

**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-0002936
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:	Conor Brady
Support inspector(s):	Conor Dennehy; Gary Kiernan
Type of inspection	Unannounced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 22 July 2015 10:00 To: 22 July 2015 20:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

HIQA became significantly concerned about the safety and the quality of life for residents in St Raphael's campus, a residential service operated by St John of God Kildare Services. St Raphael's residential campus contains seven designated centres providing residential services to 137 people with intellectual disabilities.

Following the initial inspections in 2015, inspectors undertook a series of ten planned inspections to assess the progress of the provider in addressing the issues of concern which were impacting on the lives of residents.

These unannounced inspections found evidence of institutional practices, poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued a series of immediate actions, warning letters and held regulatory and escalation meetings with the provider and members of senior management.

Due to a failure of the provider to implement effective improvements for residents, HIQA issued notices of proposal to cancel the registration of three of the centres on this campus. The provider subsequently issued HIQA with plans for the closure of one designated centre, and transitional plans to provide alternative living

arrangements for a number other residents which addressed the resident's safety, welfare and quality of life.

The most recent inspections have confirmed that the provider has undertaken substantive changes in governance and management across this campus. There have been improvements in staffing, persons in charge and other management positions. While there continues to be non compliances, and further improvements are required in relation to the quality of life for residents, the provider has demonstrated that they are now taking effective action to achieve these improvements.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection report specifically relates to an unannounced triggered inspection of one designated centred on the campus. This inspection was conducted following receipt of information by HIQA regarding an incident involving a serious injury to a resident. This was the second inspection of this centre.

This centre was described as a secure unit (by staff and in documentation reviewed) and catered for 24 full time residents with complex needs. The centre, which opened in 2001, was based on a large campus setting and comprised of a large single storey dwelling divided into four secure units. The internal doors to these units were locked. The inspectors found that the centre was a highly restrictive environment.

As part of this inspection, inspectors met with residents, the person in charge, staff nurses, a social care leader, social care workers, health care assistants and relief staff. Persons participating in the management of this centre attended preliminary feedback following this inspection. Inspectors observed practices and reviewed documentation such as care plans, person centred plans, behaviour support plans, accident and incident records, risk assessments and risk management plans, meeting minutes, safeguarding referrals, training records, staff files and policies and procedures.

Overall inspectors identified continued significant non-compliance with the regulations across all of the outcomes inspected.

Inspectors had concerns that the institutional nature of this setting and the resources available within it were having a negative impact on residents' safety and quality of life. There was an inappropriate mix of residents with highly complex needs. As a result there were a very high number of incidents of peer to peer acts of aggression resulting in poor outcomes for residents and the physical injury of residents on a frequent basis. The provider had identified that a number of residents were inappropriately placed in this centre but had failed to take appropriate action to address this situation to ensure all residents were protected from harm.

Inspectors identified very significant non compliance in the following areas;

- Safeguarding and Safety

- Positive Behavioural Support
- Health, Safety and Risk Management
- Governance and Management
- Individualised Assessment and Care Planning for Social Care Needs
- Workforce and Staffing

Governance and management arrangements were not effective. The inspectors found that this area had not improved since the previous inspection. As a result, areas of risk within the centre were not managed effectively and residents continued to be exposed to an unacceptable level of risk.

Residents' assessed needs were not met in this centre. The system of health and social planning was not effective to support residents' health and social care needs on a consistent basis. There were not sufficient numbers of staff to meet residents' assessed needs.

All of these areas will be discussed in further detail in the main body of the report and in the accompanying action plan.

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 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

As highlighted in the previous inspection report, social care needs were not fully assessed and met. Inspectors found that there had been insufficient changes since the previous inspection in terms of the standard and quality of residents individualised assessments and care planning to meet resident's social goals.

The inspectors observed some residents going out on day programmes and other residents went on a lunch outing on the day of inspection.

