

**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 Ltd
<b>Centre ID:</b>	ORG-0003230
<b>Centre county:</b>	Kildare
<b>Email address:</b>	Linda.McLoughlin@sjog.ie
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St John of God Community Services Ltd
<b>Provider Nominee:</b>	John Pepper
<b>Person in charge:</b>	Linda McLoughlin
<b>Lead inspector:</b>	Linda Moore
<b>Support inspector(s):</b>	Conor Brady;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	43
<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 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

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

From:	To:
06 February 2014 12:00	06 February 2014 20:30

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 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

**Summary of findings from this inspection**

This was an announced inspection of St John of God Community Services to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. The Service comprises eleven community houses across Kildare.

Inspectors met with management, residents and staff members over the inspection. Inspectors observed practice and reviewed documentation such as personal care plans, health plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files.

As many of the residents are out during the day, part of the inspection took place in the late afternoon and evening, when residents had returned from their day activities.

Inspectors reviewed the documentation in the provider's main office and visited three community houses where 13 residents lived. All residents from these community houses were present at inspection time.

Overall, inspectors found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, and residents' communication support needs were met very effectively. The centre was clean and had a warm, hospitable atmosphere and inspectors found that the residents were comfortable and confident in telling the inspectors about

their home. Residents were actively involved in the development of their personal plans.

While evidence of good practice was found across all outcomes, areas of non-compliance with the Regulations were identified. In particular the provider and person in charge were required to take immediate action to address the staffing risks to residents. This was addressed during the inspection.

Other areas for improvement included the development and implementation of policies to guide staff practices, staffing levels, risk management practices, governance arrangements and the use of resources. The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

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

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

In general, the inspector found that residents were supported to be involved in the development of their personal plans. However, some improvements were required to ensure personal plans were outcome focussed rather than solely activity based. Each resident had a personal plan and inspectors reviewed four of the plans. Overall, they were based on the individual support needs of the resident and there was evidence of regular review and participation of residents in the development of their plans. Some of the residents had signed the plans.

The personal plans contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests. While there were individualised risk assessments completed for some residents to ensure continued safety of residents, these were not consistently completed for residents at risk of absconding, falls, residents left alone at times, epilepsy, see also outcome 17.

While two residents spoke of their personal ambition to learn to read and write and manage their own money, there was no evidence that that these goals set for these were being realised and had been in place for 2012 and 2013. There was no up to date personal plan for one resident whose condition had deteriorated in the latter part of 2013. Staff were not familiar with the residents plans that they had not been directly involved in developing.

While there was some evidence of community involvement. Inspectors found that resident's opportunities to participate in meaningful community activities were being impeded by a lack of choice and/or inadequate supports. Residents told inspectors that they found the evening long and would like the opportunity to do more in the community.

## **Outcome 07: Health and Safety and Risk Management**

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

### **Theme:**

Effective Services

### **Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

### **Findings:**

Inspectors generally found that the provider had put sufficient risk management measures in place, however, they needed to be improved. For example, risks associated with residents who smoked, fire safety, supervision arrangements and emergency planning.

Inspectors saw evidence that the person in charge and staff took responsibility for the identification of risks and ensuring that there were appropriate systems in place to manage risk. However, inspectors were not entirely satisfied that staff took a proactive role in the management of all risk in the centre.

Inspectors found that some of the residents resided in locations with no staff present and other residents who required supervision were left unsupervised for periods of time. There was no risk assessment completed for these residents to include the control measures that may be required to minimise any risk to residents. There was no formal system in place regarding what supervision these residents to promote and sure their safety. This is further discussed under outcome 17.

Inspectors read the Health and Safety Statement for each location for 2013. A new safety management system was being developed for each location and was due to be rolled out the week after the inspection according to the person in charge.

There risk management policy did not meet the requirements of the Regulations. For example self harm, aggression and violence and the arrangements for identification, recording, investigation and learning from serious incidents were not detailed in the policy. The provider was in the process of updating the policy and showed inspectors a draft version which appeared to contain all information as required by Regulations. The person in charge also showed inspectors how they were planning to develop a risk register.

Residents commented that they felt the centre was safe and secure because the door was locked and there was a staff member in the centre at all times.

Accidents, incidents and near misses were being recorded in detail and a copy of the reports were submitted to and reviewed by the person in charge. Incidents were being discussed at the management meetings with a view to learning from them and reducing the risk of recurrence.

