

**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-0002932
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Louise Renwick
Support inspector(s):	Conor Brady;Conor Dennehy;
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
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 1 day(s).

The inspection took place over the following dates and times

From: 04 March 2015 10:50 To: 04 March 2015 19:20

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

As part of this inspection, inspectors met with residents, the person in charge, nursing staff, care assistants, agency staff and a resident's family member who was visiting during the inspection. Inspectors observed practices and reviewed documentation such as care plans, person centred plans, behaviour support plans, accident and incident records, staff files and policies and procedures.

This centre catered for 18 full time residents, and had one bed available for respite. The centre comprised of a large single storey dwelling, and was based on a campus setting. The person in charge had previously voiced her concerns to the provider of the unsuitable nature of the building and the need to locate a more suitable setting. The provider was aware of the need to move on from congregated settings in line with national guidance.

Inspectors found non-compliances across all the outcomes inspected with the Health Act 2007 (Care and Support of residents in designated centres for persons (children and adults) with disabilities) Regulations 2013. Overall, inspectors had grave concerns that the institutional practices observed during this inspection may have a

direct negative impact on the lives of residents. While some basic care needs were being met, residents had limited choice making opportunities, were not adequately supported to communicate, and were not being provided with the supports to be social and enjoy a good quality of life.

As evidenced in the following report, inspectors found that the staffing and resources of the centre led the daily routine of residents. Routines were rigid and based on staffing numbers, and tasks to be completed. Care and support provided to residents was not always offered in a person centred manner. Inspectors found a number of residents required support with behaviours that challenged, and were concerned that these behaviours could be linked to the failure to meet some residents' needs (such as communication needs and social needs). Behaviours of concern were described by staff and written in documentation as behaviours that were "disruptive" and "demanding". Inspectors found that this was not promoting positive behaviour support for all residents. The manner in which the centre was run and operated was not empowering residents to be in control of their own lives, or encouraging them to meet their full potential.

Inspectors issued an immediate action plan in relation to the numbers of staff at night time, to which the person in charge provided an adequate response.

Inspectors determined that significant improvements were required to ensure compliance with the Regulations and Standards, and to promote a positive living experience for all residents. This will be further detailed in the report and action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Privacy and dignity

Inspectors found that residents' right and dignity were not fully respected or promoted in the designated centre. On arrival into the centre, inspectors observed a resident being supported with personal care in his bedroom. The doors to this resident's room were open, and other residents and visitors had clear view of this from the communal sitting room. This was not ensuring residents' dignity during intimate care.

Inspectors found that residents' were not always spoken of in a respectful manner by staff. For example, behaviours of concern were described as "disruptive" and "demanding". These terms were also evidenced in documentation such as the accident and incident log and daily records. Inspectors also determined that information and communication regarding residents was not always done in a discreet or respectful manner. For example, on residents' arrival into the centre following their day programme, inspectors heard staff describe residents who were "wet" and needed changing to other staff.

Inspectors observed that residents' personal folders and daily record books were stored in the communal living room in a broken press. The door had fallen off the press and personal information was not securely stored.

Inspectors found that the centre was not treated as a home for residents, but as an open building. Inspectors noted 13 different access points into the centre, and observed numerous visitors coming in and out of the centre throughout the course of the day without knocking, or signing the visitors book. For example, staff from other areas

walking into the centre to borrow equipment such as wheelchairs. Inspectors also found that there was a HSE Dentist's office located within the designated centre, where residents from other designated centres attended for dental treatment on a regular basis. On the day of inspection, residents from other designated centres had freely come into the centre and were walking around unsupervised. This was not promoting the centre as a homely environment, or ensuring the dignity and privacy of residents within their home. Inspectors were also concerned that this posed a risk to residents' safety and the safeguarding of their belongings.

Choice and daily routine

Inspectors reviewed the statement of purpose prior to inspection, which outlined the centre was "promoting independence." On site, inspectors found that the routines, practices and facilities of the centre did not fully promote residents' independence or choice. For example, inspectors asked staff if residents who took part in cooking in their day services could take part in preparing the meals in the centre, and staff expressed that there wouldn't be time to support residents to do this. Inspectors observed a resident having to remain seated for 31 minutes until the floor that had just been mopped had dried, before he could attend his activity in another part of the centre. Inspectors found that the resident had to wait to avail of activities due to the cleaning routine of the centre.

Personal property and belongings

Inspectors found that there was inappropriate space for residents to store and maintain their own belongings. For example, due to inadequate storage, residents' clean clothes were left in plastic bags and boxes on the floor of their bedrooms. Inspectors noted a resident's family had previously made a complaint about clothing going missing.

Consultation

While inspectors saw documentary evidence of residents' meetings held, the minutes of these meetings did not indicate a consultative process but rather outlined basic needs. For example, minutes reviewed documented that one resident needed a referral to an allied health care professional. Inspectors were concerned that this was not promoting the privacy of residents and was an inappropriate forum to discuss individual residents' needs.

Complaints

Inspectors reviewed the complaints log, and found that a record of complaints was kept in line with the Regulations. However, inspectors found complaints were not investigated promptly, and there was no evidence to show any measures put in place to bring about improvements as required by the Regulations. Inspectors noted a high number of complaints written by staff advocating on behalf of residents. These complaints included issues such as noise issues in the centre, the inappropriate mix of residents, the effect "disruptive" behaviours of one resident was having on others, and residents from other centres found "running through" the building. While it was a positive thing that staff were voicing their concerns and advocating on behalf of residents, inspectors found a lack of evidence of appropriate corrective action or follow up to deal with these complaints. Most complaints were simply marked as "for discussion". Inspectors were also concerned that complaints made outlining one resident's "disruptive" behaviour was

not equally promoting the rights of all residents. Inspectors found no evidence of an external advocate being engaged with for these issues to support staff to speak up for residents' rights.

Activities

Inspectors determined that there were very few meaningful activities available to residents. On the day of inspection, eight residents were receiving a day programme run by the residential staff on site. This consisted of activities such as pet therapy once a week, hydrotherapy, watching DVD's, drama and walks around the campus grounds. Activities tended to be group focused and campus based, and were dictated by the routine and resources of the centre. Inspectors spoke with a number of staff who expressed that after ensuring residents' personal care and nutritional needs were met, there was little time for anything else. Inspectors found that there were long periods of the day where residents had no meaningful activation or engagement, as staff were occupied with supporting the personal care and basic needs of other residents.

Judgment:

Non Compliant - Major

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors were not satisfied that there were systems in place to meet the diverse communication needs of all residents, and that residents were promoted to communicate at all times. For example, inspectors observed interactions throughout periods of the day, and found that interactions with residents were verbal, and at times limiting due to staff being under pressure with personal care duties. Inspectors observed a resident being given his meal without staff telling him what the meal consisted of. No sign language or objects of reference were used in this interaction, as outlined for this resident in his documentation.