Inspectors reviewed a number of residents' personal plans and found an effective and meaningful assessment of each residents' health and social care needs was not in place. Inspectors did not find that personal plans were capturing residents' social needs and wishes and inspectors remained concerned that the standard of goal setting remained inadequate to ensure improved quality of life for residents.

In discussing this area with staff members it was clear that there was an acceptance of the need for a more focussed emphasis on the facilitation of pursuing and achieving goals with residents. However, the manner and pace at which this was happening had not significantly changed since the previous inspection. Inspectors found a continued theme of basic goals not achieved for residents within this centre (as was the case on the previous unannounced inspection of this centre). For example residents with social goals to go to concerts/outings had no evidence of same happening for residents. Inspectors did not find meaningful goals in place for all residents with 'meeting my family' or 'going on an activity once a week' viewed in residents' plans as annual goals as opposed to being regular activities in the person's life. Inspectors found that poor

goal planning was as a result of poor social care assessments which did not meaningfully address resident's needs in a way which facilitated the participation of the resident, family and the wider support network. In addition, a resident highlighted as requiring a formal needs assessment by senior management had no such assessment in place.

Arrangements were not put in place to meet even the most basic of goals which had been set for residents. One resident had not been facilitated to go on social outings, in line with an assessed goal for 2015. Staff told inspectors, that these outings had not occurred as a key worker had been on extended leave. In the case of another resident a large number of shopping trips had not taken place. The documentation attributed this to "behaviours". Inspectors found that failure to support residents with these activities was unacceptable and was having a direct negative impact on their quality of life. Inspectors found all plans were not reviewed/updated at the required intervals and in accordance with residents' needs, wishes preferences. Care plans were not in an accessible format having regard to the communication needs of the residents.

Personal plans did not have sufficient evidence of multidisciplinary review and input. For example, one resident who was described as having specific needs regarding his ingestion of inedible objects was described as having a 'mild' form of this condition (PICA). Inspectors found no assessment or multidisciplinary input regarding the management of this behaviour. There was a risk assessment in place that highlighted the resident was a 'low risk' of injury as a result of this behaviour, aside from this there was insufficient guidance regarding this residents' behaviour. This matter is also addressed under Outcome 7.

As a congregated setting with 24 residents (some of whom required 1:1 staffing due to behaviours) inspectors found that residents' opportunities to pursue individual interests was very limited. Inspectors found that residents' quality of life in this centre was seriously impacted by living with other residents with significant behaviours. This was resulting in a resource led service whereby residents were being managed collectively as opposed to as individuals.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were significant gaps in the provider's oversight, review systems and implementation of risk management procedures within this designated centre. While a

risk management policy was in place and risk assessments were found regarding individual residents, inspectors were concerned regarding their implementation. Inspectors found that due to the complexity of residents' behaviours within this designated centre, this area of risk management was critical in terms of residents' safety.

As highlighted in the previous inspection, inspectors found a high level of reported accidents, incidents and near misses in this centre. Inspectors found that in the four months since the previous inspection there had been 111 recorded incidents. These incidents ranged in severity and included instances of residents hitting other residents, resident falls and suspected falls, residents grabbing/hitting out at staff, residents' self injurious behaviour and unexplained injuries to residents. The provider had failed to put in place adequate control measures to reduce or prevent adverse incidents and events from re-occurring since the previous inspection.

The inspectors were very concerned regarding the management of risk and implementation of risk management procedures and safeguards regarding a recent serious incident in this designated centre involving a resident with complex behaviours. Inspectors found that although risk assessments, control measures and risk management documentation was in place, there was evidence that these control measures were not implemented which resulted in a serious incident occurring whereby the safety of this resident was significantly compromised. In addition, the inspectors were concerned with the effective implementation and staff knowledge of risk assessments in the areas of resident falls and behaviours that challenge. These areas are discussed further in Outcome 8 and Outcome 11.

Inspectors reviewed the fire register in place and found maintenance checks of the emergency lighting and alarm system. A fire drill had been carried out since the first inspection of this designated centre. Daily checks of fire exits and weekly checks of emergency lighting were being completed by staff. Such checks carried out on 2 July 2015 highlighted that certain emergency and exit lights were not working. At the time of inspection these issues had yet to be rectified.