The inspector found that while there was an organisation wide emergency plan in place, the centre specific emergency plans were still in draft and had not yet been implemented into practice.

Improvements were required with regards to elements of fire safety. For example risks associated with residents who smoked and egress from one of the locations. There was evidence of regular fire drills and both staff and residents participated. Residents and staff were able to tell the inspector about what they would do if the fire alarm went off. Records reviewed by inspectors indicated that fire training had not been provided to all staff.

The records of fire drills were detailed and included learning outcomes. Fire equipment was serviced regularly, as were fire alarms and emergency lighting. The inspector found that while almost all fire exits were unobstructed on the days of inspection. There was an area for improvement in one location, the back door was inaccessible to wheelchair users in the event of a fire. While there was a ramp from the back door, a lip on the door made it inaccessible to residents. Residents said this caused them distress. Adequate risk assessments had not been undertaken for residents who smoked to ensure their safety.

#### **Outcome 08: Safeguarding and Safety**

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

#### **Theme:**

Safe Services

#### **Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse however improvements were required in the protection of residents at outlined in outcome seven.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. All staff received training on the protection of vulnerable adults.

The policy on protecting residents from abuse contained guidelines on how any allegations of abuse would be managed. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. Staff had developed an intimate care plan for each resident to ensure privacy was respected and to protect the resident from any risk during the delivery of intimate care.

Residents confirmed that they felt safe and described the staff as being very kind and were able to tell the inspector about a number of staff whom they could talk to if they had a concern.

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

Overall, inspectors found that there were appropriate arrangements in place to support residents' health care issues as they arose. However, inspectors found that there were insufficient records to demonstrate that one resident had been provided with appropriate health care when they sustained a head injury.

Inspectors reviewed the personal plans and medical folders for four residents and found that they had access to a general practitioner, including an out of hour's service. There was evidence that residents accessed other health professionals such as chiropodists, opticians and physiotherapy services. One resident was awaiting review by the occupational therapist. There was evidence that residents with epilepsy had regular



medical reviews by their GP. Health assessments were up to date for all residents and provided valuable information for staff in the care of residents.

**Epilepsy:**

One staff member did not demonstrate competence in the management of residents with epilepsy and had not received training to manage seizures or administer as required medication. There was no policy or procedure to guide staff in the management of epilepsy. There was a comprehensive medical and nursing assessment for residents who had a diagnosis of epilepsy. However, improvements were required in the development of the care plan for one resident especially in the area of care during and post seizures and responding to any potential complications or for recording of epileptic activity to guide future interventions.

**Falls:**

Staff informed inspectors there was no policy on falls prevention and management, or how to respond should a resident fall. While some interventions had been implemented to minimise the risk of falls for one resident such as provision of additional staff, there was insufficient evidence to demonstrate that one resident had been provided with appropriate care and support when they recently sustained a suspected head injury. Neurological observations had not been completed and the staff did not seek medical review for a number of hours post the fall. In addition inspectors found that there were no falls assessment or care plans for a residents identified at high risk of falling.

The staff told inspectors that residents had a meal in the day service Monday to Friday and had their evening meal when they returned to the centre. Residents decided what they wanted for their evening meal and if any resident did not like what had been prepared, there was a range of alternatives available. The inspector found that there was an ample supply of fresh and frozen food, and residents could have snacks at any time. In addition staff ordered a take away for the residents in two locations. Overall the inspectors found that the mealtime experience was an unhurried and social occasion which provided good opportunity for social engagement.

**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

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

The provider had established a management structure, and the roles of managers and staff were clearly set out and understood. However, the management systems in place on the day of the inspection did not support and promote the delivery of safe, quality care services. The agency staff member was not appropriately supported by line management. This is discussed further under outcome 7 risk management and outcome 17 staffing.

The structure included supports for the person in charge to assist her to deliver a good quality service. These supports included the director of the services, an administrative manager, activities programme manager and director of nursing. The provider had also established monthly management meetings where the managers of services could meet to discuss common areas of interest and share their learning. This management team reports to the St John of God's Community Services. The person in charge also holds monthly meetings with the social care leaders. The social care leaders meet with the team leaders weekly. Clinical reviews take place bi monthly or more frequently if required and are attended by the person in charge.

