Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St. John of God Kerry Services - Beaufort Campus Units Area 1
Centre ID:	OSV-0003630
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Company Limited By Guarantee
Provider Nominee:	Claire O'Dwyer
Lead inspector:	Margaret O'Regan
Support inspector(s):	Mary Moore
Type of inspection	Unannounced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
10 January 2017 09:10	10 January 2017 19:30
12 January 2017 09:10	12 January 2017 19:30
13 January 2017 09:30	13 January 2017 15:15

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This inspection was carried out to monitor compliance with the regulations and standards and follow up on actions from the previous inspection.

How we gather our evidence:
As part of the inspection, inspectors met with 27 of the 31 residents. Some of the residents were able to verbally express their views of the service and facilities provided to them. Others expressed their views non verbally in the way they reacted to staff, interacted with other residents, their facial expressions and their general demeanor. Overall, inspectors formed the view that the majority of residents were happy and comfortable in the company of staff.

The inspectors noted that since the October 2015 inspection, the number of residents in the centre had reduced from 33 to 31. No further admissions were being taken into the unit which had the reduction in resident numbers. This improved the living arrangements for those remaining in the unit. For example, no more than three

residents occupied shared accommodation whereas in 2015 one room was shared by five residents.

Inspectors observed how staff interacted with residents, observed the general comfort of the environment and the atmosphere within the houses. Interactions were characterized by a relaxed, competent and caring approach from staff.

Inspectors sought the views of staff on the quality of care provided. It was clear staff took pride in their work. They told the inspector they enjoyed their work and worked well with their frontline colleagues. However, staff were not always clear on the reporting structures. Inspectors concluded staff views were not always heard by managers and that systems were such that staff were not adequately supported.

Inspectors met with members of the management team who explained the management and oversight systems in place.

Inspectors examined documentation such as resident care plans, policies and risk management assessments and procedures. Documentation was comprehensive and generally well organised; however, it was not clear the processes in place achieved the desired outcomes. For example, the complaints policy was in place, it was recently reviewed but the process of dealing with complaints was not always achieving a resolution in a timely manner. There were other examples of processes not achieving the expected outcome. For example, the risk management systems had forums where risk was monitored, reviewed and measures put in place to reduce the risk. However, one of the most significant risks in the centre had not come to the attention of the risk forum, namely the appropriateness of a resident placement.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. The statement of purpose described the centre as one which endeavored "to provide a homely environment for the residents". Overall, significant effort was made to make each unit within the centre as homely as possible.

The centre was campus based comprising of four houses in a rural area, surrounded by landscaped gardens. Services provided included residential care for 31 fulltime residential adults, both male and female.

The service supported individuals who had a range of intellectual disability, some of whom also displayed behaviours that challenge. Many of the 31 residents had high physical support needs.

A number of residents availed of day services which were available on site.

Overall judgment of our findings:
Inspectors identified a number of areas of good practice. Staff members were seen to interact with residents in a kind and caring manner and residents appeared to be comfortable in their presence. Personal plans were person-centred; however, goals were not always achieved. This is discussed under Outcome 11, Healthcare.

Since the previous inspection the provider had taken measures to improve the physical environment. A significant undertaking had taken place to bring the centre into compliance with fire safety requirements. Some further premises improvements were needed. This is discussed under Outcome 6.

Work was ongoing in identifying areas for improvement including the manner in which resident finances were managed. However, at the time of inspection, inspectors found deficits in this area. This is discussed under Outcome 8, Safeguarding and Safety.

There were weaknesses in the manner in which risk was managed. For example, some risks were not reviewed in a timely manner and the review of other risks did not adequately take into account factors that impacted on this risk. This is covered under Outcome 7 of this report ((Health and Safety and Risk Management).

Inspectors were not satisfied that there were adequate numbers of staff on duty at all times to meet the needs of residents. For example, access to activities/day services had been curtailed for some residents due to staffing arrangements. There were inadequate numbers of staff on night duty, taking into account the significant physical and psychological needs of the residents living in the centre.

