

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by St John of God Community Services Limited
<b>Centre ID:</b>	OSV-0002964
<b>Centre county:</b>	Kildare
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St John of God Community Services Limited
<b>Provider Nominee:</b>	Philomena Gray
<b>Lead inspector:</b>	Louise Renwick
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	6
<b>Number of vacancies on the date of inspection:</b>	1

## **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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
24 August 2015 09:30	24 August 2015 18:30
25 August 2015 09:30	25 August 2015 17:00

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 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was the first inspection of this centre operated by St. John Of God Community Services Limited which comprised of two bungalows located close to each other. The centre was currently offering a service to 6 residents living between the two bungalows, and the provider had originally applied to register for 8 residents. Based on the evidence gathered, inspectors determined that the centre was not suitable for this number of residents, and the provider resubmitted a revised application to Register for 7 residents following inspection.

As part of the inspection, inspectors spoke with residents, reviewed questionnaires

submitted and met with the provider nominee, person in charge, persons participating in the management of the centre and members of the staff team. Inspectors reviewed documentation such as person centered plans, policies and procedures and accident and incident records.

Inspectors found that residents appeared content with the service offered to them in this centre and that staffing was adequate and suitable to the needs of residents. Training had been provided to staff to enable them to support residents, and independence was promoted. Residents expressed to inspectors that they were satisfied with the level of staffing and the supports that were in place. The centre was community based, and inspectors found good access to the local community and its services, amenities and facilities.

Inspectors found that 7 outcomes were fully compliant with the Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013. Improvements were required across 11 outcomes inspected. Inspectors identified the following areas which were in need of improvement:

- The premises required addressing due to issues with damp and mould, and to ensure adequate communal space for residents.
- Monitoring systems and the overall governance of the centre required improvement
- Gaps were found in the care and support assessments and plans
- Policies and procedures were in need of review and update
- Written support agreements had not been put in place

Inspectors also found that additional documentation needed to be submitted by the provider to ensure full compliance with the Registration Regulations. For example, building compliance.

The full findings of this inspection are detailed in the body of the report and within the 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:**

Inspectors determined that residents were consulted with and took part in the running of the centre as far as possible. There was evidence of regular meetings with residents to discuss any changes and to gather residents' opinions. For example, to discuss issues with the cleaning or to discuss how to make complaints. Inspectors found that residents were encouraged to speak up and advocate for themselves. There was also evidence of access to an external advocate should a resident require additional support in this area.

There was a complaints policy in place in the centre and a procedure on display in the designated centre. There was evidence that residents had discussed how to make complaints through their house meetings. Inspectors found that there was a log maintained of all complaints, along with responses to same. At the time of inspection, there was one complaint ongoing raised by residents themselves in March 2015 in relation to a premises issue. This was being managed by the person in charge and senior management, but had not yet been rectified.

Inspectors found that residents were encouraged to make choices about their lives and daily routines. One unit of this centre was an un-staffed house, with set hours of drop in support by the staffing team in the other unit. Residents spoke with inspectors about how they plan their own lives and routines, and seek support where necessary. For example, with budgeting or learning to cook certain meals. Residents in the other unit were supported by staff full time. Inspectors found that residents were encouraged to make decisions about their lives in the least restrictive manner. For example, a resident who may become confused while out alone, used a watch alert system. This ensured the resident could leave the house when he chose to, and only if he went beyond a

particular distance staff would be alerted so that appropriate supervision could be put in place. This reduced anxiety for the resident, and offered a safe alternative to locking the front door.

Inspectors reviewed the policy on residents' personal property, finance and possessions and found that it required improvement. For example, the policy only discussed residents finance. This will be looked at under outcome 18 records and documentation. Inspectors found that residents' had financial decision making assessments completed, to determine their abilities and supports that may be required to manage their own finances. Account ledgers were maintained for residents who required support with managing their finances.

**Judgment:**

Substantially Compliant

**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 found that residents were supported and assisted to communicate in the designated centre. Residents in this centre were able to self advocate and voice their opinions. On review of residents' files, inspectors found that there were communication passports in place along with detailed information on residents' communication needs and abilities. Inspectors found some photograph displays in use in the centre to promote understanding. For example, photographs of which staff were on duty during the week. Photographs and signs were also used on a resident's door to assist him to identify his room, and the centre was equipped with some coloured door frames and toilet seats to support residents living with a dementia.

