Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Ltd
Centre ID:	ORG-0011513
Centre county:	Louth
Email address:	Turlach.king@sjog.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Ltd
Provider Nominee:	John Pepper
Person in charge:	Turlach King
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Day 1: Sonia McCague, Day 2: Jillian Connolly
Type of inspection	Unannounced
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	2

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times

From:	To:
14 May 2014 09:00	14 May 2014 16:00
15 May 2014 09:30	15 May 2014 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 17: Workforce

Summary of findings from this inspection

This was the first monitoring assessment of the designated centre which is part of the larger voluntary organisation, St. John of God's Community Services. The inspection took place over two days. The designated centre consists of eight residences which are based in community settings. The designated centre can provide services for 49 residents. There were 47 residents residing in the designated centre on the day of inspection.

Inspectors met with the person in charge who had responsibility for the eight community houses at the beginning of the inspection and provided feedback to the management team on the conclusion of the inspection.

Inspectors observed practice, assessed the premises, reviewed documentation and spoke with residents, some family members and staff over the days of this inspection. The designated centre provides services for individuals with a diagnosis of a moderate to severe intellectual disability.

Residents spoken to stated that they were happy and felt safe. They confirmed that they enjoyed their life in a community living setting. Many residents transferred from the main campus and there was evidence of good transitional support provided. Residents stated that they were satisfied with the staff caring and supporting them.

Residents demonstrated knowledge of the operation of the designated centre, including the complaints process and emergency procedures.

Staff spoken to demonstrated comprehensive knowledge of the residents and their needs. Staff spoken with by inspectors emphasised the importance of promoting a social care model of care and support which embraced the concept of each resident being enabled to exercise choice and control over their lives in accordance with their preferences and maximising their independence. The inspectors found many examples which evidenced this philosophy of care however, inspectors also found that not all residents could maximise the quality of their lives to its potential due to constraints imposed by staffing and to a lesser extent issues with the premises they lived in.

Improvements were required in all outcomes reviewed on this inspection. Areas requiring improvement included privacy and dignity issues for some residents, risk management, fire safety procedures, social care needs of residents, staffing, premises, medication management procedures and the statement of purpose.

The location of all community houses met the needs of residents however, the design and layout of some community house premises required review to ensure they were suitable for their stated purpose. The health and safety of residents, visitors and staff was promoted and protected as staff were in the main observant in identifying, analysing and controlling risks. However, a number of risks were not identified and assessed in a risk register.

Inspectors found evidence that staffing deployment arrangements were not adequate to meet the assessed social needs of some residents in the absence of a structured day programme and a review of the adequacy of having one staff on duty for periods during the day and throughout night duty was required.

The action plan at the end of the report identifies actions which the provider and person in charge will need to take to come into 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.

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 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

Judgement:
Non Compliant - Moderate

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

Findings:
This outcome was not fully reviewed by inspectors on this inspection. Inspectors observed some good practices that preserved and promoted residents rights and dignity however, improvements were required in some areas order to be fully compliant with the Health Act 2007 (Care and Support of residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Inspectors observed staff, for the most part, engaging with residents in a manner that was respectful. Many staff spoken with told inspectors that they had worked with in the service for many years and inspectors found that they were very familiar with the residents' needs, capabilities, their life history and family support circles.

On the day of inspection the inspectors observed staff members knocking on doors before entering and were careful to obtain residents permission before entering their bedrooms. Pre-planning for inspection by staff involved asking residents for permission for inspectors to view their rooms and care documentation in their absence due to attendance at day programmes. Some twin bedrooms required review to ensure residents were afforded privacy which may be negatively impacted upon due to floor space restrictions including use of an appropriate screen to place between them which was not readily available on the days of inspection if needed. Not all residents had access to a room where they could receive visitors in private other than their bedrooms some of which were not adequate for this purpose due to size and layout restrictions.

The inspectors noted that most residents had their rooms personalised with photographs of families and friends and had their interests reflected in their rooms, their rooms were nicely painted complete with curtains or blinds. Some bedrooms did not have curtains

fitted which inspectors were told was as a result of the expressed wish of residents and was respected. There was evidence that efforts were made to find suitable alternatives to the satisfaction of the residents concerned. However adhesive vision occlusive material placed on the window of one resident's bedroom severely obstructed this resident's view out of the window.

Residents' bedroom furniture was mostly of a good standard. Many of the residents slept on double beds and inspectors were told that residents' purchased their own bedroom furniture. However, residents in some houses had limited communal or bedroom space available to them to have the choice of a double bed and had limited personal bedroom space. This finding is discussed in outcome 6 of this report.

Two residents did not have adequate wardrobe space to accommodate their clothing, in the absence of sufficient resident monies; the provision of additional wardrobe space was not progressed.