Other improvements required included:
- a more organised, supportive and effective management system
- access to allied health/specialist services such as dietetics
- a review of the contracts of care
- provision of appropriate staff training and refresher training.

The action plan at the end of the report identifies improvements necessary 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 2013.

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

Findings:
There was a policy and procedure for the management of complaints. The policy was updated since the last inspection and identified the person responsible for managing complaints. Also identified in the policy was the independent appeals process and details of who was responsible for ensuring that all complaints were adequately addressed.

The complaints procedure was on public display. It was written in an accessible format and included a photograph of the complaints officers. The number of complaints was generally low; however, the implementation of the policy did not always achieve its aim of addressing complaints in a timely manner or ensuring all complaints were logged. For example, inspectors identified two complaints which were not recorded. In addition, there were two incidents where there was a significant delay in addressing the matter of the complaint. Where a complaint was closed, it was unclear if the complainant was satisfied with the outcome and made aware of the appeals process if dissatisfied. At times there was a lack of evidence to show that measures were taken for improvement in response to a complaint.

Consulting with residents and relatives through a relative's forum had commenced since the previous inspection. The contact details of an independent advocate were on display; however, from discussion with staff, inspectors concluded access to advocacy was inadequate. For example, it was identified that a resident could benefit from an advocate but this had not progressed to an advocate working with the resident.

Inspectors observed staff interacting with residents in a respectful manner. It was

apparent that residents were relaxed and comfortable in the presence of staff. Residents' privacy was respected insofar as the premises would allow and inspectors observed staff knock before entering bedrooms. However, bedroom accommodation in one of the houses was primarily in twin or three-bedded rooms with inadequate screening to support residents' privacy and dignity. At times it became noisy in these rooms which had a negative impact on residents. In another, house there was a twin bedroom that also had inadequate screening to support residents' privacy. These issues are further discussed under Outcome 6, Premises.

Residents were dependant on staff to support them to attend activities and outings to the community. A range of activities were available based on individual needs and preferences. For example, residents had access to massage, a swimming pool, bowling, storytelling, walks on the grounds and other holistic therapies.

Some residents attended day services either on the grounds of the centres or in local towns. However, participation in these activities was dependent on the availability of staff and there was not always sufficient staff available. For example, at least one resident that had previously attended a day service, was not attending at the time of inspection due to issues with providing suitably qualified staff. Inspectors were informed this matter was in the process of being addressed. These actions are addressed under Outcome 17, Workforce.

There was a policy on residents' personal property and finances. However, as discussed under Outcome 8 (Safeguarding and Safety) the policy was not adhered to and did not achieve the objective of ensuring residents monies were appropriately managed.

The provider was in the process of carrying out an internal audit to determine items and services residents paid for which should have been provided by the provider. In tandem with this internal audit, St John of God nationally were conducting an external audit of residents' monies. The provider was requested by inspectors to ensure this centre was part of the external audit.

Judgment:
Non Compliant - Major

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

Findings:
Inspectors were informed that the centre was currently closed to admissions and residents were transferred from the main building to other houses when vacancies arose. There was evidence that this occurred. The documentation showed and staff confirmed a transition plan was implemented when a resident moved within the service. However, the centre's admissions process did not adequately consider the wishes, needs and safety of other residents currently living in the services. For example, the resident mix in one house posed a significant restriction on the occupants of that house.

Amendments were made to the contract details since the last inspection. However, on this inspection the contracts examined by inspectors did not specify the exact fee each resident paid. In addition, the charges stated in the contract did not always equate with charges residents were likely to incur. For example, a number of residents were charged for soft furnishings such as curtains, replacement parts for equipment or fuel for vehicles.