**Judgment:**

Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**

## Individualised Supports and Care

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

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

### **Findings:**

Inspectors found that residents who had family members were encouraged to stay connected, and continue relationships. Inspectors spoke with residents and determined that they were supported to spend time with their families, partners and friends. Information on the important people in residents' lives was in their files. Inspectors found some residents' goals were working on visiting family or friends who lived far away, with supports in place from staff to facilitate this.

Inspectors found that residents were linked with the local community and participated in their communities in line with their interests and preferences. Residents spoke of the things they enjoyed doing in the local community, and further afield. Residents were observed utilising the facilities and services close to their home.

### **Judgment:**

Compliant

## **Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

### **Theme:**

Effective Services

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

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

### **Findings:**

Inspectors found that while residents had tenancy agreements in place outlining the terms of their rent, and costings associated with this, written agreements were not in place dealing with their care and support as is required by the Regulations. At the time of inspection, inspectors were shown draft template for support agreements that had been created, but had not yet been put in place for residents.

Inspectors noted that the provider was applying to cater for 8 residents to live between the two units of this centre. Inspectors reviewed the living arrangements and premises and determined that the centre was not suitable in size and layout to accommodate this number of residents, due to bedroom spaces available. This will be discussed under outcome 6 Premises. Post inspection, the provider resubmitted the application to register outlining the maximum to be applied for is 7 residents.

Inspectors reviewed the arrangements for the transfer and discharge of residents and determined that improvements were required. For example, a resident who had been admitted to a nursing home almost two years ago, still had belongings and property in the centre, and staff were still supporting this resident with money management. Staff were unclear as to what would happen to these belongings. Inspectors found that this was linked to the lack of written agreements in place, and gaps in some of the policies as required by Schedule 5. For example, the policy on residents' finance did not expand to guide staff on personal property and possessions, and the admissions policy did not clearly outline the transfer and discharge of residents from this centre.

**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 found that residents were encouraged to participate in social activities and take part in their lives and community. Inspectors determined that residents had opportunities to participate in meaningful activities, with supports in place from the staffing team where necessary. However, improvements were required in relation to the assessing and planning for the social, health and personal needs of all residents.

Inspectors reviewed the assessments and plans available and found evidence of effective plans in place for some aspects of residents' lives. For example, residents with dementia had been appropriately assessed by allied health care professionals, and comprehensive dementia care plans put in place. Likewise, residents with epilepsy had their needs outlined in epilepsy support plans.

Inspectors found that residents had a yearly information gathering assessment as part of their person centred plan, which resulted in goal setting for the year. These goals were reviewed quarterly, and were based upon residents' wishes or desires. For example, goals such as wanting to go on a holiday, or take up kayaking.

Other needs assessments had been carried out using a validated tool, however inspectors found that these assessments had not resulted in supports being applied to areas identified as needing it. Staff in the centre had not been trained in the completion or analysis of these assessments tools, and as such had not been equipped to use the information to create clear plans for residents.

**Judgment:**

Non Compliant - Moderate

**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:**

There were significant concerns with regard to the physical environment provided for residents.

This designated centre comprised of two bungalows located in the same estate. One house currently accommodated four residents living semi-independently and had ample private and communal space for this number of residents.

The other unit currently catered for two residents with one vacancy. Inspectors determined that the design and layout of this unit of the designated centre was not suitable in its layout for the current residents. This unit comprised of three bedrooms and a large sitting room that had been made into a fourth bedroom. This had reduced the amount of communal space for the residents living in the centre. This unit had a small kitchen with a small adjoining living room. One resident was assessed as requiring quiet private space and liked to use the living room for this. However, the current lay out of the bedrooms was still negatively impacting on the amount of communal space available.

There was adequate garden and outdoor space in both units, with appropriate outdoor furniture for residents' use. The two units were observed to be accessible for the current residents, who were mobile and had no particular mobility needs. Ramps had been added to the properties off the back fire exits to assist residents to evacuate easily. Inspectors determined that there was a sufficient number of bathrooms in the centre, with each house having one main bathroom for 3-4 residents. One bathroom had been

recently renovated, and residents spoke positively about this.

