinforced the significance of implementing all Standard Operating Procedures/ Corporate Policies.
2. All staff will be re-orientated into all relevant local Standard Operating Procedures/ Corporate Policies by Person In Charge
3. Staff from this Designated Centre have received Safeguarding Training
4. Additional Training on Nutrition and Record Keeping facilitated by Dietician will be completed for staff in this Designated Centre.

Proposed Timescale: 31/05/2015

Theme: Use of Information

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

The policy for the provision of behavioural support, including the use of restrictive practices, had not been reviewed in the previous three years.

Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

1. The Policy for management of Positive Behaviour Supports has been reviewed and is in draft format and is awaiting approval from the Board of Saint John of God Limited.

Proposed Timescale: 31/07/2015

Theme: Use of Information

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

Records of food provided for residents did not contain sufficient detail to determine if the diet was satisfactory and if special or modified diets were adhered to.

Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

1. The Dietician has completed review of all residents within this Designated Centre following the Inspection.
2. The Dietician is providing training for all staff on Food and Nutrition which includes best practice food and nutrition recording charts.
3. The Person In Charge will complete an audit to ensure sufficient records are maintained and modified diets are adhered to and action appropriately

Proposed Timescale: 30/06/2015

Theme: Use of Information

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

Medication administration sheets were left blank at a number of times where medication was due to be administered.

Records in relation to resident observations, oral intake and weight were not consistently and accurately completed.

Action Required:

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

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

1. Re-orientation has taken place and will continue to take place for all staff on Medication Policy and procedure to ensure practices are safe and in line with overall Corporate Medication Policy.
2. Medication audit will take place for this Designated Centre and the actions will be prioritised.
3. Medication plans for each resident will be reviewed and actioned accordingly.
4. As part of a staff team meeting on 21/04/15 the Person In Charge re-inducted staff into a number of records keeping forms including oral intake and weights charts.

Proposed Timescale: 31/07/2015