Listening devices were observed in a number of residents' bedrooms, some were in place as a listening device for night-time use, particularly in community houses where only one staff member was on-duty. Inspectors were informed that some were no longer needed or used but were still insitu. These devices infringed on residents' right to privacy in their bedrooms.

Access to a staff office was gained through one resident's bedroom. This finding did not promote this resident's right to privacy in his bedroom. An office desk and equipment for sole use of staff was located in the corner of a kitchen in another community house,

There were assessments relating to the social needs of each individual however, however these were not translated in practice for a number of residents. For example not all residents had access to a day programme to meet their recreational and occupational needs. As many residents did not have access to a day programme they remained in the community houses during the day. Their freedom to exercise choice and control in their daily life or to engage in 1:1 meaningful therapeutic activities was negatively impacted upon by the numbers of staff available in some community houses while other residents in the community houses went to their activation programmes accompanied by staff. In addition staff availability to engage with and supervise residents was also negatively impacted upon by their requirement to complete residents' laundry, cleaning of community houses and to prepare varied and nutritional meals for residents throughout the day. This finding is discussed further in outcome 17 in this report.

Access to advocacy and complaints were not inspected against thoroughly during the inspection, there was a complaints policy in place.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

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

Findings:
The designated centre accommodates 47 residents who have a diagnosis of moderate to severe intellectual disability and four residents were assessed as having dementia. While there were a number of risk assessments carried out including the dependency level of residents there was no guidance regarding the interpretation of the assessed level and some of the assessment forms were not signed and dated.

Each resident had an Individual Personal Plan which referenced assessments completed and identified the arrangements in place to meet their needs. The personal care plans were developed in respect of each individuals care and addressed key aspects of the social, emotional, psychological and health care needs of the residents. Many residents' aspirations and goals for themselves were stated in addition to evidence that residents were empowered and supported in achieving their personal goals, which many did successfully. However, some residents' specific goals for themselves were not clear and as such this information was not fully utilised to ensure positive outcomes for residents. The inspectors discussed the value of applying SMART (specific, measurable, appropriate, realistic and timely) criteria to improve the process of goal setting with residents.

Residents' personal plans were updated annually, some residents' plans were not reviewed to inform whether a personal goal was achieved or reassessment was required. There was evidence of consultation with residents in their personal plan development however, consultation where they lacked capacity, with their significant others was not always clearly stated. For example documentation did not confirm consultation with the family of a resident requiring intermittent wearing of protective clothing which restricted this resident's personal freedom. Another resident's personal plan was signed as having been with the agreement of a resident however inspectors were told that the document was signed by another on behalf of the resident. Staff in their communications with the inspectors demonstrated that they were knowledgeable of residents' needs and there was evidence of behaviour management plans and risk

assessments in respect of residents' daily living routines such as using the stairs in two storey houses and travelling by bus. Inspectors saw that residents' communication needs were identified in the residents' personal care plan with appropriate assistive aides implemented, for example the use of pictorial aids. However one resident was observed by inspectors communicating by signing however, translation was not documented detailing the meaning of the signals. While staff could interpret same without difficulty, the absence of reference details hindered others communicating effectively with this resident.

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

Judgement:
Non Compliant - Moderate

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

Findings:
Overall, some houses were well maintained and recently decorated, however, inspectors found inconsistency in the suitability of design and layout of the houses in meeting their stated purpose.

Following inspection of this designated centre's community houses, Inspectors were of the view that while most residents had good personal space available to them, restricted space in a number of bedrooms occupied by residents in some houses may negatively impede the capability of individuals residing there with reduced dexterity or need to use support equipment and/or mobility aides. While most community houses generally met their stated purpose one house in particular occupied by residents required a full review in terms of suitability of layout and design including individual and communal space available, to ensure it met the needs of residents living there. The size and layout of some single bedrooms occupied and used by residents throughout this particular house were inadequate and did not facilitate adequate space for basic bedroom furnishings and lighting. For example, some residents did not have adequate space for a locker by their bedside or a chair, if they wished to have one or wished to meet with their visitors in their bedrooms. Many residents did not have access to a bedside lamp which necessitated their use of the main light in their bedrooms as their only choice option. A resident in one house had a television inappropriately placed in a storage unit in the bedroom which was being viewed at very close range due to lack of space.

Due to the close proximity of beds in some twin rooms the ability of the residents residing there to undertake personal activities in private may also be compromised. Behaviours exhibited by some residents or persons visiting may impact on those residing within some twin bedrooms. Inspectors were told that twin rooms were undergoing review with a plan to reduce them to single accommodation where feasible.

While residents had access to a bathroom and a small number of bedrooms had en-suite facilities, one resident's en-suite facility was the only toilet available to residents on the ground floor in one community house and as such was used by other residents during the day. A second toilet was located on the ground floor but was used by staff and contained the personal belongings of staff including items of clothing. The inspectors were told this toilet was for staff use only. This finding directly impacted on the comfort and privacy of the resident concerned living in this accommodation. Not all residents' bedrooms had sinks fitted in them.