Inspectors were concerned to find an ongoing issue with mould in the two units of the centre. This was noted back in 2013 through an external assessment of the buildings. While mould had been cleaned off and walls repainted since this, the ongoing issue of mould, damp and poor ventilation remained. Inspectors found that residents had submitted a written complaint in relation to this ongoing issue. While the provider had sought external advice in relation to this and had costed a solution, no action had been taken as yet to satisfactorily address this issue.

On inspection, inspectors found that:

- Residents' bedrooms had a damp smell
- there was visible mould on residents' bedroom blinds, walls and ceilings
- Damp stains and breakdown of plaster on some bedroom walls
- it was difficult to see out residents' bedroom windows due to a build up of condensation within the panes of glass

Inspectors were concerned that the effect of this issue on residents' health had not been considered or risk assessed, based on the aging population of residents, and the various health needs such as COPD (Chronic Obstructive Pulmonary Disease) and Asthma.

As well as these issues, inspectors found that the centre required decorative works in general in order to improve overall appearance of house. For example, en-suite bathrooms which were in need of repair, old and cracked kitchen presses and counters and replacement of carpets.

**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 found that some improvements were required to ensure the health and safety of residents, staff and visitors was consistently promoted in the designated centre through the effective identifying and management of potential risks to health and safety. Inspectors reviewed policies and procedures and found that the documentation as required by the regulations were in place. For example, health and safety policies, guidance on infection control, a fire safety policy and emergency and evacuation plans.

Inspectors found that there was a risk management policy in place in the centre which was meeting the requirements of the Regulations. This policy was supplemented with an active risk register to outline the control measures in place for risks that had been identified, and included the management of specific risks such as self harm or aggression and violence.

The practices and systems in place to identify and respond to all risks in the centre were in need of improvement to ensure all risks were appropriately managed. For example, no assessment had been carried out to determine the risk to residents' health from living and sleeping in rooms with damp and mould as mentioned under outcome 6 premises. Inspectors also found that the gaps in some assessments and plans could pose a risk to residents needs being met as outlined in outcome 5 and will be mentioned in outcome 11 and 12.

Inspectors reviewed the fire safety systems and documentation and found that the risk of fire was in general well managed. However some improvements required. Inspectors found that the fire alarm and emergency lighting was routinely checked and serviced by a relevant professional with records maintained. Equipment was in place such as fire extinguishers and there was also evidence of routine checks on all fire equipment. Staff carried out regular fire drills in both units of the centre, and residents who lived semi-independently could clearly outline to inspectors what to do in the event of a fire, and how they would respond. Staff had received mandatory training in fire safety and confirmed this with inspectors. Fire exits were found to be unobstructed and assembly points known to staff and residents. While there were keys on hooks close to the fire exits, there was no break glass unit for all exits to ensure ease of egress in the event of an emergency. This was in need of address. Not all exits were clearly identified as a fire exit. However, staff and residents could identify them to inspectors.

A record of accidents and incidents was maintained in the designated centre and reviewed by the person in charge regularly. Inspectors found appropriate follow up to any adverse event, and escalation if necessary to senior management for events that required additional controls to prevent reoccurrence. There was a policy in place on the reporting of adverse events.

**Judgment:**

Non Compliant - Moderate

**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:**

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

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

**Findings:**

Residents were protected and safeguarded from abuse or harm in the designated centre. However, improvements were required to some policy documentation.

Inspectors found that residents were offered a safe environment and residents told inspectors that they felt safe living there. Residents were assisted to understand about self advocacy, speaking up and protecting themselves. Residents explained to inspectors that they had been supported to understand fire and security procedures. Through the review of staff files, inspectors found that staff members had been Garda Vetted and had received training the prevention, detection and response to abuse. Staff could discuss with inspectors how to respond to and report any allegations or suspicions of abuse or harm, and could identify who was the designated liaison person for the organisation.

Inspectors found that a restraint free environment was promoted in the designated centre. One resident was using a watch alert as mentioned under outcome 1. Inspectors found that this was proving less restrictive than other alternatives, and offered the resident control and independence over when to leave the building.