Residents with behaviours of concern were described as "disruptive" by staff when observed vocalising. Through observations, inspectors found a resident dropped an object that he was playing with, and began to make vocalisations. Staff responded to this resident by continuing to offer him a drink. Inspectors informed staff that the object had been dropped, and this was what the resident was trying to communicate. This resident had objects of reference stored in his wardrobe, which were not implemented in practice. The resident's documentation in relation to supporting his behaviours also

outlined the use of sign language, along with picture exchange communication. Inspectors did not observe any of these communication styles in use for this resident during the day of inspection.

On review of a sample of residents' communication plans, inspectors found that the documentation, implementation and observations of interactions were inadequate to fully meet residents' needs in this regard. The communication care plan of one resident consisted of a few lines outlining that the resident can display restlessness. There was no mention of the resident's visual impairment, sensory needs or communication styles within the care plan. Inspectors were informed by staff that the resident had been linked with the Speech and Language Therapist (SALT) who recommended the use of Objects of Reference. This was not included in the communication care plan, and was not observed in use during the inspection. Inspectors asked to see the objects of reference for this resident, and it took staff several minutes to locate these from the back of a press. Inspectors did not observe these being used up to this point of the afternoon, and did not observe them in use following on from discussions with staff.

Inspectors found that there was a communication policy in place which was encouraging a total communication approach. However, it was not observed as being fully implemented in practice in this centre. Inspectors found that there had been access to SALT for some residents to gain advice on how to support them to communicate. However, there was no system of overview in place in this centre to ensure that any communication tools were fully implemented in practice to promote residents to communicate. This failing was most notable for residents with "disruptive" behaviours, who were not being supported to access to the tools to assist them to express themselves more appropriately. Staff informed inspectors that they had been provided with training in sign language for people with intellectual disabilities. This was a positive finding, however was not observed in use during the inspection, and not all residents had been assessed as this being a suitable communication method to meet their needs. Inspectors determined that due to the resources and routines in the centre, the staffing numbers were not adequate to meet residents' communication needs, and to ensure the policies, care plans and training provided were fully used and implemented.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors determined that residents' social care needs were not being met in the designated centre. As evidenced across other outcomes, failings were identified in:

- access to meaningful activities
- time for meaningful interactions with staff
- promoting positive communication

Inspectors reviewed a sample of residents' outcomes based plans which consisted of an interview with the resident or family member, and goal setting for the coming year. Inspectors found this document to be in written format and not inclusive of the communication needs of residents. Inspectors found that while some interviews had taken place, there was no evidence that residents had been supported to contribute to the process, and plans were not in an accessible format. Inspectors noted one resident who had such a planning interview completed in August 2014. This resident had only achieved 4 positive outcomes across 23 areas. No planning meeting was evident, and no goals had been identified since August 2014 to show inspectors how this resident's quality of life was being promoted.

On review of documentation, and through observations inspectors could not determine a link between residents' personal plans and the care delivered to them in the centre. As mentioned in previous outcomes, staff outlined the majority of their time was used to support resident with meal times and personal care needs.

On review of activities available and recorded in the activity log, inspectors determined that activities were not based on resident's goals or plans. For example, nail cutting was logged as an activity for some male residents. Inspectors determined while this was meeting a basic need, it did not provide a meaningful activity based on residents preferences and wishes.

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):

This was the centre's first inspection by the Authority.

Findings:

This designated centre was an old styled congregated setting, based on a large campus. Apart from the centre being a congregated setting for 19 residents, inspectors had concerns with the design, layout and general upkeep of the designated centre.

Inspectors noted a number of risks during inspection due to the inadequate layout and design of the building. These will be discussed and evidenced under outcome 7 Health and Safety and Risk management.

As mentioned in outcome 1, inspectors found there to be 13 open access points into the building. This was not ensuring the safety of residents, and the protection of their personal belongings. Complaints logs indicated this had been raised as an issue, along with accidents and incidents records outlining a resident had left the building without staff's knowledge.

Inspectors found that the design and layout of the centre was not fully accessible to meet residents' needs. For example, inspectors observed a resident being hoisted in the communal area and wheeled into the bathroom, as there was inadequate space to do this in the bathroom area.

Inspectors found there to be an inadequate number of functioning showers in the designated centre for the number of residents. Staff informed inspectors that the main shower could not be used due to flooding issues with the drain. This had not been addressed by the provider. Inspectors found there to be two bathrooms available for residents use in the designated centre for 19 residents, and as mentioned above staff had difficulties in using the hoist within them due to the space available. Inspectors found that some residents received personal care on their beds and as there was greater space for staff to manoeuvre the hoist.

Inspectors determined there to be inadequate storage in the designated centre. For example, hoists were stored in the bathroom area along with residents' clean clothes. As mentioned under outcome 1 there was insufficient space for residents' personal belongings.

Inspectors noted the centre was in poor state of repair throughout and in need of decorative work. Paint work and plaster work was cracked and in need of repair, curtains were hanging off windows.

Inspectors also noted inadequate kitchen and cooking facilities. While there was a small kitchen, it was not large enough to be accessible to all residents. Staff informed inspectors that no cooking was done in the centre, all meals were provided by the canteen, and held in a bain marie style heater before serving.

As mentioned under outcome 1, inspectors noted residents using wheelchairs could not easily sit at the dining tables due to the height of the tables. Inspectors found that some

residents were sharing rooms with 2-3 other people. Inspectors found there to be inadequate space for personal belongings in these rooms. This was not in line with the Statement of Purpose which outlined a maximum of two residents per room.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors were not satisfied that the health and safety of residents, staff and visitors was adequately promoted in the centre. Inspectors found that the inadequate design and layout of the centre was posing some risks. For example:

- poor manual handling due to insufficient space for hoists in the bathroom area
- cross infection risks due to unsuitable storage of equipment and clothes in bathrooms
- risk of harm from broken furniture and loose wires in the garden
- risk of unwanted visitors having free access to the building unsupervised

Inspectors were concerned that poor manual handling practices were evidenced numerous times during the inspection. While some of these observations were due to the inappropriate lay out of the building, inspectors also observed inappropriate transport of a resident across a room while hoisted to a height in the activity room. On the day of inspection, inspectors found residents were pushed sometimes as far as 18 feet while suspended from the hoist which posed significant risk to residents.

Inspector reviewed the accident and incident records, and found details of a resident who had a near miss when they nearly fell while being hoisted. The control measures identified to reduce the likelihood of this happening again had not been implemented. Inspectors found a reassessment of the hoist by the Occupational Therapist had not been facilitated.

Inspectors found that there was a risk management policy in place, which included the measures to deal with the four specific risks as outlined in the Regulations. On review of a recent action plan regarding risk management, inspectors noted two staff required training in manual handling. Inspectors asked the clinical nurse manager if these staff were actively engaging in manual handling tasks, and the inspectors were informed that they were. Based on the poor practices observed, and the near miss documented, inspectors were concerned that this was not ensuring appropriate controls were in place

to reduce the likelihood of injury from manual handling tasks.

Inspectors observed wires exposed in residents bedrooms. While these were not aesthetically pleasing, inspectors were concerned that they could pose a risk to residents. Inspectors reviewed an accident and incident record that outlined a resident was found pulling at wires in his bedroom. The control measure identified to reduce this happening had been to move the resident's bed away from the wires. On the day of inspection, inspectors found these wires still exposed.