Training records indicated that most staff had undergone the required fire safety training within the previous two years. However from the list provided two staff members had not undergone such training. A review of records indicated that some staff members had received training in the use of an evacuation chair while others had not. The use of an evacuation chair for residents was highlighted as being necessary in the centre's local evacuation plan.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

The systems in place to protect residents from being harmed were inadequate.

While there were clear reporting protocols and procedures found regarding the reporting of allegations, disclosures or suspected cases of abuse, there was not appropriate action taken by the provider to reduce risk and protect all residents from exposure to physical harm and to repeated incidents of violence and aggression.

The provider had not ensured that adequate controls were in place to protect residents from physical harm. Inspectors reviewed the documentation and spoke to staff regarding a recent serious incident involving a resident, which had been notified to the Authority. The resident, exhibited complex behaviours and had ingested an inedible object. As a result of this incident the resident required transfer to hospital and serious medical intervention. Inspectors were concerned that the levels of risk assessment regarding this resident did not reflect the severity of the behaviour displayed. The resident had exhibited similar behaviour on many occasions and this was well documented and known to staff. Despite this, documentation reviewed by inspectors, indicated that the control measures to protect this resident were found not to have been fully implemented on the date the incident took place. Specifically, the documentation indicated that the resident did not have one to one staff supervision, in accordance with the resident's risk assessment, at the time the incident took place. The issue of staffing levels is addressed under outcome 17.

As highlighted in the previous outcome, inspectors were concerned with the high number of reported accidents and incidents in this centre. This was also the case in terms of the number of safeguarding referrals to the designated liaison person (DLP) for this designated centre. The inspectors reviewed 26 safeguarding referrals in a 3 month period (April-June 2015). Inspectors found that many of the issues regarding safeguarding were directly linked to the inappropriate mix of residents with significant behaviours that challenge within this centre. These incidents were mainly made up of residents hitting/assaulting other residents and unexplained bruises/injuries to residents. The provider had not taken sufficient action to address this situation since the previous inspection.

Inspectors found multiple incidents whereby residents were assaulted by other residents. In some instances certain residents were being targeted and getting hit on a regular basis. For example, following a previous inspection one particular resident was identified as a risk of continual targeting of assault. Inspectors found that the provider's response to protecting this resident, which involved temporarily moving the resident to

another part of the centre, was inadequate and there had been continued instances whereby this resident was subject to assaults. The provider's DLP clearly highlighted in their assessment of the safeguarding of this resident as 'extremely vulnerable in his residence'. Inspectors found that this resident was not being appropriately protected by the provider.

Another resident was observed as expressing regular bouts of screaming/crying at a very intensive pitch and loud level. Staff reported that this happened 5-7 times a day usually. Other residents living with this resident were exposed to this level of noise on a daily basis which was found to be impacting on their ongoing quality of life. Inspectors found that one resident who became agitated by this constant noise, recently became quite aggressive and caused injury to the other resident as a result. This further demonstrated to inspectors the negative effects of an inappropriate mix of residents with complex behaviours living together.

Regarding the provision of emotional, behavioural and therapeutic support in the management of behaviours that challenge, inspectors found instances of inconsistent behavioural support planning and staff knowledge of proactive and reactive strategies in supporting residents.

This centre was a highly restrictive environment by design as the centre was established as a 'secure unit'. Residents resided in locked 'pods' whereby staff carried keys and the majority of doors were locked. Inspectors noted a seclusion room but were informed by the person in charge that this had not been used since the previous inspection and that no residents were 'written up' for seclusion.

As highlighted in the previous inspection report, inspectors were very concerned at the levels of restraint and restriction in the centre and found that residents were subject to restrictions not necessarily in line with their own assessed needs. For example, residents who lived with other residents (who were deemed to require restrictions such as locked internal doors) were subject to the same restrictions by default.