Inspectors found that the person in charge was appropriately qualified and had continued her professional development. She had sufficient experience in supervision and management of the delivery of a community based group home. She was reasonably knowledgeable about the requirements of the Regulations and Standards, and had very clear knowledge about the support needs and personal plans of each resident.

A local quality steering group and HIQA planning committee are in place, with the responsibility of reviewing the services against the requirements of the Regulations.

The person in charge and staff had arranged regular meetings for residents in the centre as a way of supporting residents to communicate their views. The inspector reviewed the minutes and notes of some of these meetings and residents also told the inspector that they used the meetings to make decisions on what they wanted to eat during the week and what activities they wanted to engage in. Issues discussed at the meetings were raised with the person in charge as needed.

**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

**Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that while resources had been provided to meet the needs of residents these were not sufficient and not in line with the statement of purpose. There were examples where the centres routines were resource led and not person centred. There were insufficient staff on duty to meet the support needs of residents. Residents said and inspectors confirmed that resources had not been allocated to ensure the premises met the needs of residents.

A minibus had been provided to enable residents to travel to use community facilities, the person in charge told the inspector that this could be used at request. The provider had ensured that sufficient assistive had been provided. One resident with complex needs had been provided with a specialised chair and bed which supported him to be as independent as possible.

The centres were suitably furnished and well equipped but there were improvements required. There was no handle on a door in the kitchen in one of the locations, residents said the lighting was insufficient in another location and a resident had difficulty accessing the shower due to its design. The person in charge said this was being addressed. Inspectors found that one of the locations could have been improved if appropriate resources were allocated to ensure the premises had been suitable for the needs of a resident with dementia.

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

**Judgement:**

Non Compliant - Major

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were concerned that staffing levels did not meet the assessed needs of residents. Improvements were also required in relation to recruitment of staff.

Inspectors found that there were poor supervision arrangements in some of the community houses and the temporary staff member on duty on the evening of the inspection was not knowledgeable of the residents care needs. The staff member had not received any mandatory training and therefore was not knowledgeable on the procedures to follow in the event of a fire or in the protection of vulnerable adults.

Because of the risks identified in the staffing and supervision, the provider and person in charge were required to take immediate action. This issue was addressed on the inspection. An additional staff member was allocated to the location.

In addition to above, as identified in outcome 7, Inspectors found that many of the residents resided in community houses with no staff present and other residents were left unsupervised for periods of time. This was due to the fact that staff provided care to residents in up to three locations at any one time. The person in charge could not demonstrate that this staffing number were effective in practice. There was no documented evidence to suggest that one staff member was sufficient to provide supervision and care.

Staff files were reviewed and they did not contain all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, the provider had not sufficient evidence of two written references. There was only one reference for some staff. There were no evidence of a vetting disclosure on staff files.

The person in charge had not ensured that the current roster included the waking staff in one of the locations; this staff member was identified on the staff diary. The person in charge had ensured that staff were aware of the regulations and had attended training in this regard.

There were appropriate arrangements in place to ensure that permanent staff are supervised on an ongoing basis. Inspectors read the individual and team based performance reviews and noted that the outcome of these reviews were linked to a continuous professional development programme.

All staff had completed mandatory training including fire safety training, other training included CPR (cardio pulmonary resuscitation), hand hygiene and non violent crisis prevention training.

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Linda Moore  
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 Ltd
<b>Centre ID:</b>	ORG-0003230
<b>Date of Inspection:</b>	6 February 2014
<b>Date of response:</b>	24 March 2014

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

#### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

There was a lack of a robust system to assess the effectiveness of residents personal plans.

**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. A) As from the 13/02/2014 a Dementia Care Plan has been developed and included in personal care plan to ensure all needs of residents' are met in accordance with the regulations

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

B) The changing needs of residents will be included on the agenda for weekly Staff team meetings and monthly programme manager/ co-ordinator Meetings. Changes in circumstances and new developments will be reflected in each residents IIP. This will identify supports required to care for residents changing needs.

2. To ensure personal plans are outcome focussed rather than activity based:

A) On 6th March 2014 further training on Personal Outcome Measures (POM's) was provided. Further dates will be made available for staff to attend refresher training by 30/09/2014.

B) One Social Care Leader is presently participating in Enabling Excellence Training which includes Social Role Valorisation. This discovery process is currently under way with one resident and will be completed by 30/09/2014.