Inspectors determined that there were ineffective systems in practice to identify, assess and managed all risks within the centre as evidenced in the examples above.

Accidents and incidents

While there was a system in place to record all accidents, incidents and near misses, inspectors were concerned that there was a lack of overview to ensure control measures had been put in place to reduce any risks. For example, as mentioned above a resident who almost fell from a hoist did not have a reassessment completed.

Inspectors found inconsistencies with who was responsible for signing off on accidents, incidents and near misses. No one person had responsibility to review each form and decide upon control measures. The person in charge for that shift had responsibility to sign off on any records. Sometimes this was a staff nurse, or clinical nurse manager 1 or 2. These forms were then sent to the person in charge who inputted the information into a database. Inspectors found that there was no review to ensure control measures were fully implemented, and while the database showed the number and type of adverse events each month, this did not lead to any further audits or learning gained to prevent further occurrences and promote positive outcomes for residents.

Fire precautions

Inspectors found documentary evidence of routine service checks on the fire detection and alarm systems. Inspectors also noted documentary evidence of fire drills being conducted on a consistent basis. This was in line with the requirements of the Regulations. Inspectors reviewed the Emergency Evacuation plan which was dated June 2013. Inspectors found that this plan was in need of review. Due to gaps in the training records available on the day of inspection, inspectors could not verify if all staff had up to date training in fire safety as required by the Regulations.

Through review of documentation, inspectors found evidence that the night previous to the inspection two staff had been directed to leave post in this centre to assist in another centre on campus. This resulted in one staff being in the building with 18 highly dependent residents for a period of time. Inspectors found that this was against the centre's own emergency evacuation plan which outlined twelve residents required two staff to support them to evacuate safely. Inspectors spoke with staff who explained that this was not a once off occurrence. Inspectors were so concerned that the safe evacuation of residents would be compromised with this inadequate level of staffing, that the provider was issued with an immediate action plan. In response to this, inspectors received written assurances from the nominated person in charge, that from the day of inspection onwards, the night time staffing would not fall below three staff.

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):

This was the centre's first inspection by the Authority.

Findings:

Through observations, reviewing documentation and speaking with staff, inspectors found that practices and care in the designated centre were institutionalised and resource led. As evidenced across all outcomes, residents were found to have had little choice over their daily lives, and the direction of the day was determined by the staffing routine and resources available. Inspectors found inadequate responses to meet all residents' diverse needs. Inspectors were concerned that the manner in which this centre was operated was institutional in nature.

Inspectors were concerned that there were inadequate protocols in place for the reporting of suspected, alleged or witnessed abuse in this centre. Inspectors found ambiguity in how staff were reporting issues in relation to the safeguarding of residents. For example, some staff were reporting unexplained marks or bruised as an accident or incident, along with filling in the relevant safeguarding form. Other similar incidents were only recorded by staff as an accident or incident. Inspectors spoke with the clinical nurse manager who explained that not all staff had up to date training in safeguarding and protection of residents from abuse. Training records available to inspectors did not reflect that training had been provided to all staff. Inspectors were also concerned at high recordings of unexplained bruises and marks on residents, and a significant lack of oversight to determine the possible causes of such.

Inspectors found that restrictions were in place for some residents. While there was a system in place for the clinical team to review the use of restraints in the centre, inspectors found a lack of oversight to ensure that all restrictive procedures were being applied in line with written protocols, and that proactive and reactive strategies and behaviour support plans were fully implemented by the staff team. Inspectors found that this again was linked to a lack of effective supervision in the designated centre.

Inspectors had some concerns regarding the use of restraints in the centre, and the

clear rationale for their use. For example, a resident who had been wearing arm splints since 2003 was described in the quarterly notifications as not needing this restraint "when full staff supervision is guaranteed and provided". This was discussed with the person in charge and clinical nurse manager during the inspection. Inspectors were informed that during the day in an external day programme, this resident was facilitated to remove these splints for periods of time as the staffing numbers facilitated this. Inspectors determined that the use of this restraint was not in the least restrictive manner for the least amount of time, due to the inadequate staffing resources available in the designated centre.

Inspectors were concerned that for some residents, the use of restraint could be linked to a lack of clear understanding for the underlying cause of the behaviour. For example, the use of a closed vest garment for a resident to prevent stripping had been in place since 2007. Inspectors found a lack of evidence to show the efforts that had been made to determine the underlying cause of this behaviour. Inspectors were informed by staff that the resident did not always like the feel of clothing, and this was a possible reason for stripping. Inspectors were informed that a referral had been sent to the Occupational therapist, but to date no sensory assessment had been completed since the restraint was first used. Staff explained that the vest was not always necessary, and this was based on the resident's mood at the time. For example, at the beginning of the inspection the resident was not wearing the garment, but by the end of the day when all residents had returned to the centre, inspectors noted the resident was wearing this garment. Documentation to show inspectors when this was/ was not being used was lacking.

Inspectors found that some staff in the organisation had access to a longitudinal training in multi elemental behaviour support. This training included completing full functional analyses of residents' behaviour, which was then used to complete comprehensive behaviour support plans. Through speaking with staff, inspectors found that this training was not available to all, and access to this behaviour analysis was not consistent for all residents. For example, some residents had a completed "Multi-element behaviour support" (MEBS) analysis and plans written up, other residents with unwanted behaviours did not. Some residents had both a proactive and reactive strategy, while others only had a reactive one. On review of residents' files inspectors noted inconsistent information in both the behaviour support plans, the proactive and reactive strategies for some residents. For example, one resident's behavioural plan outlined the use of picture exchange, or picture cards along with a visual schedule to assist communication. The proactive strategy outlined staff should use sign language. Inspectors found that neither communication type was in use on the day of inspection. Again, clinical oversight was lacking to ensure all documentation was clear, and consistently implemented to promote positive outcomes for residents.

From speaking with staff, inspectors found that the content of some of these detailed behaviour support plans were not known to the staff team, and had not been implemented. For example, staff continued to respond to a resident's vocalisations by offering a beverage, or telling him that staff would get him one later. From reviewing the behaviour support plan carried out in 2008, inspectors found that a full functional analysis of this resident's behaviours determined that only 16% of the time, the resident was looking for a beverage. Over 83% of the findings determined that this resident was

trying to communicate that he wanted some interaction. Inspectors noted this resident displaying these behaviours at times when not engaged in meaningful activation or interaction. This resident was described by staff as being verbally disruptive. Inspectors determined that this failing was again linked to a lack of effective supervision, and a lack of adequate staffing to ensure adequate time for staff to engage positively with all residents.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
On review of the accidents and incidents log, inspectors determined that not all notifiable events had been submitted to the Authority as required by the Regulations. For example, inspectors reviewed an incident log detailing that a resident had left the building without staff knowledge. Inspectors also found that not all quarterly notifications were submitted as required by the person in charge. Following discussion, these quarterly notifications were made available to inspectors. However, they had not been submitted as required.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

Findings:

On review of a sample of residents' files and from speaking with staff, inspectors found that there was access to a range of allied health care professionals for the residents living in this centre. For example, the organisation provided speech and language support, occupational therapy, physiotherapy and hydrotherapy. Residents were also supported to avail of dentistry, psychology, psychiatry and behaviour support were required. This was in line with the requirements of the Regulations in relation to health care.