Some improvements had occurred for residents since the last inspection. For example, due to the reduction in resident numbers, doors to the secure garden were now open and residents could now access this area independently. While inspectors, saw this as a positive development for the residents, it was noted that the reduction in numbers and subsequent improvements had not taken place as a result of planned interventions taken by the provider.

Inspectors found inconsistencies in the levels of behavioural support guidance and therapeutic guidance in terms of residents' plans. For example, inspectors found multi-element behavioural support plans (MEBS) that were not appropriately updated (since 2011/2013) and contained strategies and techniques that were not used in practice and were no longer relevant. For example, one resident's plan contained details of systematic instruction to be used with a resident that included the use of assistive technology and communication boards. The inspectors found that neither of these communicative approaches were used with this resident in terms of behavioural management practice. This particular resident was noted as being involved in a number of incidents/instances of hitting out/assaulting other residents.

Inspectors were concerned in reviewing one resident who was subject to two instances of physical holds and restraint in the months prior to inspection. This resident was described as requiring a 1:1 (male staff) due to challenging behaviour. The inspector found that while staff on duty in the early part of the day knew this resident very well and demonstrated strong knowledge of his behavioural management plan, other staff did not. For example, all staff members spoken to by inspectors, on the evening shift did not demonstrate the required knowledge of the resident's behavioural support plan and, in particular, the proactive/reactive elements of this plan prior to the use of restraint. For example, behavioural warning signs, triggers to behaviour and staff responses that should occur before restraint/physical holds are used. Inspectors found that this could lead to inconsistent care practices and poor outcomes for the resident. This was discussed directly with management at feedback meeting to ensure it was immediately and appropriately addressed by the provider at the close of inspection.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

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

Findings:

Inspectors found some examples whereby residents had access to allied health professionals and were reviewed medically to promote good health. However inspectors also found instances whereby residents' health care planning, access to services and assessment required improvement to ensure residents were continually and consistently supported to enjoy best possible health.

The inspectors found there was good access to the G.P. and to the psychiatrist. Inspectors reviewed some good examples of assessments for residents regarding eating, drinking and swallowing. For example, speech and language and dietician review along with corresponding assessments were found in place for residents. However this was not consistent for all residents reviewed.

Inspectors found that the quality of healthcare assessments was inconsistent across the designated centre. For example, a resident at risk of falls had not had their assessment updated following a recent fall. In addition, inspectors found that while hip protectors had been recommended by a physiotherapist they were not in place at the time of inspection. This resident did not have a comprehensive falls prevention care plan to

guide staff. Inspectors spoke to the staff member who was responsible for supervising this resident. This staff member was not aware that the resident was at risk of falls. Staff knowledge with regard to keeping residents safe is also discussed under outcome 17.

Inspectors were not satisfied with aspects of epilepsy management within this centre. For example, staff did not have a clear understanding as to which residents had epilepsy and were prescribed emergency (PRN) rescue medication. Inspectors saw that one resident was prescribed PRN medication in the event of a seizure. However, inspectors spoke to a number of staff and found that they had no knowledge of this. In addition, there was no epilepsy management care plan in place in the event that this resident had a seizure. While staff stated that this resident had no recent history of seizure, the systems for responding to this health care need were not adequate. The actions relating to residents' assessments and care planning are included under outcome 5 while actions relating to staff knowledge are addressed under outcome 17.

Regarding food and nutrition inspectors observed residents eating bacon and cabbage for their dinner on the day of inspection. Meals were provided from a centralised canteen which was observed to be an institutional model of care regarding the provision of food. Inspectors observed some marginal improvements since the previous inspections. For example, the use of the hatch system to pass food out to the residents had been discontinued and staff served some food from a trolley in the dining room. Inspectors observed open doors to the kitchen while residents were eating. Inspectors found residents with difficult behaviours were eating in isolation to minimise the impact of their behaviour on other residents. Place mats had also been introduced which contained residents individual dietary requirements.