C) There are currently two other staff members from St John of God Kildare Services participating in Enabling Excellence Train the Trainer programme. Trainers will facilitate staff training in the use of the Discovery Tool. Training will commence by 31/10/2014.

3. Risk assessments will be carried out with all Residents that:

- A) Are at risk of falls.
  - B) Are at risk of absconding.
  - C) Are left alone for a period of time.
  - D) Are diagnosed with Epilepsy
- By 30/04/2014.

Risk assessments will be completed by the staff team at each location within the designated centre and will be reviewed by the programme manager and or co-ordinator.

Reviews of risk assessments will be carried out at house level quarterly or sooner if needs change. Risk assessment reviews will also be discussed at monthly house review meetings.

4. A) Supports Intensity Scale Assessments will be carried out with all Residents. We will initially assess Residents that currently reside in Supported locations without sleepover staff by 30/06/2014. With the remaining assessments completed by 30/09/2014.

B) The assessments will enable the person in charge to review staffing levels /rosters to provide adequate supports for all residents by 31/12/2014.

**Proposed Timescale: 31/12/2014**

## Outcome 07: Health and Safety and Risk Management

**Theme:** Effective Services

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

The risk management policy did not meet the requirements of the Regulations.

**Action Required:**

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

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

1. The St John of God Risk Management Policy has been reviewed to ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents. (February 2014).

2. The revised Risk Management Policy has been disseminated to all locations on 12/03/2014.

**Proposed Timescale:** 01/04/2014

**Theme:** Effective Services

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

There were no plans or procedures for responding to emergencies other than fire.

**Action Required:**

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

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

1. A Site Specific Emergency Plan Template has been devised to identify site specific risks/ hazards relevant to each location.

2. The administrative Manager and PIC will review the Plan at each location and make specify the emergency procedures for that location by 30/04/2014.

3. The Site Specific Plan will be disseminated to all locations. Staff teams at each location will review the plan and sign their understanding of the plan by 31/05/2014.

4. The degree of implementation and understanding of the site specific emergency plan will monitored and evaluated through quality and safety walk around audit by the programme manager and co-ordinator by 30/06/2014

**Proposed Timescale:** 30/04/2014



**Theme:** Effective Services

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

There was insufficient hazard identification and assessment of risk throughout the designated centre.

**Action Required:**

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

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

1. The revised Risk Management Policy has been disseminated to all locations on 12/03/2014.

2. A Risk Register is in draft stage. The risk register will be finalised and disseminated by 31/05/2014. Any additional risks identified in the proactive risk assessments will be used to populate this risk register.

3. As previously stated in Outcome 5

Risk assessments will be carried out with all Residents that:

A) Are at risk of falls.

B) Are at risk of absconding.

C) Are left alone for a period of time.

D) Are diagnosed with Epilepsy By 30/04/2014.

Risk assessments will be completed by the staff team at each location within the designated centre and will be reviewed by the programme manager and or co-ordinator.

Reviews of risk assessments will be carried out at house level quarterly or sooner if needs change. Risk assessment reviews will also be discussed at monthly house review meetings.

4. Risk assessments will be carried out with all residents that smoke.

Risk assessments will be completed by the staff team in each location within the designated centre and will be reviewed by the programme manager and or co-ordinator by 31/03/2014.

**Proposed Timescale:** 31/05/2014

**Theme:** Effective Services

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

An adequate means of escape was not provided.

**Action Required:**

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

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

1. A) Egress via the kitchen back door has been identified as a hazard due to the height of the threshold not meeting regulations. A new door/frame will be fitted to ensure egress by 30/04/2014.

B) The resident has been risk assessed which identifies the supports that are required to evacuate in the event of an emergency. This information is also contained in his Fire Evacuation Profile.

**Proposed Timescale:** 30/04/2014

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

There was insufficient records to demonstrate that one resident had been provided with appropriate health care when they sustained a head injury.

**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. Social care leaders have informed all staff that in the event of a resident sustaining injury, any observations and follow on care is to be documented in the residents Daily Progress Report.

2. The Falls Management Policy will be finalised by 30/06/2014 A Falls Assessment will be completed with residents identified at risk of falls and identified supports put in place.

3. A)As of the 10/02/2014 the Epilepsy Care Plan identified in the inspection has been updated to include care during and post seizures including responding to any potential complications, as has the recording of future epileptic activity in order to guide future interventions.