Residents held financial passports. Recorded in this passport was information such as the level of control the resident had over his or her monies, details of where his or her money was kept, procedure for the maintenance of receipts and details of what the resident must pay. It was stated in the financial passport that residents paid for personal care items, clothing, social activities and foot care. No reference was made to paying for furnishings or fuel; items that would ordinarily be paid by the provider. At the time of inspection, the provider was in the process of finding out the extent of the inappropriate charges. Inspectors were informed that inappropriate charges would be refunded to residents.

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Each resident had an assessment of their personal and social care and support needs. Based on these assessments, each resident had a personal plan developed by their key worker. However, it was unclear from the documentation the level of consultation that took place with residents and/or their relatives about the care plans and personal goals.

The written plans were person-centred. However, they were inconsistent in showing the involvement of members of the multi-disciplinary team. In particular, nursing management had limited involvement in the annual care plan reviews or the interim reviews of the plans which took place four times a year. Inspectors concluded that this was primarily a governance issue and the limited availability of nursing management to support staff and residents in achieving their goals. This is further discussed under Outcome 14, Governance and Management.

Care plans were available to residents in an accessible format and this was an improvement from the last inspection. Other improvements from the previous inspection were the completion of a nutritional assessment for each resident, the monitoring of food and fluid intake where this was indicated and the completion of a pressure risk assessment for residents at risk of developing pressure sores.

Much effort was made to fulfil personal plans; however, as discussed elsewhere in this report, the achievement of some goals was hindered by insufficient staff numbers and inappropriate skill mix. For example, a resident's goal to go on a trip to a local amenity had not progressed in over 12 months. In other instances residents assessed needs to go on regular drives had not materialised due to a lack of trained staff to accompany them.

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

Findings:
This was a designated centre for adults with a disability. The centre comprised of four units on the grounds of a large campus in a rural area of Co. Kerry. The extensive grounds were well maintained. On the days of this inspection the centre was home to

31 residents.

The first unit was home to eight residents. Sleeping accommodation in this unit comprised eight single bedrooms. Bedrooms were adequate in size to meet the needs of the residents living there. Should the dependency levels of residents increase, their bedrooms may be insufficient in size, for example, to manoeuvre assistive equipment such as hoists and large specialized chairs.

Communal space in this unit comprised a large sitting room with a 3-seater couch, an armchair and a play area that provided a safe environment for one resident. There was a large dining room with two dining tables and a kitchen.

Sanitary facilities comprised two bathrooms, one with an assisted shower and one with a bath. Toilets were available for residents and staff. There was a sluicing area in one of the bathrooms that contained a sluice sink but was also used to store equipment. Inspectors were not satisfied that the sluicing area was suitable for its stated purpose and posed a risk of cross-contamination and infection.

The second unit adjoined the first unit and had its own separate entrance but was also accessible through a door from the first unit. This unit was also home to eight residents. Sleeping accommodation in this unit comprised six single bedrooms and one twin bedroom. The single bedrooms were adequate in size to meet the needs of the residents living there. The twin bedroom, however, did not support the provision of privacy and dignity to residents due to inadequate screening between beds and inadequate wardrobe space for residents to store their clothing.

Communal space comprised a kitchen/dining area, an activity room, a sitting room and a relaxation/multi-sensory room.

Sanitary facilities comprised two bathrooms, one with a shower and assisted bath and the other with a shower. Similar to the first unit, there was a sluicing area in one of the bathrooms that was not suitable for its stated purpose. One of the toilets used by a resident had a commode chair placed over the toilet bowel with a lap belt secured to the commode. Inspectors were informed that this was in place to support the resident when using the toilet. Inspectors were not satisfied that this was supported by a clear protocol, was risk assessed or that it complied with good infection prevention and control practice.

The third unit was located in a separate part of the campus to the first two units. It was home to six residents with sleeping accommodation in six single bedrooms and also a staff bedroom. All of the bedrooms were small in size but, based on inspectors' observations, they were suitable for the needs of the residents living there on the days on inspection. Communal space comprised a sitting room and a sunroom/dining room. Sanitary facilities comprised a bathroom with an assisted shower and a standard bath. There were three toilets for use by residents.