Inspectors reviewed the policies in relation to this outcome and found this as an area in need of some improvement. For example, the policy for managing behaviour was not up to date nor reflected current practice. The restraint policy while offering guidance in line with best practice was in need of review. The suite of safeguarding policies and procedures had not been updated in line with changes to national policies, and did not offer clear guidance to staff. This will be further discussed and actioned under outcome 18 Records and Documentation.

**Judgment:**

Compliant

**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:**

Inspectors found that a record of accidents, incidents and near misses were maintained in the designated centre. On review of these documents, inspectors determined that any event as outlined in the Regulations had been notified as required within the timeframe.

**Judgment:**

Compliant

**Outcome 10. General Welfare and Development**

*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors found that residents were supported to participate socially in activities, suitable to their age, interests and needs. Inspectors spoke with staff and reviewed documentation and found that residents were provided with suitable activation in line with their own goals and preferences. Residents had access to day services run by the provider suitable to their needs. For example, some residents were availing of a day service for people of retirement age. Other residents spoke with inspectors about their paid employment and how they spent their day. As mentioned under outcome 5 Social care needs, residents had access to the community, and utilised the local services, amenities and facilities.

**Judgment:**

Compliant

**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:**

Inspectors reviewed residents' files and spoke with staff and residents, and determined that residents were promoted to have good health in the centre, and supported to maintain healthy lifestyles. There was evidence of timely access to allied health care professionals such as dieticians, dentists and speech and language therapists. Each year, residents were assisted to complete an annual health assessment with their key worker, which gathered the most up to date information on their health history or any ongoing issues. Residents had yearly check up with their general practitioners and evidence was maintained of all appointments with health professionals.

However, Inspectors found that there were gaps in documentation to ensure all health needs as identified were adequately planned for. This has been actioned under outcome 5 Social Care Needs. For example, health issues as highlighted in residents' health assessments did not have corresponding plans in place to support residents with health issues such as diverticulitis and COPD (Chronic Obstructive Pulmonary Disease). While there was evidence of access to allied health care professionals for residents, advice did not always result in support plans being drawn up. For example, specific advice from dietician about healthy eating did not inform a plan for a resident. This had also been identified as something the resident wished to learn about through the goal setting exercise. Inspectors felt that these gaps in documentation could present as a risk to residents' health care.

Inspectors spoke with residents and reviewed the weekly menu plans for the centre. Residents' preferences and choices were incorporated into these menus and healthy options encouraged. Residents' daily records kept details of food eaten.

**Judgment:**

Compliant

**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 determined that adequate medication management practices were in place in the designated centre, guided by the organisational policy on medication management. Inspectors reviewed the systems in place for prescribing, ordering, storing and disposing of medication in the centre, and found them to be adequate. Medication was stored securely, and was administered by social care staff. Residents who had been assessed as suitable to self administer medication had this evidence on their records, and were

reviewed regularly to determine any additional guidance or supports required. Medication management was audited by an external person on a six monthly basis, the most recent audit outlined good practice.

Inspectors found each resident had medication management plans in their personal files which outlined the medication they were taking, its purpose and possible side effects. Residents with epilepsy had epilepsy care plans drawn up to outline their supports. Inspectors reviewed identified gaps in some of the medication documentation. Prescription records did not have the signature of the General Practitioner (GP) for all individual medications. Inspectors found some discrepancies in the information provided in PRN (as required) medication protocols and what was outlined in the epilepsy care plans and prescription records. This conflicting information could pose a potential risk of error. Inspectors also found that not all staff had received training in the administration of emergency medication for epileptic seizures. This will be discussed under outcome 17 Workforce.

Overall, inspectors determined that resident were protected by safe medication practices, with some minor improvements required to the documentation to ensure best practice, and to reduce the likelihood of potential errors.

**Judgment:**

Substantially Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Inspectors determined that there was a written statement of purpose in place for this centre. However, it was not a true reflection of the services on offer, and was in need of further amendments and additions to ensure full compliance with Schedule 1 of the Regulations. For example, the photograph on the statement of purpose was of a different house, the room sizes had not been included in the description, and more information was required in relation to the complaints process.