There was a multi-adapter inserted in an electrical socket behind a television in one communal sitting-room supplying electricity to a number of electrical items connected to it. This was not risk-assessed to ensure suitability or to mitigate the level of fire risk it posed. A number of over wash-basin lights in showers/bathrooms were not in place and the redundant electrical wiring supply was visible with ends covered by insulation tape. Door self-closing units were found to be very tight in some areas which may pose a difficulty with opening for some less able residents.

The layout of some houses did not enable residents to meet visitors in private or to have an area to spend time alone other than in their bedrooms.

Residents' bedroom furniture was mostly of a good standard. Many of the residents slept on double beds and inspectors were told that residents' purchased their own bedroom furniture. However, residents in some houses had limited communal or bedroom space available to them to have the choice of a double bed. This finding is discussed in outcome 1 of this report.

One resident's bedroom window had restricted views due to an adhesive vision restrictor placed over the majority of the window glass. Inspectors were told this was to promote the resident's privacy as the resident concerned did not wish to have window curtains fitted. However, the extent of window glass occlusion required review to ensure there was balance with meeting privacy needs and facilitating a reasonable view out for this resident. The resident concerned had engaged in removing part of the adhesive vision restrictor material. This is also discussed in outcome 1.

Natural or mechanical ventilation in showers in one community house was absent.

There was an issue of large cracks appearing in the wall of a bathroom in one house, inspectors were told that this was due to building subsidence however, there were no definitive plans in place to address this issue.

Many bathrooms, shower rooms and toilets required upgrading. Inspectors found that tiles were chipped or loose; paint work was damaged in some areas and in need of repair. Rust was prevalent on surfaces in some of these facilities, and there were a large

number of toilets that had no toilet roll holders, no hand towels dispensers or appropriate waste bins.

Some carpeting on bedroom flooring was stained and required cleaning.

External grounds of some of the houses required maintenance. The surfaces on the driveway and the area in front of some houses required resurfacing as it was uneven and pot-holed. The roadway surface to one house was heavily pot-holed and was reported to inspectors as having a direct negative impact on the health of one resident. Some grass and shrubbery areas were overgrown and in need of attention.

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

Theme:
Effective Services

Judgement:
Non Compliant - Major

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

Findings:
A system for responding to emergencies was in place, however, a health and safety statement specific to the centre had yet to be finalised.

While the risk management policy was in draft format, the inspectors found that the health and safety of residents, visitors and staff was promoted and protected. However, a local risk register specific to each house was not maintained and for this reason, many individual and environmental risks were either partially, or had not been identified with controls to mitigate risks established. Examples of unassessed risks found by inspectors included lack of handrails on steps in some areas, unsecured doors to cleaning chemicals, access to bottles of hand hygiene gel placed on surfaces around houses, sloping ground or uneven external grounds and security of the medication keys (discussed further in Outcome 12).

The centre has a policy in place for the prevention and control of infection. Staff informed inspectors of the systems in place to ensure that laundry was washed at appropriate temperatures and soiled laundry management was adequate. There were inconsistencies in the facilities available for staff hand hygiene. There was use of open bins for disposed hand towels. Not all toilets had bins for disposal of sanitary wear in areas where females were accommodated. Access to personal protective equipment required assessment to ensure it was readily available but did not pose a risk to residents' safety. Toilet rolls were not protected from excessive handling due to an absence of toilet roll holders in some toilets. Inspectors noted storage of toiletries and dental hygiene equipment on shelves in some communal toilet/washing areas which

posed a risk of communal use and cross infection. Carpets were stained in some areas. While some staff had personal hand hygiene gel dispensers, bottles of hand hygiene gel for communal use were not fitted in dispenser units. This practice hindered assessment and monitoring to ensure sufficient supply. It also posed an ingestion risk to vulnerable persons in the houses.

Overall, inspectors concluded from evidence of findings that while fire evacuation procedures were in place, this area required further planning and review to ensure safety of residents and others was optimised in the event of a fire occurring in any of the houses. There was evidence that fire drills were conducted at appropriate intervals within the houses in the designated centre and each resident has an individual evacuation plan informing staff of the supports residents require in the event of an emergency. These evacuation plans identified potential compliance issues and identified support plans to ensure timely evacuation would be achieved. However, the documented fire evacuation plan was found to be generic and did not take into account the differing layout of houses or varying staffing levels in each. Inspectors found that there were periods when there was only one member of staff in the centre throughout the day and night. This was not assessed or reviewed to determine the specific procedures to be followed should a fire occur in any of the houses. Some residents spoken with told the inspector what they were informed to do in the event of a fire in the centre which was appropriate.