B) A local operational procedure to guide staff in the management of epilepsy is being developed and disseminated to each location by 30/04/2014.

C) An individualised protocol template for the administration of Buccal Midazolam has been devised and will be completed with all residents prescribed Buccal Midazolam PRN by 31/03/2014

D) All Staff permanent staff working in locations where Buccal Midazolam is prescribed have participated in training. All remaining relief staff will participate in training by 30/06/2014

4. An individualised protocol template for the administration of PRN medication has been devised and will be completed with all residents prescribed PRN's by 30/04/2014.

**Proposed Timescale:** 30/06/2014

#### **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 management systems in place did not ensure that the service provided was safe, appropriate to the residents needs and consistent and effectively monitored.

**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. As and from the 6th February 2014 the Service has engaged the services of an alternative employment agency. All agency staff are Social Care Worker Grade and are trained in Safe Administration of Medication (SAM).
2. The provider will recruit 3 relief panel Social Care Workers to replace staff on leave.
3. Relief and agency personnel will receive a general induction and a comprehensive induction at each location prior to commencing shifts.
4. Where relief or agency personnel have not worked at a location for a period of more than 1 calendar month they will receive re induction at house level by a permanent member of staff.
5. Supervision Performance Development Reviews for relief staff will be carried out at least once yearly and staff support meetings will be arranged as necessary by the co-ordinator or social care leader (if a staff is attached to a particular location)

**Proposed Timescale:** 31/08/2014

## Outcome 16: Use of Resources

**Theme:** Use of Resources

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

The resources were not effective to meet residents needs are per outcome 16.

**Action Required:**

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

1. As actioned in outcome 5, Supports Intensity Scale Assessments will be carried out with all 43 residents. We will initially assess residents that currently reside in supported locations without sleepover staff by 30/06/2014. The remaining assessments will be completed by 30/09/2014.
2. The assessments will support the person in charge to review staffing levels /rosters to provide adequate supports for all residents by 31/12/2014.
3. The maintenance issues identified in the report have been addressed these include the door handle in kitchen of 3 The park and Lighting in the kitchen of 5 Priory Drive. Action completed.
4. Planning is underway for the transfer of a resident with Dementia to an appropriately resourced designated centre. The transition plan is being developed by the staff team and keyworker in conjunction with the resident, his family and the Dementia Centre.

**Proposed Timescale:** 31/12/2014

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

There was insufficient number of staff available to meet the needs of residents.

**Action Required:**

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

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

1. As actioned in outcome 5 & 16, all residents will receive a Supports Intensity Scale assessment to identify supports required and ensure appropriate and sufficient supervision and care for their individual needs by 30/09/2014.

2. The assessments will support the person in charge to review staffing levels /rosters to provide adequate supports for all residents by 31/12/2014.

3. As and from the 10/03/2014 the staff roster has been amended to include staff providing waking night staff cover.

**Proposed Timescale:** 30/09/2014

**Theme:** Responsive Workforce

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

Staff files did not meet the requirements of the Regulations.

**Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

1. The Human Resources Department are auditing staff files to ensure they contain all the documents as required by schedule 2 of the Health Act 2007 Regulations 2013. Completed 21/03/2014.

2. The provider will ensure that each staff file has evidence of two references for all staff. By 05/04/2014.

3. The provider will ensure that each staff file has evidence of original Garda Vetting (GDVU).

**Proposed Timescale:** 30/09/2014

**Theme:** Responsive Workforce

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

There was a lack of evidence to demonstrate adequate supervision of temporary/agency staff.

**Action Required:**

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

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

1. As and from the 6th February 2014 the Service has engaged the services of an alternative recruitment agency. All agency staff are Social Care Worker Grade and are Safe Administration of Medication Trained (SAM).

2. The provider will recruit 3 relief panel personnel to accommodate leave.
4. Relief and agency personnel will have a general induction and a comprehensive induction at each location prior to commencing shifts.
5. Where relief or agency personnel have not worked at a location for a period of more than 1 calendar month they will receive re induction at house level.
6. Supervision Performance Development Reviews will be carried out with relief staff at least once yearly and staff support meetings will be arranged as necessary by the co-ordinator or social care leader (if a staff is attached to a particular location)

**Proposed Timescale:** 31/08/2014