**Judgment:**

Substantially Compliant

**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 determined that there was a lack of an effective and comprehensive systems in place to ensure that the service given to residents in this centre was safe and of good quality.

No annual review had been completed by the provider on this designated centre. Inspectors found that the provider had arranged for unannounced visits to be carried out in this centre on a six monthly basis. However, some unannounced visits only focused on 1-2 outcomes such as the person in charge, or the absence of the person in charge, and didn't comprehensively monitor quality and safety in the centre.

There were very few local audits being completed to identify areas for improvement or to monitor progress. Not all audits completed were specific to this designated centre, but rather looked at a regional area as a whole. Inspectors determined that the unannounced visits along with the audits were not adequately capturing gaps in the quality and safety of care for residents, and driving improvements.

Actions that arose as a result of these reviews were not all addressed in a timely manner. For example, it took 6 months to get approval of funding to order new carpet in one of the units hallways, as this was old and had been identified as a possible falls risk.

Inspectors found that the provider had not submitted full documentation as part of the application to Register this centre, and therefore was not fully compliant with the Registration of designated centres for persons (Adults and Children) with disabilities Regulations 2013.

**Judgment:**

Non Compliant - Major

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the*

*designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Inspectors found that there were adequate arrangements in place to ensure effective management in the absence of the person in charge. There was a team leader in post who would deputise in the absence of the person in charge. The person in charge was aware of the requirement to notify the Authority of any absence longer than 28 days.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

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

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

**Findings:**

Inspectors found the centre to be adequately resourced with staff and transport to meet the needs of residents. Inspectors identified issues regarding the upkeep of the premises, as mentioned under outcome 6. While inspectors did not evidence anything to suggest the centre was not adequately resourced to ensure the effective delivery of care and support, this would be reviewed with regards to the provider's response to the action plan, and the ability to address any issues of concern.

**Judgment:**

Compliant

**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:**

Inspectors reviewed the staffing roster for the centre and found that staffing levels were suitable for the needs of the current residents. One unit had staffing full time including a sleep over shift each evening. The second unit was semi-independent and was offered set hours each evening for staff in the other unit to offer supports. At the time of inspection, inspectors determined that this arrangement was working well based on the current number and needs of residents. Residents who spoke with inspectors felt they had adequate staff input and enough supports in order for them to live as independently as possible.

Inspectors found that there was access to training for staff working within the designated centre to ensure they were skilled to meet the needs of residents. Training records determined that staff working in the centre had up to date training in all the mandatory fields. For example, fire safety and safeguarding residents. Other training had been made available to the staff team to ensure they could meet residents changing needs. For example, training in dementia. Inspectors found that not all staff had received training in the administration of emergency medication for residents with epilepsy. This was in need of address having regard to the needs of the residents.

Inspectors reviewed staff files and found that they contained the required information as outlined in Schedule 2 of the Regulations. Inspectors found good practice regarding the maintenance of staff records, and determined that staff were recruited, selected and vetted in accordance with best recruitment practices.

**Judgment:**

Substantially Compliant

**Outcome 18: Records and documentation**

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**

Use of Information

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

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

**Findings:**

Inspectors found that the records as outlined in Schedule 3 and 4 of the Regulations were in place. Inspectors found that directory of residents was maintained and up-to-date.

Written operational policies and procedures were in place as required by Schedule 5 of the Regulations. However improvements were required in relation to their full implementation and review. For example, a number of policies had been last reviewed in 2009 such as the intimate care policy. Other policies had been reviewed within the previous three years, but were in need of address as they had not been updated following changes to national policy. As mentioned under outcome 8, the policy in relation to behaviours that challenge was in need of address as it no longer guided the practice that was in place. The regional director was aware of these policy issues, and informed inspectors of work being carried out at present to address this.

Inspectors reviewed a sample of staffing records and found that they were adequately maintained as outlined under outcome 17 Workforce.

**Judgment:**

Non Compliant - Moderate

**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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by St John of God Community Services Limited
<b>Centre ID:</b>	OSV-0002964
<b>Date of Inspection:</b>	24 August 2015
<b>Date of response:</b>	22 October 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:**

Timely improvements had not been put in place to respond to residents' complaint regarding the premises issue.