Inspectors found that residents were not supported to buy, prepare or cook their own meals in the centre. Satisfactory systems were not in place to ensure residents' hot food was maintained at an appropriately warm temperature. For example, having arrived from the canteen the main meal was stored at room temperature. As this food was delivered, twenty minutes before some residents returned to the centre from their day service, there was a risk of food becoming cold. For the evening meal, staff were observed using a heated trolley to store hot food.

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):

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

implemented.

Findings:

Improvements were required to ensure compliance with the Regulations regarding medication management practices.

Inspectors reviewed prescription, administration records and procedures for the storage and administration of medication. Practices for administration of medications were in place as was a medication policy. Staff told inspectors that medications were only administered by the nursing staff in this centre.

Inspectors found that some medication records were not clearly legible to all staff and did not contain all of the required information to allow staff to consistently administer medications safely. For example, the maximum dosage of PRN medications that could be administered in a 24 hour period was not stated. In addition to this, inspectors were concerned that prescriptions/protocols for PRN medications were not supported by enough detail to describe the conditions under which they were to be administered.

As highlighted in Outcome 11, inspectors were concerned to find that staff were not aware that a resident was prescribed emergency epilepsy medication and no care plan was in place.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The provider's governance, management and oversight of this designated centre was not sufficient to ensure that residents were provided with an appropriate level of care on a consistent basis. Inspectors found that the centre's quality enhancement plan (a plan based on improving quality of care of residents) was not being fully implemented at a pace that ensured the centre was compliant with the Regulations and Standards.

There was a person in charge in place who was 5 months in post. The person in charge managed one other centre of a similar profile. The person in charge held the role of Clinical Nurse Manager 3 (CNM 3) within the organisation and worked full time as is required by the Regulations. Inspectors were concerned that the person in charge was responsible for two large campus based settings providing services for residents with complex needs. Inspectors found that given the complexity of needs of the residents and given the number of improvements which were required, the provision of one person for these two centres was not sufficient.

The person in charge informed inspectors that the provider's quality team had completed the auditing of quality and safe care within the centre since the previous inspection. However inspectors found a quality enhancement plan (2015) had not yet been implemented to a satisfactory level. For example, the rate of change and implementation of actions in areas such as individualised assessment and social care needs, health, safety and risk management and safeguarding and safety was not adequate. Inspectors reviewed previous reviews/audits (2014/2015) highlighting proposed changes for residents and residents deemed to require transfers out of this centre. Inspectors found these changes were not implemented and these transfers did not happen for residents. As a result, some of these residents were exposed to continued incidents of aggression and violence from their peers, as described under outcome 8.

Inspectors noted that a number of high-level strategic measures were highlighted in action plans regarding this centre in the form of committees and review groups. For example, organisational structural review, quality enhancement strategic committee, person in charge implementation committee, designated centre committee and a quality and safety committee. However, these systems had not been effective to date and did not result in tangible improvements for residents in a timely way. Inspectors found that this related directly to ineffective governance and management systems. This theme is also discussed under outcome 18 with reference to the lack of a system for ensuring staff were adequately trained.

The person in charge highlighted that she had not yet conducted any audits within the designated centre, as part of her role, but planned to audit the implementation of a new medication management system when it was implemented in the centre. Inspectors found some auditing of incidents and accidents, by other staff, and the person in charge stated that this process was in its infancy. Inspectors were not satisfied with the auditing that was taking place in this centre and furthermore with the implementation of necessary change within the centre in response to audits.

Based on the findings of this inspection and the serious incident leading to this triggered inspection, inspectors were not satisfied that the provider's governance and management of this centre was effective in the delivery of safe and quality care to all residents. Inspectors found that, as highlighted in Outcomes 5, 7 and 8 in particular, the service provided to residents was not always safe, appropriate to residents' needs or consistently and effectively monitored. For example, the provider's failure to take appropriate action to ensure all residents were protected from harm and on-going peer to peer assault. Inspectors found it unacceptable that residents who were being continually physically assaulted/targetted by other residents, remained exposed to this

risk and aggression on an on-going basis. It was furthermore concerning as this matter had been specifically highlighted to the provider following the previous inspection.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

The number of staff was not adequate to meet residents' needs. Some staff did not have the required knowledge and training to support residents. The system to ensure that staff were provided with the necessary training was not adequate.