While there was access to a range of allied health care professionals, inspectors identified gaps in relation to the consistent implementation of their advice. As evidence in outcome 2 Communication, and outcome 8 Safeguarding and Safety, inspectors found evidence of assessments not always resulting in clear plans to meet residents' needs. Along with a lack of clear plans, the advice from some assessments had not been implemented in practice such as use of alternative communication tools, or skills teaching as outlined in behaviour support plans. Inspectors determined that this failing was due to a lack of effective supervision in the designated centre, and the staffing resources not being adequate to ensure sufficient time to implement all aspects of care and support in line with residents' needs.

Inspectors found that residents in the centre were provided with a varied diet. However, inspectors had concerns regarding residents' access to food and access to suitable kitchen facilities. As evidenced in outcome 6, inspectors found that residents were not supported to buy, prepare or cook their own meals due to a lack of appropriate facilities, a lack of staff training in food safety, and the set daily routine of the centre. Inspectors were informed, and observed that the campus canteen provided all meals which were transported to the designated centre in a heat box. Residents were offered the two choices for each meal the day previous. Apart from these set meals, inspectors found that there were inadequate facilities to prepare nutritious meals or snacks in the centre outside of these set meal times. Inspectors were also concerned that portion size was predetermined by the canteen, and residents did not have ease of choice in this regard. Inspectors observed the meal time experience, and found it to be task orientated, and not fully promoting a positive mealtime experience for residents. For example, inspectors observed some residents' were given their meals, without being told by staff what they were eating. As evidenced in previous outcomes, there was a lack of appropriate communication in a style suitable for each resident. Inspectors saw a resident being given a modified diet which had been all mixed altogether. When the inspector asked staff supporting the resident what was in the dinner, they could not answer, and needed to check with other staff. Inspectors observed some residents having difficulty with their meal. For example, one resident who was encouraged to eat independently had lost most of the food on his plate onto the table during the course of the meal. Inspectors found that the provision of food in this centre was not wholly provided in a person centred manner.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors were satisfied that the practices in relation to medication management were on the most part protecting residents, with some improvements in relation to documentation required. Inspectors found that the prescription forms were formatted in such a way that there was not enough space under certain sections to clearly write medication prescribed. For example, inspectors noted PRN (as required) medications on some prescription forms had been written under the routine medication section. This could pose a potential risk of medication error. Inspectors also noted that not all medication was individually prescribed by the General Practitioner with some prescription forms only have one signature for all medication within. Inspectors reviewed the administration records and noted that the spaces allocated for staff to record times of administration had been predetermined. For example, the form had a space for recording under 6 am, and 8-9am. On one administration record reviewed, inspectors noted a resident received their medication at 6am on morning, while another day it was recorded at 9.10am. While inspectors saw evidence of a medication management audit completed back in 2013, there was a lack of oversight in relation to medication management practices to ensure continuous review of practices. For example, to determine if medication was routinely administered at the time prescribed.

On observation of medications being administered, inspectors found good practice in this regard. For example, the medication trolley was locked when staff stepped away, good hand hygiene was noted, and medication was only signed as administered after they had been taken. This was found to be in line with best practice. Inspectors noted the newest member of staff had been given the task of medication administration in the evening while other staff nurses who were more familiar with residents went on their break. Inspectors noted the staff checking with others about the manner in which residents' took their medication. This was promoting safe practice and continuity for residents. However, inspectors were concerned that there was a lack of direct supervision in place to support new staff, with the clinical nurse manager engaged in other duties, and the nominated person in charge not located in the designated centre. This is referred to under outcome 14 Governance and management.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors were very concerned at the lack of governance and oversight by the provider and persons participating in the management of this centre as evidenced by the high number of non-compliances. This level of non-compliance did not demonstrate that the provider has engaged in the regulatory process since commencement. Inspectors found deficits in the provision of safe care, quality of life and healthcare for residents. The failure of the provider to review and engage in oversight of the service provided to residents has resulted in negative outcomes for residents.

Inspectors determined that the person in charge was not adequately or actively involved in the governance, operational management and administration of the designated centre on a consistent basis. The person in charge held the post of Director of Nursing and was responsible for eight designated centres overseeing the care of 147 residents across all of these centres. Following on from feedback after the inspection, the person in charge informed the inspectors that this decision was currently being reviewed by the provider and restructuring was planned.

On the day of this inspection, the person in charge was engaged in various meetings and was not available until later in the day. Staff informed inspectors that on a daily basis, one of two clinical nurse managers (CNM's) took on the role of nurse in charge, and the CNM's were responsible for the supervision of care and staff. For this inspection, inspectors spoke mainly with the clinical nurse manager on duty. This proved challenging at times, as inspectors found that the CNM was on the roster, and was not in a supernumerary role, but worked supporting residents with all aspects of their care. Staff informed inspectors that the person in charge did not attend hand over meetings, staff meetings, and was not often in the centre. Staff reported directly to the clinical nurse managers (CNM's), and they in turn reported to the person in charge. While this offered some structure to the management team, inspectors determined a lack of clarity with who was accountable in the designated centre. Due to the failings identified in this report under all outcomes, inspectors were concerned that the designated centre was not being managed appropriately in accordance with the requirements of the Regulations and Standards.

Inspectors determined a lack of effective oversight in place in the centre. There was no system in place to ensure all aspects of care and support were being monitored and reviewed on a consistent basis. As evidenced in previous outcomes there was a lack of:

- review and learning from accidents and incidents
- ensuring the implementation of policies and procedures
- ensuring the full implementation of residents' care plans, and advice from allied health care professional was followed
- audits and review on basic care practices such as falls management, pressure care
- review of the quality of life of residents, and that personal goals were being worked on and achieved

While inspectors saw evidence of three audits completed in 2013 and 2014, these were on areas such as hand hygiene, and documentation. Two unannounced inspections had taken place in March and October of 2014 by a team appointed by the provider. This was in line with the requirements of the Regulations. These had generated action plans, which inspectors determined had in part been acted upon and changes made.

Inspectors noted that these inspections focused mainly on health and safety and risk management, and were mainly concerned with documentation and premises. There was a significant lack of systems to ensure the service that residents were receiving was of a good quality, was meeting their needs and that residents had a good quality of life. When inspectors asked staff what changes had happened as a result of these provider inspections that brought about positive outcomes for residents and improved their quality of life, staff did not know.

Inspectors determined a lack of appropriate supervision was in place in the designated centre. This was due to clinical nurse managers being engaged in the hands on duties and supports of residents, and the lack of operational oversight from the person in charge. This was resulting in the failings as outlined throughout this report.

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):

This was the centre's first inspection by the Authority.