**1. Action Required:**

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

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:**

- a. Social Care Leader and staff have met with residents in the unstaffed house to keep them up to date in relation to the complaint.
- b. Deep cleaning was completed to address some issues relating to the complaint.
- c. Architects survey carried out on the premises.
- d. Surveyors report was obtained regarding the remedial work necessary to resolve the complaint.
- e. Application for funding to the housing association signed off by CEO and Regional Director of the service.
- f. With the funding in place, work will be complete by end Dec 2015 on the unstaffed house.

(Please note, these actions refer to the unstaffed house of this designated centre)

**Proposed Timescale:**

- a. Complete, 12/3/15, 22/4/15, 9/6/15, 11/8/15, 8/6/15
- b. Complete, 30/7/15, 4/8/15
- c. Survey report 28/5/15
- d. Complete, 16/7/15
- e. Complete, 1/10/15
- f. 31st December 2015

**Proposed Timescale:** 31/12/2015

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

There were no written agreements in place.

**2. Action Required:**

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

The Registered Provider shall ensure that each resident or his/her representative will be provided with a contract of care which will set out the terms on which that resident shall reside in the designated centre.

**Proposed Timescale:** 30/11/2015

### **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:**

The information from assessments was not informing or resulting in plans.

#### **3. Action Required:**

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

The Person in Charge shall ensure that:

- a. The Supports Intensity Scale (SIS) assessments completed will be analysed and recommendations produced.
- b. Recommendations from SIS assessments will inform residents' personal plans moving forward into 2016

**Proposed Timescale:** 31/12/2015

### **Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

One of the units was not designed or laid out to meet the needs of the two residents currently living there (see examples regarding the need for private space for one resident, which was limiting the other).

At full capacity, one of the units would not provide suitable communal space for the number of residents in its current lay out (large sitting room used as a bedroom).

#### **4. 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. As part of planned refurbishment of the house, the layout will be re-configured to meet the needs of residents with regard to private space.
- b. New, level access ensuite/wet room will be provided in one bedroom allowing the sitting room to return to its original function.

(Please note, these actions refer to the staffed house in the designated centre)

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

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

All parts of the centre were not in a good state of repair, or promoting safe and comfortable living environments.

- Visible mould present on bedroom blinds, some on ceilings and walls
- Damp stains and breakdown on some internal walls
- Lack of clear view out windows due to build up of condensation within panes of glass
- Kitchen units/counter tops old and cracked and in need of upgrade/replacement
- En-suite bathroom not functional and in need of upgrade and repair
- Damp smell in some residents' bedrooms

**5. 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:**

- a. Dehumidifiers have been installed in damp affected bedrooms.
- b. Work on the unstaffed house will go to tender on 28th October 2015.
- c. Tendering process will be complete and contractor appointed from 11th November
- d. Works will be complete by 31st December 2015

(Please note, these actions refer to the unstaffed house in the designated centre)

- e. Five window panes have been replaced where the view was obstructed by condensation between panes of glass.
- f. Planned refurbishment of the house will address issues with mould on ceilings and walls, damp smell, stains and breakdown of internal walls, kitchen units & counter tops, en-suite bathroom.
- g. Specification of work to be completed will be ready by 6th November 2015.
- h. Tendering process will be complete and contractor appointed on Friday 27th November 2015.
- I. Works will be complete by 28th February 2015

(Please note, these actions refer to the staffed house in the designated centre)

Proposed Timescale:

- a. 20/10/2015
- b. 28/10/2015
- c. 11/11/2015

- d. 31/12/2015
- e. 16/09/2015
- f. 28/02/2016
- g. 06/11/2015
- h. 27/11/2015
- I. 28/02/2015

**Proposed Timescale:** 28/02/2016

### **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:**

Systems in place had not identified the health and safety risks associated with the premises issues and the presence of mould and damp in residents' bedrooms.

**6. 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:**

Risk assessment has been carried out regarding the effect of the environment issues on resident's health.

**Proposed Timescale:** 27/08/2015

**Theme:** Effective Services

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

Fire exits did not have break glass key units.  
Fire exits were not identified.