Inspectors found that residents' care plans referred to 'supervision levels' such as level 2, level 3 supervision. The inspector discussed these levels with staff and found that there was no formal guidance around what this actually meant and consisted of.

Inspectors found there were residents who required to be 'specialied' by staff on a 1:1 basis. However this was not always provided for as staff were expected to also support/supervise other residents in addition to the individuals assessed as requiring 1:1 support. Inspectors found other residents who were described by staff as requiring 2:1 support (for outings) but their care plans highlighted 1:1 support. The inspectors found a failure to provide the required level of staffing and supervision guidance based on assessed need compromised residents safety.

Inspectors spoke to a number of staff and found some staff knew residents very well and others did not. For example, some staff who worked long term in this centre described residents' needs wishes and preference's and openly discussed the practical difficulties involved in the management of some residents' behaviours within the setting of this designated centre. Other staff spoken to were not appropriately aware of residents' assessed needs and care plans. This was a concern given the complexity of behaviours that were prevalent in this centre. Inspectors noted this was particularly an issue when part time or relief staff were rostered to work with residents they were not familiar with. The roster showed that relief staff regularly worked in the centre.

In discussing residents' safety, a number of staff stated that they did not think residents

were safe at all times and attributed this to the inappropriate mix of residents in the centre.

Inspectors found there had been some progress since the previous inspection regarding training but further improvement was required to ensure all staff were fully trained and refreshed in the necessary areas to provide appropriate and safe care. Training records indicated that training was provided to staff in areas such as food safety, dysphagia, and the therapeutic management of violence (TMV). However there was no system in place to confirm the accuracy of these training records and to ensure that staff attended refresher training at the required intervals. For example, the TMV training list indicated that staff had received training in this area in 2015, however, two staff members were listed as last receiving such training in 2012 and 2013 respectively. The person in charge did not have a system to verify the accuracy of these records. No training certificates or sign in sheets, related to recent TMV training, were found in staff files reviewed by inspectors. Similar issues were evident in training lists provided in areas such as safeguarding and manual handling. This matter is also addressed under outcome 14.

Inspectors were informed that a programme of training in the area of autism had commenced the day before this inspection took place which was attended by five staff members. Further training dates in this area had been arranged for the following weeks along with training for key workers in meaningful days. This was an action in the previous inspection of this centre (March 2015) as 19 residents in this centre were highlighted as having Autism.

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:

Conor Brady
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-0002936
Date of Inspection:	22 July 2015
Date of response:	08 September 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 05: Social Care Needs

Theme: Effective Services

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

An adequate assessment of health and social care need was not in place for residents.

1. Action Required:

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive

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

assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

The Person In charge shall ensure that:

- 1.A schedule for the completion of a comprehensive 'Annual Health Assessment' is in place for each resident.
- 2.All Health Assessments will be completed by 30th September 2015.
- 3.A review of current social goals will be undertaken with the residents and or their representative to support the identification and achievement of meaningful goals.
- 4.Additional Speech and Language Therapist has been provided to support the communication needs of residents.

Proposed Timescale:

1. 08/09/2015
2. 30/09/2015
3. 30/11/2015
4. 02/09/2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

Arrangements were not put in place to consistently meet residents' assessed needs.

2. 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.Staffing arrangements have been reviewed to ensure the allocated staff compliment is adequate to support residents with their identified health, personal and social care needs.
- 2.Person In Charge shall ensure that designated staff teams, including team leaders, will be assigned to each home to support residents' assessed needs.
- 3.My Personal Plans (MPPs) will be reviewed by staff and if required by relevant members of the resident's Multi-Disciplinary Team (MDT), annually and or more frequently as per each resident's individual needs.