Findings:

On review of the staffing roster, through observations and as evidenced in the failings across all outcomes, inspectors determined the number of staff was inadequate in the

designated centre. While inspectors found basic needs such as personal care, and support with meals was provided, the manner in which the centre was resourced and operated was resulting in poor quality of life for residents. Staff explained that they had little time to spend with residents outside of this basic care, and this was clearly evident throughout the day of the inspection. Inspectors observed staff leaving the centre for their breaks during the course of the day, on one occasion during a medication round when a nurse was actively engaged in the task. There was little oversight and supervision in place to ensure breaks and the skill mix of staff on duty at all times was planned out to ensure appropriate staffing at times of high activity. As evidenced across a number of outcomes, inspectors found that the staffing and resources led the daily routines of the residents and the centre.

Inspectors were not satisfied that all staff were appropriately trained to meet the complex needs of residents. Gaps were identified in mandatory training for staff, and records provided on the day of inspection did not clearly assure inspectors that all training needs were being met. As evidenced in outcome 7 and 8 some staff had not received training in the protection of vulnerable adults or manual handling.

A sample of staffing files were reviewed as part of this inspection. Inspectors determined that these mostly met the requirements of the Regulations as outlined in Schedule 2.

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:

Louise Renwick
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-0002932
Date of Inspection:	04 March 2015
Date of response:	20 April 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:

There was little opportunity for residents to display choice and control over their daily lives.

Action Required:

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

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. Weekly residents meeting with the staff team will commence with an agreed agenda to ensure that each resident has the opportunity to exercise choice and control in the running of the house.
2. A record will be maintained of this weekly meeting. The outcomes of these meetings will inform each resident's weekly social and activity timetable.
3. The Clinical Nurse Manager 2 will coordinate the systematic review all Personal Outcomes Measures (POMS) to ensure they are adequate & to ensure identified social goals of each resident are adequately met.
4. A review of the mealtime options will be undertaken by Person in Charge Clinical Nurse Manager 2 and catering department manager to enhance participation and choice at mealtimes.
5. Food safety and hygiene training will be reviewed to ensure that all staff have the required training in food safety and hygiene.
6. An audit of the mealtime experience will be undertaken by the catering manager to evaluate the mealtime experience of residents.
7. The catering facilities will be reviewed to review opportunity for smaller groups to avail of more meaningful mealtime experiences.

Proposed Timescale:

1. 11th May 2015
2. 11th May 2015
3. 20th July 2015
4. 22nd May 2015
5. 22nd May 2015
6. 31st August 2015
7. 30th June 2015

Proposed Timescale: 31/08/2015

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 the designated centre.
Resident's personal information was not securely stored.

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. Develop a local operational procedure (LOP) on privacy and dignity. All staff will be inducted to this LOP. An accessible version will be devised for residents.
2. The clinical nurse manager 2 will coordinate the review of all residents intimate care plans to ensure they comprehensively meet the needs of residents.
3. A new storage unit will be in place to ensure the storage of all residents' personal folders are securely stored.
4. Signage will be erected to identify main entry and exit points to the house.
5. All visitors entering the house will be requested to sign the visitor's book on arrival & on leaving.

Proposed Timescale:

1. 21st April 2015
2. 21st April 2015
3. 21st April 2015
4. 19th May 2015
5. Commenced

Proposed Timescale: 19/05/2015

Theme: Individualised Supports and Care

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

There was no evidence of the use of an external advocate to support residents to speak up about their rights.

Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

1. An information session will be organised for the staff team residents and families to educate on accessing advocacy services for residents & information regarding residents' rights. This information session will be facilitated by the national advocacy services.
2. A review of each resident's rights awareness checklist will be coordinated by the clinical nurse manager 2 and key workers to ensure a rights restoration plan is in place

for each resident who may require one.

3. The service is currently reorganising a Rights review committee to ensure all rights restrictions are reviewed.

4. Posters relating to the national advocacy services will be displayed in prominent areas in the house.

Proposed Timescale:

1. 30th September 2015
2. 26th May 2015
3. 30th September 2015
4. 22nd August 2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

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

The centre had insufficient space for securing personal belongings and possessions.

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. A local operational procedure will be devised to ensure each resident's personal clothing is maintained and stored appropriately.

2. Storage options will be reviewed for each resident by the clinical nurse manager 2 in conjunction with key workers. This review will identify any gaps relating storage and personal property of residents.

3. Follow this review priority will be given to any resident requiring additional storage for clothing, personal property and possessions.

Proposed Timescale:

1. 21st April 2015
2. 18th May 2015
3. 1st June 2015

Proposed Timescale: 01/06/2015

Theme: Individualised Supports and Care

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

Activities were not based on resident's interests or needs.

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. Weekly residents' meeting with the staff team will be commenced to ensure that residents have a choice with regard to what activities they participate in. These activities will reflect their interests, capacities and developmental needs.
2. A record will be maintained of this weekly meeting. The outcomes of these meetings will inform each resident's weekly social and activity timetable.
3. The outcomes of these activities for residents will be documented in the daily record book.
4. The person in charge will review the activities to ensure residents are receiving positive outcomes from these activities
5. The Clinical Nurse Manager 2 will coordinate the systematic review of all Personal Outcomes Measures (POMS) and ensure they are up to date to ensure identified social goals of each resident adequately met.

Proposed Timescale:

1. 11th May 2015
2. 11th May 2015
3. 11th May 2015
4. 11th May 2015
5. 22nd July 2015

Proposed Timescale: 22/07/2015

Theme: Individualised Supports and Care

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

There was no evidence to show that complaints had been investigated.

Action Required:

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

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

1. All complaints will be managed and investigated in line with Saint John of God Complaints policy SJOGCS17 Management of Consumer Feedback to include Comments, Compliments & Complaints
2. All staff members to be re-inducted to the complaints policy by the person in charge to ensure they understand the process to follow in the event of a complaint being made.
3. The person in charge will review the complaints log and amend as required to ensure it demonstrates improvements have been made regarding responding to complaints.
4. The complaints log is present & maintained in the residents' home.
5. All local complaints will be reviewed at the forth-nightly staff meeting to ensure complaints are been investigated promptly.
6. The Person in Charge will review all complaints at the designated centre management team meeting to ensure complaints are being investigated promptly.
7. All data from the complaints log will be reviewed and analysed at the monthly Quality and Safety committee meetings to ensure measures put in place were effective in resolving the complaints.

Proposed Timescale:

1. 22st April 2015
2. 22st April 2015
3. 11th May 2015
4. 11th May 2015
5. 11th May 2015
6. 29th May 2015
7. 25th May 2015

Proposed Timescale: 29/05/2015

Theme: Individualised Supports and Care

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

There was no evidence that appropriate measures had been put in place to deal with the issues raised in the complaints log.

Action Required:

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for

improvement in response to a complaint.

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

1. All complaints will be managed and investigated in line with Saint John of God Complaints policy SJOGCS17 Management of Consumer Feedback to include Comments, Compliments & Complaints
2. All staff members to be re-inducted to the complaints policy to ensure they understand the process to follow in the event of a complaint being made.
3. The person in charge will review the complaints log and amend as required to ensure it demonstrates improvements have been made regarding responding to complaints.
4. The complaints log is present & maintained in the residents' home.
5. All local complaints will be reviewed at the fortnightly house meeting to ensure complaints are been investigated promptly.
6. The Person in Charge will review all complaints at the monthly designated centre Management Team meeting to ensure complaints are been investigated promptly.
7. All data from the complaints log will be reviewed and analysed at the monthly Quality and Safety committee meetings to ensure measures put in place were effective in resolving the complaints.