**7. Action Required:**

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

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

- a. Fire exit identification signs to be purchased and put up at fire exit doors.
- b. A review will take place of the appropriateness of break glass units and/or other alternatives in this domestic setting.
- c. Action to improve emergency egress of house to be carried out following review (b) and alternatives identified.

Proposed Timescale:

- a. 17/10/2015
- b. 05/10/2015
- c. 30/11/2015

**Proposed Timescale:** 30/11/2015

## 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:**

Records contained conflicting information in relation to the prescribed medication for a resident in the event of a seizure.

### **8. Action Required:**

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

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

The Person in Charge ensured that:

- a. Prescribed medication records were reviewed by the resident's keyworker and social care leader.
- b. Conflicting information was removed and clarified in line with GP's instructions on the Kardex.

**Proposed Timescale:** 02/09/2015

## Outcome 13: Statement of Purpose

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not include sufficient detail as outlined in Schedule 1 of the Regulations.

### **9. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Statement of Purpose was reviewed and updated following recommendations in the above report.

**Proposed Timescale:** 08/10/2015

**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 provider failed to submit all required documentation for the application to Register this centre.

**10. Action Required:**

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

- a. Form A2 was resubmitted
- b. Planning compliance submitted

Proposed Timescale:

- a. 14/09/2015
- b. 01/10/2015

**Proposed Timescale:** 01/10/2015

**Theme:** Leadership, Governance and Management

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

The management systems in place were not effectively monitoring and improving quality and safety in the centre.

**11. 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:**

- a. A schedule of audits will be identified in order to effectively monitor and improve quality and safety in the centre
- b. Review of quality and safety of care and supports for 2015 will be completed and report compiled.
- c. Recommendations from review will be on the quality enhancement plan for the designated centre in 2016.

Proposed Timescale:

- a. 31/12/2015
- b. 31/12/2015
- c. 31/ 01/2016

**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:**

No annual review had been carried out by the provider for this centre.

**12. 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:**

A review of quality and safety of care and supports for 2015 will be completed and a report compiled.

**Proposed Timescale:** 31/12/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Not all staff had received training in the administration of emergency medication for epilepsy.

**13. Action Required:**

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

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

The Person in Charge shall ensure that:

- a. Staff members who have not received training in the administration of emergency medication for epilepsy are identified.
- b. Training is organised for staff requiring this training.
- c. Staff will attend training in the administration of emergency medication for epilepsy.

Proposed Timescale:

- a. 30/09/2015
- b. 01/10/2015
- c. 25/11/2015

**Proposed Timescale:** 25/11/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Not all policies were fully implemented in practice.

**14. Action Required:**

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

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

- a. The board of sponsors approved the safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures for implementation within Saint John of God Hospitaller Ministries on 27/7/2015
- b. HSE National Policy & Procedures for Safeguarding Vulnerable Persons at Risk of Abuse has been distributed to the designated centre
- c. The Positive Behavioural Support Policy was approved on 25/6/2015.
- d. The Positive Behavioural Support Policy was rolled out to staff in the designated centre.
- e. These policies have been discussed at staff team meetings.
- f. Staff to read and sign that they have read and understood these policies

Proposed Timescale:

- a. 27/07/2015

- b. 24/09/2015
- c. 25/06/2015
- d. 24/09/2015
- e. 24/09/2015 , 8/10/2015
- f. 31/10/2015

**Proposed Timescale:** 31/10/2015

**Theme:** Use of Information

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

A number of policies were in need of review, and some required updating to reflect changes in national policy.

**15. Action Required:**

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

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

- a. The registered provider shall ensure that any policies and procedures on the matters set out in schedule 5 that are in need of review will be reviewed and updated in accordance with best practice.
- b. The board of sponsors approved the safeguarding Vulnerable Persons at Risk of Abuse, National Policy & Procedures for implementation within Saint John of God Hospitaller Ministries on 27/7/2015. It has been rolled out to all staff in the designated centre.
- c. The Positive Behavioural Support Policy was approved on 25/6/2015. It has been rolled out to all staff in the designated centre.

Proposed Timescale:

- a. 31/ 03/2016
- b. 24/09/2015
- c. 24/09/2015

**Proposed Timescale:** 31/03/2016