Fire equipment was easily accessible and prominently placed throughout the designated centre and servicing was up to date. Throughout the inspection of the houses in the designated centre, inspectors observed areas of risk relating to fire evacuation routes. Inspectors observed the absence of break glass units at some fire exits locked by a key. Obstruction of designated fire exit doors by various items of furniture or equipment was also found. In addition, a back yard of one centre was totally enclosed by a wall effectively trapping any person who entered this area in the event of a fire. A fire panel was not in place in all houses. A smoke detector alarm in one house was not functioning.

Residents described to the inspectors what to do in the event of the fire alarm sounding and staff training in fire safety, basic life support, manual handling and techniques in managing aggression and violence was provided and with refresher courses ongoing. Inspectors observed staff assisting residents and found that the manual handling practices of staff were satisfactory.

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

Judgement:
Non Compliant - Minor

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

Findings:
This outcome was partially reviewed on this inspection. The designated centre has a policy and procedure in place relating to the prevention, detection and response to an allegation or suspicion of abuse. Use of an intermittent restrictive intervention for a resident was reviewed and found to be adequately described in a positive behaviour plan. Authorisation of this restrictive intervention was completed and documented in the register of restrictive interventions was completed. A reduction in the use of restrictive interventions was evident however there was room for further improvement with the implementation of proactive strategies. For example, the pot-holed road triggered a resident to have episodes of significant anxiety requiring psychotropic medication following travel on this surface.

The inspectors reviewed the systems in place regarding positive behavioural support plans and found that staff had access to specialist and therapeutic interventions.

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
From an examination of documentation and the views of residents and staff it was evident that residents are supported on an individual basis to achieve and enjoy good health. There was a health care plan available in each resident's care planning documentation. Residents' healthcare needs were well monitored and treatments were implemented as recommended or prescribed. Inspectors were told that some residents had chronic health conditions such as epilepsy and diabetes. The inspector was informed that 20 residents had a diagnosis of epilepsy. Staff used baby monitors to alert them to residents experiencing seizure activity at night. Inspectors were not satisfied that uses of these units were adequately assessed to ensure the privacy and dignity of residents was not compromised. This finding is discussed further under outcome 1.

There was evidence that there were services and supports in place to assist these residents. Referrals and meetings with key significant personnel in the lives of residents including behavioural therapy, occupational therapy, community medical, nursing, care staff, key workers and family members was in place. A behavioural therapist and psychologist were also available to assist/support residents and care staff.
There were inconsistencies in use of pain assessment documentation. Inspectors found a lack of clarity in the assessment tool as it did not include a protocol regarding appropriative and timely pain relief to residents.

There was evidence of appropriate referrals and appointments to residents' GPs and allied health professionals such as, opticians and speech and language therapists as required. However, not all care plans were up to date, for example a resident who had lost weight and was commenced on a care plan informed by a review by the dietician with interventions to promote weight gain was having monthly weight assessments completed. There was no evidence of weight increase but care plan was not reviewed in response to this.

Inspectors observed residents mealtimes in some of the houses within the designated centre. Meals were noted to be varied, provided choice and were provided at times suitable to the residents. Residents with swallowing difficulties were provided with soft consistency dishes. Snacks and fruit bowls in the kitchens were available to residents to support intake at mealtimes. Residents' records showed that their weights were monitored. Salads were prepared in most houses to provide a balanced nutritional intake for residents. Many residents required assistance with eating and this was provided with sensitivity and patience. Some houses had pictorial menu cards on tables to inform residents about the dish options available to them.

A care plan was reviewed for management of challenging behaviour by one resident; inspectors noted that the daily record referenced several episodes of behaviour that challenged. However, there was no detail included to inform what interventions were effective. This lack of detail hindered adequate update of the behavioural support plan with documentation of effective strategies two months later on the 12 May 2014.

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

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
There was a written operational policy informing ordering, prescribing, storing and administration of medicines to residents. A system was in place for reviewing and monitoring safe medication management practices.

Individual medication prescription and administration records did not adequately reference whether any residents had a medication allergy. Inspectors also found that all nurses had a copy of the medication trolley lock key which staff told the inspector they kept on their person both on and off duty. This finding is not in compliance with professional or legislation.

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

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Moderate

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

Findings:
While there was a statement of purpose available which described the services, facilities and care provided to meet the diverse needs of residents and which contained, most of the information required as set out in schedule 1 of the legislation. However, a number of areas required review to ensure the details of the service provided was accurately stated. A copy of the revised statement of purpose must be forwarded to the Chief Inspector.

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

Judgement:
Non Compliant - Moderate

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

Findings:
Inspectors found staff to have a comprehensive knowledge of the residents likes, dislikes and life history. Staff throughout the two day inspection were helpful and responded to some of the non compliances with the legislation as they arose. Inspectors viewed copies of planned rosters for all houses. Inspectors found that staffing arrangements required comprehensive review to reflect the service and the needs of residents the centre is able to meet in respect of each house. Arrangements were in place to manage planned and unplanned staff leave. However, there was evidence of some staff on rosters in two houses for the same day. Inspectors were told that this was to reflect their responsibility to provide on-call cover in one or more houses while part of the staffing numbers in another. Attendance by the person in charge in the community houses was not recorded on the duty rosters.