Proposed Timescale:

1. 22st April 2015
2. 22st April 2015
3. 11th May 2015
4. 11th May 2015
5. 11th May 2015
6. 31st May 2015
7. 25th May 2015

Proposed Timescale: 31/05/2015

Theme: Individualised Supports and Care

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

There was no evidence that a review of all complaints had taken place to ensure they had all been responded to appropriately.

Action Required:

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

maintained.

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

1. All complaints will be managed and investigated in line with Saint John of God Complaints policy SJOGCS17 Management of Consumer Feedback to include Comments, Compliments & Complaints
2. All staff members to be re-inducted to the complaints policy to ensure they understand the process to follow in the event of a complaint being made.
3. The person in charge will review the complaints log and amend as required to ensure it demonstrates improvements have been made regarding responding to complaints.
4. The complaints log is present & maintained in the residents' home.
5. All local complaints will be reviewed at the fortnightly house meeting to ensure complaints are been investigated promptly.
6. The Person in Charge will review all complaints at the monthly Management Team meeting in the designated centre to ensure complaints are been investigated promptly.
7. All data from the complaints log will be reviewed and analysed at the monthly Quality and Safety committee meetings to ensure measures put in place were effective in resolving the complaints & accurate complaint records are been maintained.

Proposed Timescale:

1. 22st April 2015
2. 22st April 2015
3. 11th May 2015
4. 21st April 2015
5. 11th May 2015
6. 31st May 2015
7. 25th May 2015

Proposed Timescale: 31/05/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Residents were not facilitated to communicate according to their needs.

Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

1. The Clinical Nurse Manager 2 & key workers in conjunction with the Person in Charge will co-ordinate the review and update of all Communication passports in the house.
2. The Clinical Nurse Manager 2 in conjunction with the Person in Charge will ensure that residents with communication tools will be supported to use them in all environments as per speech and language therapist guidelines.

Proposed Timescale: 22/04/2015

Theme: Individualised Supports and Care

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

Personal plans did not all outline the communication supports for residents. Staff were not implementing the communication supports for residents.

Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

1. The Clinical Nurse Manager 2 & key workers in conjunction with the Person in Charge will co-ordinate the review and update of all Communication passports in the house.
2. The Clinical Nurse Manager 2 in conjunction with the Person in Charge will ensure that residents with communication tools will be supported to use them in all environments as per speech and language therapist guidelines.
3. The clinical nurse manager will co-ordinate the review and updates of Communication passports for all residents.
4. These passports will be included in the residents personal Plan.
5. The staff team will sign a log to indicate they have read and understand the information relating to residents' communication needs which is documented in revised communication passports.
6. The communication needs of residents will be discussed with the staff team at fortnightly meetings.

Proposed Timescale:

1. 22nd April 2015
2. 22nd April 2015

3. 22nd April 2015
4. 22nd April 2015
5. 22nd April 2015
6. 11th May 2015

Proposed Timescale: 11/05/2015

Theme: Individualised Supports and Care

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

Residents were not facilitated to access their communication tools.

Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

1. The Clinical Nurse Manager 2 in conjunction with the Person in Charge will ensure that residents with communication tools & communication passports will be supported to use them in all environments as per speech and language therapist guidelines.
2. Communication passports will be included in the residents personal Plan.
3. The staff team will sign a log to indicate they have read and understand the information relating to residents' communication needs which is documented in communication passports.
4. The communication needs of residents will be discussed with the staff team at fortnightly.
5. The Clinical Nurse Manager 2 & key workers in conjunction with the Person in Charge will co-ordinate the review and update of all Communication passports in the house.

Proposed Timescale:

1. 22nd April 2015
2. 22nd April 2015
3. 22nd April 2015
4. 22nd April 2015
5. 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

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

Residents were not supported to use the communication aids created for them.

Action Required:

Under Regulation 10 (3) (c) you are required to: Ensure that where required residents are supported to use assistive technology and aids and appliances.

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

1. The Clinical Nurse Manager 2 in conjunction with the Person in Charge will ensure that residents with communication tools & communication passports will be supported to use them in all environments as per speech and language therapist guidelines.
2. Communication passports will be included in the residents personal Plan.
3. The staff team will sign a log to indicate they have read and understand the information relating to residents' communication needs which is documented in communication passports.
4. The communication needs of residents will be discussed with the staff team at fortnightly.
5. The Clinical Nurse Manager 2 & key workers in conjunction with the Person in Charge will co-ordinate the review and update of all Communication passports in the house.

Proposed Timescale:

1. 22nd April 2015
2. 22nd April 2015
3. 22nd April 2015
4. 22nd April 2015
5. 30th September 2015

Proposed Timescale: 30/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

Arrangements and resources were not in place to meet the social needs of residents.

Action Required:

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

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

1. A committee was established to review the content of 'My Personal Plan' (MPP). A

revised personal planning template has been agreed.

2. All personal plans will now be reviewed by the person in charge in conjunction with the resident / their representative and their circle of support to ensure their assessed needs are met in a timely manner.

3. Following the reviews the personal plans will be updated by the residents' key workers to ensure personal plans meet their assessed needs.

4. The Person in Charge will meet with Clinical Nurse Manager and the team on a monthly basis for regular review and updates on progress relating to personal plans.

Proposed Timescale:

1. 21st April 2015
2. 30th September 2015
3. 30th September 2015
4. 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

Plans were not in an accessible format for residents.

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:

A committee was established to review the content of 'My Personal Plan' (MPP). A revised personal planning template has been agreed in an accessible version for residents.

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Planning process did not promote the maximum participation of residents.

Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

All personal plans will now be reviewed in conjunction with the resident / their representative and their circle of support to ensure their assessed needs are met in a timely manner with their maximum participation.

Proposed Timescale: 30/09/2015

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 premises were not designed, laid out to meet the needs of residents, or to reduce certain risks.

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:

A committee is been established to identify and plan suitable interim accommodation for residents in the designated centre.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

The building was in need of decorative repair internally and externally.

Action Required:

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

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

The Person in Charge will ensure a schedule of maintenance, improvement and refurbishment will be developed for the house.

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

The building lay out and furniture was not promoting maximum accessibility for wheelchair users.

Action Required:

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

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

A committee is being established to identify and plan suitable interim accommodation for residents in the designated centre.

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

- Inadequate private accommodation for residents.
- Bathrooms of unsuitable size to meet the manual handling needs of residents.
- inadequate storage facilities.
- Insufficient cooking facilities.
- Unsuitable numbers of showers.

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. A committee is being established to identify and plan suitable interim accommodation for residents in the designated centre.
2. All entrances to the house will be reviewed and secured to reduce the risk of persons entering without the permission of residents and supporting staff. One point of entrance for persons entering the building will be identified.
3. All visitors entering the house will be requested to sign the visitor's book on arrival.