4. Daily 'Activity Schedules' will be used to plan for residents identified and meaningful social activities.

5. Terms of Reference and agenda of staff team meetings has been reviewed to ensure that residents assessed needs and subsequent recommendations are a standing item at such meetings.

Proposed Timescale:

1. 17/08/2015
2. 30/09/2015
3. 30/11/2015
4. 31/10/2015
5. 01/09/2015

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:

Personal plans were not in an accessible format to residents.

3. Action Required:

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

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

1. A template of the MPP has been developed and a number of documents are presently in an accessible format. Further documents are being sourced to support a complete accessible MPP.

2. Person In Charge will develop a schedule for the completion of the accessible MPP with each resident and where appropriate their representatives.

3. Daily 'Activity Schedules' will be used to plan for residents identified and meaningful social activities; schedules will be in accessible format.

Proposed Timescale:

1. 31/12/2015
2. 30/09/2015
3. 31/10/2015

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

There was not evidence of multi-disciplinary involvement in all residents' personal plans requiring same.

4. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

1.Evidence of Multi Disciplinary Team (MDP) input will be documented in residents' personal plan, where required.

Proposed Timescale: 08/09/2015

Theme: Effective Services

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

There was not evidence of maximum participation of residents and/or their representatives in the formulation and review of their personal plans.

5. 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:

1.All personal plans will be reviewed, as per schedule, with the participation of the resident and or their representative.

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:

There was not an appropriate review of effectiveness found regarding all residents personal plans.

6. Action Required:

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

circumstances and new developments.

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

1.All personal plans will be evaluated and reviewed with the participation of the resident and or their representative,

Proposed Timescale: 31/12/2015

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:

Risk assessments and the management and review of risk was not robust. Risk management systems were not effective and/or implemented to ensure the continued safety of residents at all times.

7. 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.Risk Management Policy & Procedure has been reviewed in terms of hazard identification and control measures.

2.All control measures identified from Risk Assessments will be implemented.

3.Daily 'Handover' reports highlight incidents/accidents.

4.Terms of Reference and agenda for staff team meeting has been reviewed to ensure that hazards, incidents/accidents and risk management is a standing item on minutes of meetings.

Proposed Timescale:

1. 19/08/2015

2. 30/09/2015

3. 17/08/2015

4. 01/09/2015

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 not evidence that all staff were appropriately trained in fire safety.

8. 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.All staff will have appropriate training in fire safety.

Proposed Timescale: 08/09/2015

Theme: Effective Services

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

All emergency lighting and exit signage were not found to be functioning.

9. Action Required:

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

1.The emergency and exit lights found to be not working on the day of the inspection have been repaired.

Proposed Timescale: 27/08/2015

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:

All staff were not knowledgeable, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

10. Action Required:

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

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

1. Staff supporting residents with their behaviours of concern will be familiar with the residents Behaviour Support Plan (BSP).

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

Residents were not protected from all forms of abuse. Residents were not protected from physical harm. Residents were suffering peer abuse and some residents were being physically targeted on a regular and on-going basis.

11. 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. In the short term, the Person in Charge and Clinical Nurse Managers have reviewed the current living arrangements and prioritised residents at risk of on-going abuse with a view to carrying out internal transitions.

2. Staffing arrangements have been reviewed to ensure the allocated staff compliment is adequate to support residents with their identified health, personal and social care needs, resulting in the reduction of safeguarding concerns.

3. Designated staff teams are being assigned to each home to ensure that identified supports are implemented.

Proposed Timescale:

1. 20/08/2015
2. 17/08/2015
3. 30/09/2015

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

Appropriate action was not taken to protect all residents from harm in this centre where there was a known history of incidents.

12. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

1. In the short term, the Person in Charge and Clinical Nurse Managers have reviewed the current living arrangements and prioritised residents at risk of on-going abuse with a view to carrying out internal transitions.
2. Staffing arrangements have been reviewed to ensure the allocated staff compliment is adequate to support residents with their identified health, personal and social care needs, resulting in the reduction of safeguarding concerns.
3. Designated staff teams are being assigned to each home to support the residents.