In addition actual rosters did not reflect the finding that staff were often shared between units, and floaters or staff who left the designated centre to assist and relieve staff in other areas for breaks or where there may have been a medical emergency were not indicated on the roster. Due to the unrepresentative nature of the staff rosters, It was not possible to conclude whether staffing levels were adequate to meet all needs of all residents as a validated dependency tool to assess residents' level of need was not used by the organisation to determine this. Inspectors found that a single staff member was rostered for prolonged periods during the day with responsibility for care of two to three residents without on-site support should an incident or emergency occur. Inspectors also observed that while acknowledgement was made that the centre was promoting a social model of care, residents could not be afforded engagement in 1:1 or communal activities during these periods as staff skilled in caring were also tasked with responsibility for providing residents' meals, completing cleaning of the house and laundry duties for residents. Most houses had one staff member also rostered with responsibility for all residents on night duty.

Staff files were not inspected on this inspection.

Training records were not reviewed in detail during the inspection. However, training records seen confirmed that staff training was up to date and ongoing.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Ltd
Centre ID:	ORG-0011513
Date of Inspection:	14 May 2014
Date of response:	15 July 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: DCAD10 Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As many residents did not have access to a day programme they remained in the community houses during the day. Their freedom to exercise choice and control in their daily life or to engage in 1:1 meaningful therapeutic activities was negatively impacted upon by the numbers of staff available in some community houses.

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.

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

Please state the actions you have taken or are planning to take:
1. A Meaningful Day Questionnaire shall be completed with all residents and their representatives to ascertain the social preferences of each resident.

2. This will be co-ordinated by key-workers with a view to developing an Individualised Plan for all residents to access integrated activities within appropriate time-lines and with appropriate supports.

3. All recommendations from the meaningful day questionnaire will be prioritised, implemented and will be monitored by the Person in Charge.

Proposed Timescale: 30/08/2014

Theme: DCAD10 Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some twin bedrooms required review to ensure residents were afforded privacy which may be negatively impacted upon due to floor space restrictions including use of an appropriate screen to place between them which was not readily available on the days of inspection if needed.

Not all residents had access to a room where they could receive visitors in private other than their bedrooms some of which were not adequate for this purpose due to size and layout restrictions.

Adhesive vision occlusive material placed on the window of one resident's bedroom severely obstructed this resident's view out of the window.

Listening devices were observed in a number of residents' bedrooms, some were in place as a listening device for night-time use, particularly in community houses where only one staff member was on-duty. Inspectors were informed that some were no longer needed or used but were still in-situ.

Access to a staff office was gained through one resident's bedroom.

An office desk and equipment for sole use of staff was located in the corner of a kitchen in one community house.

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. In bedrooms where residents, in the medium term, continue to share a bedroom, rails and curtains shall be installed to ensure privacy for each resident.

2. Room for receiving visitors in private other than their bedrooms has been agreed with residents as a second communal area within each residence as required.

3. Adhesive vision occlusive material has been removed and replaced with privacy blinds.

4. All listening devices including those that were no longer in use have been removed from the designated centre.

5. An office desk and equipment for staff administrative use will be moved to a more suitable area.

Proposed Timescale: 15/08/2014

Theme: DCAD10 Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two residents did not have adequate wardrobe space to accommodate their clothing, in the absence of sufficient resident monies; the provision of additional wardrobe space was not progressed.

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:
Individual residents have been purchased and installed for each resident

Proposed Timescale: 30/05/2014

Theme: DCAD10 Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were assessments relating to the social needs of each individual however, however these were not translated in practice for a number of residents. For example not all residents had access to a day programme to meet their recreational and occupational needs. Inspectors noted that a number of residents in some community houses remained in the houses throughout the day and due to the ratio of residents to staff, outings were not feasible for some residents who did not leave the houses to attend a day programme.

Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
1. A Meaningful Day Questionnaire shall be completed with all residents and their representatives to ascertain the social preferences of each resident.

2. This will be co-ordinated by key-workers with a view to developing an Individualised Plan for all residents to access integrated activities within appropriate time-lines and with appropriate supports.

3. All recommendations from the meaningful day questionnaire will be prioritised, implemented and will be monitored by the Person in Charge.

Proposed Timescale: 30/08/2014

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence of consultation with residents in their personal plan development however, consultation where they lacked capacity, with their significant others was not always clearly stated.

Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
1. All personal plans shall be reviewed as a priority by a Clinical Nurse Manager to ensure that all residents assessed needs (from members of the nursing team and the wider multi disciplinary team) have been identified and incorporated into the residents personal plan.
2. A review to establish the involvement of residents and significant others or advocates in the personal planning process and the review process will be conducted by the key-workers and will be monitored by the Person In Charge.
3. Residents will be supported to participate in a meaningful way by key-workers (in consultation with Supervisors) who shall ensure the involvement of family/ representatives / members/ advocates
4. Education and Training will be rolled out on accessible format of Personal Plans.