Proposed Timescale:

1. 15th May 2015
2. 22nd April 2015
3. 22nd April 2015

Proposed Timescale: 15/05/2015

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:

There was no system in place to identify, manage and review risks in this centre.

Action Required:

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

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

1. The Risk Management Policy for the house will be reviewed in light of concerns observed regarding manual handling and infection control.
2. An audit on Manual Handling practices in the house will be conducted. All manual handling assessments will be updated as required following the completion of the audit.
3. The Person in Charge will review all staff training records to ensure all staff have completed training in Manual handling.
4. The person in charge in conjunction with the staff team review all risk assessments associated with manual handling to ensure the documented controls are adequate to meet the safety needs of residents in their home.
5. All other risk assessments will be reviewed and updated as required by the staff team within the house. This review will be coordinated by the person in charge.
6. Reviews of risk assessments will be carried out at house level as per documented review dates.
7. Risk assessment reviews will also be discussed at forth-nightly house meetings.
8. Training re risk assessment will be scheduled for clinical nurse managers.
9. The site specific emergency plan will be reviewed and updated.
10. The Person in Charge will ensure, a schedule of maintenance, improvement and refurbishment will be developed for the designated centre.

11. All broken furniture has been removed.

12. All entrances to the house will be reviewed and secured to reduce the risk of persons entering without the permission of residents and supporting staff. One point of entrance for persons entering the building will be identified.

13. All visitors entering the house will be requested to sign the visitors book on arrival & departure.

14. All Incidents/Accidents will be reviewed at the fortnightly staff meeting and corrective Action/Learning will be communicated to all staff.

15. All data and analysis from Incidents/Accidents will be reviewed by the person in charge and programme manager. This will be reviewed also through the Quality and Safety Committee.

Proposed Timescale:

1-6. 30th May 2015

7. 11th May 2015

8. 30th September 2015

9. 22nd April 2015

10. 22nd April 2015

11. 22nd April 2015

12. 22nd April 2015

13. 22nd April 2015

14. 30th May 2015

15. 30th May 2015

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

There was a lack of appropriate investigation of and learning from adverse events to prevent re-occurrence.

Action Required:

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

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

1. An operational procedure is under development for the designated centre to support staff in completing the Adverse Incident forms, and the process of reporting accidents and incidents.

2. All staff members will receive refresher training in the process of adverse incident reporting and the operational procedure.

3. All Incidents/Accidents and near misses, will be reviewed at the fortnightly staff meeting

4. Corrective Action/Learning will be communicated to all staff to prevent the likelihood of re-occurrence through the completion of minutes which all staff members will sign to say they have understood and read the information.

5. All data and analysis from Incidents/Accidents will be reviewed by Person in Charge, Programme Manager & Quality and Safety Committee Meetings

6. The Person in Charge will conduct an annual audit of adverse incidents & devise an improvement plan & shared learning for the designated centre.

Proposed Timescale:

1. 30th June 2015

2. 30th June 2015

3. 11th May 2015

4. 12th May 2015

5. 30th May 2015

6. 30th November 2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Practices and storage in the designated centre were not ensuring residents were protected from the risk of infection. For example, overflowing incontinence bins and inadequate storage.

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:

A standard operational procedure will be developed to assist staff in implementing infection control measures which is explicit with regard to the storage and disposal of infectious material.

Proposed Timescale: 21/04/2015

Theme: Effective Services

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

There was a lack of documentary evidence to show that all staff had received training in fire safety.

Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

1. The Person in Charge will complete an immediate audit of staff training in fire safety
-
2. Fire safety training will be scheduled accordingly.

Proposed Timescale:

1. 22nd April 2015
2. 27th April 2015

Proposed Timescale: 27/04/2015

Theme: Effective Services

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

****IMMEDIATE ACTION****

Numbers of staff at night had been reduced to 1 to facilitate other centres. This was not in line with the evacuation plan, and did not ensure the safe evacuation of residents in the result of a fire.

Action Required:

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

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

1. As P.I.C I assure the Authority that staffing levels will be reviewed as a matter of urgency. I assure the Authority that staffing levels will not fall below 3 on duty, to ensure the safe evacuation of residents.
2. The Person in Charge will review the Emergency Evacuation Plan for the designated centre. (21.03.2015)

Proposed Timescale: 04/03/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was a lack of evidence to show the efforts made to identify and alleviate the underlying cause of all residents' behaviour that was challenging.

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. The Person in Charge will coordinate with the clinical nurse manager 2 a review of the behaviour support plans currently in place for residents and ensure where necessary a functional assessment is completed.
2. An audit of staff training in the Management of Actual Potential Physical Aggression (MAPPA) in the designated centre will be undertaken by the Person in Charge.
3. Staff training in the area of MAPPA will be scheduled.

Proposed Timescale:

1. 30th September 2015
2. 30th September 2015
3. 21st December 2015

Proposed Timescale: 21/12/2015

Theme: Safe Services

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

The provider was failing to consistently promote a restraint free environment in line with evidence based practice, or ensure that the resources of the centre were supporting residents to use these restraints for the shortest duration necessary.

Action Required:

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

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

The Person in Charge will ensure that any restrictive procedure being implemented including physical, chemical or environmental restraint, if applied will be in accordance with national policy and evidence based practice.

Proposed Timescale: 21/04/2015

Theme: Safe Services

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

There were inadequate reporting mechanisms for the reporting of suspicions of abuse. Practices in the centre were resource led, and institutionalised.

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. The Person in Charge will conduct a review of staff training records in safeguarding.
2. Refresher safeguarding training in relation to safeguarding residents and the prevention, detection and response to abuse will be scheduled for all staff.
3. All incidents of a safeguarding nature will be reported to the Designated Person.

Proposed Timescale: 21/04/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

The accident and incident log identified a resident left the building unknown to staff. This had not been notified to the Authority.

Action Required:

Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

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

1. The Person in Charge will ensure all required notifications will be sent in promptly and within the required timeframe.
2. The incident referred to in the report has been reviewed and a risk assessment

completed for the resident.

3. The Person in Charge will review the current standard operational procedure for missing persons.

Proposed Timescale: 21/04/2015

Theme: Safe Services

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

The person in charge had not submitted full quarterly notifications for this centre for the March and September of 2014.

Action Required:

Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

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

1. The Person in Charge has reviewed all incidents retrospectively and forwarded all required notifications the authority.

2. The Person in Charge will ensure all required notifications will be sent in promptly and within the required timeframe.

Proposed Timescale: 21/04/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Insufficient implementation of advice from allied health care professionals, such as SALT and behaviour therapists.

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. The Person in Charge will review all SALT assessments as required and ensure all recommendations are in place and communicated to staff team.

2. In the event that any allied health care professional makes a recommendation in relation to the support / care of any resident this will be documented on the resident

personal plan. Any observations and follow on care is to be documented in the residents nursing notes/ daily record books.

3. All recommendations relating to residents assessed needs will be discussed at the fortnightly staff meeting.

4. Where observations are being taken and charted it will be referenced in the nursing notes.

Proposed Timescale:

1. 21st April 2015
2. 21st April 2015
3. 11th May 2015
4. 21st April 2015

Proposed Timescale: 11/05/2015

Theme: Health and Development

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

The manner in which the centre was resourced and operated did not facilitate resident to be supported to buy, prepare and cook their own meals.