Proposed Timescale:

1. 20/08/2015
2. 17/08/2015
3. 30/09/2014

Proposed Timescale: 30/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Recommendations from an allied health professional regarding a resident at risk of falls were not implemented.

13. 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. All recommendations from allied health professionals have been implemented for resident as identified in report and incorporated in a Falls Care Plan

Proposed Timescale: 27/07/2015

Theme: Health and Development

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

Residents had no involvement in the buying, preparation and cooking of their meals.

14. 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. Residents will be supported, as far as reasonable practicable to purchase and to participate in the preparation of foods of their choice in the house.

2. Residents will be supported to be involved in preparing and serving their meals as they so choose.

3. Residents' involvement in the buying, preparation and cooking of snacks/meals will be documented.

Proposed Timescale:

1. 01/09/2015

2. 01/09/2015

3. 08/09/2015

Proposed Timescale: 08/09/2015

Theme: Health and Development

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

Residents' food was not served at an appropriate temperature.

15. Action Required:

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

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

1. The arrangements regarding the delivery and storage of hot meals have been reviewed.

2. A local procedure regarding maintaining food temperature and food recording charts has been developed and implemented.

Proposed Timescale:

1. 28/08/2015

2. 08/09/2015

Proposed Timescale: 08/09/2015

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:

Medication management practices regarding clear and accurate prescription records, medication labelling and staff knowledge of same required improvement.

16. Action Required:

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

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

1. New kardex system will be introduced, which will address the issue of legibility
2. Protocols and epilepsy management plans for the administration of PRN medications are in place.
3. Staff administering medications has the required information to administer all medication safely to residents.

Proposed Timescale:

1. 31/09/2015
2. 08/09/2015
3. 08/09/2015

Proposed Timescale: 30/09/2015

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 person in charge did not demonstrate full effective governance, operational management and administration of the designated centre concerned. The provision of one person in charge for two designated centres was not sufficient.

17. 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 shall be exclusive to the Designated Centre 4.

Proposed Timescale: 31/10/2015

Theme: Leadership, Governance and Management

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

Management systems in place in the designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored at all times. The system in place to ensure that all staff were provided with the required training was not adequate.

18. 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 of organisational structures has been completed.
2. The role of the Person in Charge shall be exclusive to the Designated Centre 4.
3. A Permanent Programme Manager is in place and is actively involved to support the Person in Charge in the governance and management of the designated centre.
4. The Person in Charge will develop a schedule of audits to support the monitoring of safety and wellbeing of residents
5. Registered Provider will ensure that staffing levels are adequate to meet the assessed needs of residents.
6. Person in Charge shall ensure that designated staff teams, including team leaders, will be assigned to each home to support residents' needs.

Proposed Timescale:

1. 30/07/2015
2. 31/10/2015
3. 31/08/2015
4. 30/09/2015
5. 17/08/2015
6. 30/09/2015

Proposed Timescale: 31/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The number of staff was not adequate at all times. All residents who required 1:1 care were not provided with same at all times.

19. Action Required:

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

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

1. Staffing arrangements have been reviewed to ensure the allocated staff compliment is adequate to meet the assessed needs of residents.

Proposed Timescale: 17/08/2015

Theme: Responsive Workforce

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

Some staff who were not full time/permanent did not have the required knowledge to provide consistent care to residents based on their assessed needs.

20. Action Required:

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

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

1. The Person in Charge shall ensure that where staff are not full time/permanent that they are inducted into the identified needs of residents'.

2. A system for the allocation of Agency /Relief staff is in place to ensure that such staff provides consistent care to residents in their care.

Proposed Timescale: 07/09/2015

Theme: Responsive Workforce

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

There was not evidence that all staff had up to date training in all required areas.

21. 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. Training and Professional Development will continue to take place.
2. All training records have been reviewed to identify staff training needs.
3. All appropriate training including refresher training will be delivered.

Proposed Timescale: 09/09/2015