Proposed Timescale: 30/10/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents' plans were not reviewed to inform whether a personal goal was achieved or reassessment was required.

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
1. All personal plans shall be reviewed as a priority by a Clinical Nurse Manager to ensure that all residents assessed needs (from members of the nursing team and the wider multi-disciplinary team) have been identified and incorporated into the residents personal plan.
2. The Person Centred Planning section will contain short as well as long term SMART goals based on the preference of the resident.
3. A Critical Information Sheet will be introduced and completed with each resident by their key-worker and placed in Section One of the Personal Plan. This section will be updated to account for changes in circumstances and new developments.
4. A schedule of annual review meetings will be documented for all residents in the Designated Centre to ensure effective review of the personal plans.
5. A review template will be devised and introduced with residents and their representatives to ensure the effective review of each personal plan.
6. An appointment calendar will be introduced to all personal plans in the designated centre so that the evaluation and follow up of all required supports of residents is present.

Proposed Timescale: 30/10/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were a number of assessments carried out there was no guidance or standard regarding residents' dependency level and some of the assessment forms were not signed and dated.

Some residents' specific goals for themselves were not clear and as such this information was not fully utilised to ensure positive outcomes for residents.

One resident was observed by inspectors communicating by signing however, translation was not documented detailing the meaning of the signals. While staff could interpret same without difficulty, the absence of reference details hindered others communicating effectively with this resident.

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

Please state the actions you have taken or are planning to take:
1. All personal plans shall be reviewed as a priority by a Clinical Nurse Manager to ensure that all residents assessed needs (from members of the nursing team and the wider multi disciplinary team) have been identified and incorporated into the residents personal plan.
2. The Person Centred Planning section will contain short as well as long term SMART goals based on the preference of the resident.
3. The Person In Charge will conduct a personal planning audit to monitor progress.
4. A Critical Information Sheet will be complete by each key worker with each resident and placed in Section One of the personal plan.
5. A schedule of annual review meetings will be documented for all residents in the designated centre to ensure effective review of the personal plan.
6. A review template will be devised and introduced with residents and their representatives to ensure the effective review of each personal plan.
7. An appointment calendar will be introduced to all personal plans in the designated centre so that the evaluation & follow up of all required supports of residents is present.
8. Each communication profile will be reviewed and up-dated by key workers to ensure information is reflective of communication supports of each resident in the designated centre

Proposed Timescale: 30/10/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restricted space in a number of single and twin bedrooms occupied by residents in some community houses may negatively impede the capability of individuals residing there with reduced dexterity or need to use support equipment and/or mobility aides. One house in particular occupied by residents required a full review in terms of suitability of layout and design including individual and communal space to ensure it met the needs of residents living there. The size and layout of some single bedrooms occupied and used by residents throughout were inadequate and did not facilitate adequate space for basic bedroom furnishings and lighting.

A resident in one house had a television inappropriately placed in a storage unit in the bedroom which was being viewed at very close range due to lack of space.

One resident's en-suite facility was the only toilet available to residents on the ground floor in one community house and as such was used by other residents during the day. Not all residents' bedrooms had sinks fitted in them.

Two residents did not have adequate wardrobe space to accommodate their clothing,

The layout of some houses did not enable residents to meet visitors in private or to have an area to spend time alone in other than in their bedrooms.

One resident's bedroom window had restricted views due to an adhesive vision restrictor placed over the majority of the window glass. The extent of window glass occlusion required review to ensure there was balance with meeting privacy needs and facilitating a reasonable view out for this resident.

Natural or mechanical ventilation in showers in one community house was absent.

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. Transition is in progress for a resident to transfer to more suitable accommodation
2. The draft development plan has been developed by the management team. This outlines the medium and long terms strategy of the organisation to support residents to transition out of the existing premises and into the community using the residential models to meet current and emerging needs of the residents. In the interim a schedule has been developed to address immediate privacy and comfort needs of the residents.

3. There are two toilets on ground floor in this house and this is referenced in factual accuracy check.

4. Individual wardrobes have been purchased and have been installed for each of the individual residents

5. Room for receiving visitors in private other than their bedrooms has been identified and agreed with residents as second communal area within each residence as required.

6. Adhesive vision restrictor material has been removed and replaced with privacy blinds.
7. Natural or mechanical ventilation in shower in one house to be assessed by maintenance supervisor and appropriate ventilation arrangements will be put in place following this assessment.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a multi-adapter inserted in an electrical socket behind a television in one communal sitting-room supplying electricity to a number of electrical items connected to

it.

A number of over wash-basin lights in showers/bathrooms were not in place and the redundant electrical wiring supply was visible with ends covered by insulation tape.