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. A review of the mealtime options will be undertaken by Person in Charge Clinical Nurse Manager 2 and catering department manager to enhance participation and choice at mealtimes.
2. Food safety and hygiene training will be reviewed to ensure that all staff have the required training in food safety and hygiene.
3. An audit of the mealtime experience will be undertaken by the catering manager to evaluate the mealtime experience of residents.
4. The catering facilities will be reviewed to review opportunity for smaller groups to avail of more meaningful mealtime experiences.
5. Key workers will explore opportunities to support residents in meaningful participation of buying, preparing and cooking meals should when they choose to..

Proposed Timescale:

1. 22nd May 2015
2. 22nd May 2015
3. 31st August 2015
4. 30th June 2015
5. 30th October 2015

Proposed Timescale: 30/10/2015

Theme: Health and Development

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

Access to meals at all times was limited due to the manner in which the centre was resourced and operated.

Action Required:

Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

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

1. A review of the mealtime options will be undertaken by Person in Charge Clinical Nurse Manager 2 and catering department manager to enhance participation and choice at mealtimes.
2. An audit of the mealtime experience will be undertaken by the catering manager to evaluate the mealtime experience of residents.
3. The catering facilities will be reviewed to review opportunity for smaller groups to avail of more meaningful mealtime experiences and improve access to choices of food including snacks.

Proposed Timescale:

1. 22nd May 2015
2. 31st August 2015
3. 30th June 2015

Proposed Timescale: 31/08/2015

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:

Documentation in relation to prescription records and times of administration were

unclear.

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:

1. The Person in Charge will review all prescription records to ensure administration times are clear.
2. All new staff receives an induction into the medication management of the designated Centre.

Proposed Timescale: 21/04/2015

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 nominated person in charge was not adequately involved in the governance, oversight and management of the designated centre.

Action Required:

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

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

1. The role of the Person in Charge has been reviewed.
2. An interim arrangement is now in place for the Designated Centre.
3. A recruitment drive has been undertaken to recruit a permanent Co-ordinator who will assume the role of Person in Charge for this Designated Centre.
4. This Person in Charge will be actively involved in the governance, management and oversight in the Designated Centre.

Proposed Timescale:

1. 21st April 2015
2. 21st April 2015
3. 30th June 2015
4. 30th June 2015

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

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

There were not clear lines of accountability and authority in the centre.

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 Review will be completed re the governance and management in the Designated Centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of Designated Centre.
2. The Statement of Purpose (SOP) will be reviewed in line with new governance management structures.
3. A service organogram will be distributed to all staff highlighting the new structure.

Proposed Timescale:

1. 30th June 2015
2. 30th June 2015
3. 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

Reviews completed were ineffective to ensure care and support was delivered in line with the standards. Little evidence of positive outcomes for residents as a result of reviews.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

1. The Quality & Safety committee will review all audits, data and other relevant reports i.e. unannounced visits, to the Designated Centre, ensure action plans are developed and ensure all recommendations on quality and safety is followed up and monitored by the Person in Charge.

2. An annual review of the Quality and Safety of the Designated Centre will be completed

Proposed Timescale:

1. 25th May 2015
2. 31st January 2016

Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

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

There were inappropriate means for staff to raise concerns in the centre as evidenced through the use of the complaints procedure.

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. All complaints will be managed and investigated in line with Saint John of God Complaints policy SJOGCS17 Management of Consumer Feedback to include Comments, Compliments & Complaints.

2. All staff members to be re-inducted to the complaints policy by the person in charge to ensure they understand the process to follow in the event of a complaint being made.

3. Staff are encouraged to voice raise concerns about the quality and safety of the care and support provided to residents at the fortnightly staff meetings and/or as concerns arise.

4. Unresolved concerns will be escalated to Person in Charge regarding safety of care and support of residents.

5. The Person in Charge will review staff supervision in the designated centre, and develop a local operational procedure for staff supervision.

6. Clinical Nurse Managers attend fortnightly meetings with the Person in Charge

7. The Person in Charge attends fortnightly meetings with the Programme Manager.

Proposed Timescale:

1. 21st April 2015
2. 30th May 2015
3. 11th May 2015
4. 30th May 2015
5. 30th June 2015
6. 30th July 2015
7. 30th September 2015

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

There were ineffective management systems in ensure overview of the service provided to residents, and that care and support was provided in line with standards.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

1. A Review has been completed re the governance and management in the Designated Centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of Designated Centre
2. The role of the Person in Charge has been reviewed.
3. An interim arrangement is now in place for the Designated Centre.
4. A recruitment drive has been undertaken to recruit a permanent Co-ordinator who will assume the role of Person in Charge for this Designated Centre.
5. This Person in Charge will be actively involved in the governance, management and oversight in the Designated Centre.
6. The Quality & Safety committee will review all audits, data and other relevant reports i.e. unannounced visits, to the Designated Centre, ensure action plans are developed and ensure all recommendations on quality and safety is followed up and monitored by the Person in Charge
7. The Person in Charge will review staff supervision in the designated centre, and develop a local operational procedure for staff supervision.

8. Clinical Nurse Manager attend fortnightly meetings with person in Charge

9. There are fortnightly staff team meetings in the Designated Centre.

Proposed Timescale:

1. 21st April 2015
2. 21st April 2015
3. 20th April 2015
4. 30th June 2015
5. 30th June 2015
6. 25th May 2015
7. 11th May 2015
8. 11th May 2015
9. 21st April 2015

Proposed Timescale: 30/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

****IMMEDIATE ACTION****

Staff numbers had been reduced to 1 on duty for periods of the night with 18 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:

As P.I.C I assure the Authority that staffing levels will be reviewed as a matter of urgency. I assure the Authority that the staffing levels at night will not fall below 3 on duty to ensure the safe evacuation of residents.

Proposed Timescale: 04/03/2015

Theme: Responsive Workforce

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

Staffing levels were inadequate to meet the social needs of residents and ensure a good quality of life.

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:

A full review of staffing roster, numbers and skill mix will be undertaken by the Person in Charge.

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:

Not all staff were appropriately trained.

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. The Person in Charge will conduct an audit of staff training records and identify training needs for the Designated Centre.
2. A training plan will be developed appropriate to meet staff requirements.

Proposed Timescale: 21/05/2015

Theme: Responsive Workforce

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

There was a lack of oversight and supervision of staff in the designated centre.

Action Required:

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

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

1. The Person in Charge will review staff supervision in the designated centre, and develop a local operational procedure for staff supervision.
2. Clinical Nurse Manager attend fortnightly meetings with person in Charge
3. There are fortnightly staff team meetings in the Designated Centre.

4. Performance Development Review (PDR) will be completed with all staff and evidenced in their Human Resource file.

Proposed Timescale:

1. 11th May 2015
2. 11th May 2015
3. 21st April 2015
4. 29th May 2015

Proposed Timescale: 29/05/2015