Door self-closing units were found to be too tight in some areas which may pose a difficulty with opening for some less able residents,

Natural or mechanical ventilation in showers in one community house was absent.

There was an issue of large cracks appearing in the wall of a bathroom in one house, inspectors were told that this was due to building subsidence.

Many bathrooms, shower rooms and toilets required upgrading. Inspectors found that tiles were chipped or loose, paint work was damaged in some areas and in need of repair and the surface of some toilet seats were damaged. Rust was prevalent on surfaces in some of these facilities, and there were a large number of toilets that had no toilet roll or toilet roll holders, no hand towels dispensers or appropriate waste bins.

External grounds of some of the houses required maintenance. The surfaces on the driveway and the area in front of some houses required resurfacing as it was uneven and pot-holed. The roadway surface to one house was heavily pot-holed. Some grass and shrubbery areas were overgrown and in need of attention.

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

Please state the actions you have taken or are planning to take:
1. Electrical sockets in communal sitting room to be assessed by maintenance supervisor and remedial action taken immediately

2. Electrical wiring supply to over washbasin lights in showers/bathrooms has been removed.
3. Review of door self-closing units to be carried out by maintenance supervisor and remedial action taken.

4. Natural or mechanical ventilation in shower in one house is being assessed by maintenance supervisor and appropriate ventilation arrangements put in place

5. Large cracks in wall of bathroom have been repaired by maintenance.

6. Maintenance audit of all bathrooms to be carried out and remedial maintenance actions will be taken

7. Quotations have been secured for two driveways which require resurfacing and is will be included in the overall minor capital works / maintenance plan

8. Immediate temporary action will be taken to repair the potholes in the interim subject to local Authority approval.

Proposed Timescale: 30/08/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some carpeting on bedroom flooring was stained and required cleaning.

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

Please state the actions you have taken or are planning to take:
Carpet identified during the monitoring inspection visit has been cleaned.

Proposed Timescale: 30/05/2014

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 system for responding to emergencies was in place, however, a health and safety statement specific to the centre had yet to be finalised.

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

Please state the actions you have taken or are planning to take:
The Health and Safety statement for the designated centre is being finalised and will be communicated to all staff members by the Person in Charge.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A local risk register specific to each house was not maintained and for this reason, many individual and environmental risks were either partially, or had not been identified with controls to mitigate risks established. Examples of unassessed risks found by inspectors included lack of handrails on steps in some areas, unsecured doors to cleaning chemicals, access to bottles of hand hygiene gel placed on surfaces around houses, sloping ground or uneven external grounds and security of the medication keys.

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 risk management policy with supporting operational controls and action plan have been developed for the designated centre and is being implemented into practice by the Person in Charge
2. A local risk register for the designated centre is presently under development and will be implemented locally
3. Lack of hand rails referred to OT for assessment so appropriate rails can be installed.
4. All doors containing cleaning chemicals are now secure.
5. Dispensers fitted for hand hygiene products.
6. Quotations have been secured for two driveways which require resurfacing and is will be included in the overall minor capital works / maintenance plan
7. Immediate temporary action will be taken to repair the potholes in the interim.
8. Medication keys are now stored appropriately.

Proposed Timescale: 30/08/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in the facilities available for staff hand hygiene. There was use of open bins for disposal of hand towels. Not all toilets had bins for disposal of sanitary wear in areas where females were accommodated.

Access to personal protective equipment required assessment to ensure it was readily available but did not pose a risk to residents' safety.

Toilet rolls were not protected from excessive handling due to an absence of toilet roll holders in some toilets.

Inspectors noted storage of toiletries and dental hygiene equipment on shelves in some

communal toilet/washing areas which posed a risk of communal use and cross infection. Carpets were stained in some areas.

While some staff had personal hand hygiene gel dispensers, bottles of hand hygiene gel for communal use were not fitted in dispenser units to avoid excessive handling.

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. A full audit of equipment for staff hand hygiene and infection control will be completed by Person in Charge and areas for improvement identified and appropriate action will be taken
2. All personal protective equipment has been assessed and stored safely.
3. Toilet roll holders have been installed in all centres.
4. All residents now store personal hygiene items in their bedrooms.

Proposed Timescale: 15/08/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed areas of risk relating to fire evacuation routes. Inspectors observed the absence of break glass units at some fire exits locked by a key. Obstruction of designated fire exit doors by various items of furniture or equipment was also found. In addition, a back yard of one centre was totally enclosed by a wall effectively trapping any person who entered this area in the event of a fire.

The documented fire evacuation plan was found to be generic and did not take into account the differing layout of houses or varying staffing levels in each. Inspectors found that there were periods when there was only one member of staff in the centre throughout the day and night to assist residents to evacuate in the event of fire. This was not assessed or reviewed to determine the specific procedures to be followed should a fire occur in any of the houses.

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

Please state the actions you have taken or are planning to take:
1. Break glass units are in place in all residential premises which were identified as absent during the Inspection visit.
2. The external evacuation routes which were obstructed as identified during the Inspection Visit have been cleared.

3. Fire Safety Checklist has been amended to include the daily checking and recording of fire exits to ensure they are clear of obstructions.

Proposed Timescale: 30/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire panel was not in place in all houses. A smoke detector alarm in one house was not functioning.

Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
A new fire safety checklist is in place which includes checking smoke detectors in the designated centre.

Proposed Timescale: 16/07/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A reduction in the use of restrictive interventions was evident however there was room for further improvement with the implementation of proactive strategies. For example, the pot-holed road triggered a resident to have episodes of significant anxiety requiring psychotropic medication following travel on this surface.

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

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

1. Immediate temporary action will be taken to repair the potholes in the interim subject to local Authority approval.

2. An antecedent control form has will be completed for this resident to ensure that the least restrictive strategy will be used at all times for this resident and this will be monitored through the Governance of Restrictive Interventions Committee.

Proposed Timescale: 30/08/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in use of pain assessment documentation. Inspectors found a lack of clarity in the assessment tool as it did not include a protocol regarding appropriative and timely pain relief to residents.

Not all care plans were up to date, for example a resident who had lost weight and was commenced on a care plan informed by a review by the dietician with interventions to promote weight gain was having monthly weight assessments completed. There was no evidence of weight increase but care plan was not reviewed in response to this.

A care plan was reviewed for management of challenging behaviour by one resident, inspectors noted that the daily record referenced several episodes of the behaviour. However, there was no detail included to inform interventions were effective. This lack of detail hindered adequate update of the behavioural support plan with documentation of effective strategies two months later on the 12 May 2014.

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. Protocol for administration of pain relief to be developed in line with pain assessment tool.

2. All personal plans shall be reviewed as a priority by a Clinical Nurse Manager to ensure that all residents assessed needs (from members of the nursing team and the wider multi-disciplinary team) have been identified and incorporated into the residents personal plan.

3. The Clinical Nurse Manager will ensure that documentation used to record episodes of challenging behaviour will include information confirming the effectiveness of interventions.

4. A Critical information sheet will be introduced and completed with each resident by their key-worker and placed in Section One of the Personal Plan. This section will be updated to account for changes in circumstances and new developments.

5. A schedule of annual review meetings will be documented for all residents in the Designated Centre to ensure effective review of the personal plans.

6. A review template will be devised and introduced with residents and their representatives to ensure the effective review of each personal plan.

7. An appointment calendar will be introduced to all personal plans in the designated centre so that the evaluation and follow up of all required supports of residents is present

Proposed Timescale: 30/09/2014

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Individual medication prescription and administration records did not adequately reference whether any residents had a medication allergy.

Individual medication prescription and administration records did not adequately reference whether any residents had a medication allergy.

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

Please state the actions you have taken or are planning to take:
Medication administration records have been amended to reflect known allergies

Proposed Timescale: 14/05/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of areas required review to ensure the details of the service provided was accurately stated. A copy of the revised statement of purpose must be forwarded to the Chief Inspector.

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

Please state the actions you have taken or are planning to take:
A revised statement of purpose and function is being developed in accordance with the Regulations to reflect the revisions to the makeup and service units of the designated

centres as requested by HIQA.

Proposed Timescale: 15/08/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Make a copy of the revised statement of purpose available to the Chief Inspector.

Action Required:
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

Please state the actions you have taken or are planning to take:
A revised statement of purpose and function is being developed in accordance with the Regulations to reflect the revisions to the makeup and service units of the designated centres as requested by HIQA.

Proposed Timescale: 15/08/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence of some staff on rosters in two houses at the same time. Attendance by the person in charge in the community houses was not recorded on the duty rosters.

Actual rosters did not reflect the finding that staff were often shared between units, and floaters or staff who left the designated centre to assist and relieve staff in other areas for breaks or where there may have been a medical emergency were not indicated on the roster.

Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
1. Individual rosters have been developed for each house within the Designated Centre.
2. Individual roster for Person in Charge will be available in each house.
3. A review of all rosters will be completed for this designated centre as part of an overall review of rosters in the Northeast services and will take account of the current and changing needs of all resident's within this Designated Centre and the appropriate

supports required to meet their social care needs in an holistic way.

Proposed Timescale: 30/09/2014

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that there was insufficient staff on-duty to meet the assessed needs of residents in some community houses.

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. A review of all rosters will be completed for this designated centres as part of an overall review of rosters in the Northeast services and will take account of the current and changing needs of all resident's within this Designated Centre and the appropriate supports required to meet their social care needs in an holistic way.
2. Following verbal feedback from the Monitoring Inspection an immediate review took place to ensure that the staffing levels were adequate to meet the fire and safety requirements of all residents and actioned appropriately.

Proposed Timescale: 30/09/2014