The fourth unit was located in an older building that also contained a unit from another designated centre and a number of administrative offices. This was a two-storey building however, all residents' accommodation and facilities were on the ground floor.

This unit was home to nine residents on the days on inspection.

Bedroom accommodation comprised two 3-bedded rooms, one twin-bedded room and one single bedroom. Inspectors were satisfied that the reduction in resident numbers improved the privacy in the multi-occupancy bedrooms. Inspectors were also assured by the provided that no further admissions were taking place and when a vacancy would arise on campus the multi occupancy rooms would be further reduced in terms of occupancy numbers.

However, at the time of inspection some rooms in this unit did not adequately supported the privacy and dignity of residents. Communal space comprised a large sitting room that also served as a dining room and a large activation room. Sanitary facilities comprised 2 spacious bathrooms, each of which contained a bath, a shower and two toilets. The bathrooms were bright and clean.

Overall the centre was bright and clean, however, some improvements were required as paintwork was chipped and damaged in a number of the units.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There was a risk management policy, a safety statement and an emergency plan. There was a risk register in each unit that identified risks from an individual resident perspective and there were also risk assessments for individual residents. The process of risk management could be enhanced by the identification and inclusion of general risks in the risk register.

Some risks were identified by inspectors during the initial walk around of the units that warranted a risk assessment to ensure that residents were not exposed to risk. These included:
- the appropriateness of resident placements
- the reduction in staffing levels in one house.

While systems were in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies, these systems did not always

achieve their objective. For example, a significant risk around the appropriateness of a resident's placement and the learning required from incidents which had occurred had not come to the attention of the risk forum.

Inspectors reviewed a sample of incident records and found that incidents were recorded and reported; however, measures to minimise the risk were not always put in place nor were all risks communicated to the risk forum.

The standards for the prevention and control of healthcare associated infections were inadequate. As already stated under Outcome 6, some improvements were required in this area which included:
- provision of adequate sluicing facilities and practices
- provision of adequate storage facilities for bedpans to dry appropriately
- provision of suitable storage area for mops.

Records were available to demonstrate that fire safety equipment was serviced annually and the fire alarm system was serviced quarterly. Significant work had been undertaken since the last inspection in upgrading the fire safety arrangements. Emergency lighting was in place as were fire doors, an upgraded panel alarm and compartmentalised doors.

There were fire drills at regular intervals and fire records were kept which included details of fire drills, fire alarm tests and fire fighting equipment. Records indicated there were daily checks of the fire alarm panel and verification that escape routes were free from obstruction. Training records indicated that most, but not all, staff had up-to-date training in fire safety.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
There was a policy on, and procedures in place in relation to safeguarding vulnerable

adults, which provided guidance to staff. Staff had up-to-date training in safeguarding of vulnerable adults. From speaking with staff, inspectors found them to be knowledgeable in relation to what constitutes abuse and on the related reporting procedures. The staff members were also aware that there was a designated person to deal with any allegations of abuse.

Inspectors viewed a sample of residents personal financial accounts and saw that there were procedures in place to ensure that their monies could be accounted for. Items purchased by residents required a receipt and their personal monies were checked by two staff members daily to ensure accuracy. However, inspectors found that residents were being charged for furniture, medical aids and medical appointments; items which were expected to be covered by the provider or by accessing public health services.

For example, between 2013 and 2016 a number of residents were charged for the cost of specialised chairs while another was charged in excess of €2000 for an aid they used daily. Residents were regularly referred to private dieticians without a full exploration of their entitlement to this service through the public health system. It was also a regular practice for residents to pay for the fire proofing of curtains. This expense was usually in the region of €200 to €300 and was an expense the provider would be expected to cover.

These irregularities had already come to the provider's attention prior to this inspection. The provider was in the process of carrying out an internal audit to determine the extent of the inappropriate charges. Inspectors were informed residents would be refunded. As a result of concerns raised during this inspection the provider was formally requested to ensure this centre was part of the national external review being conducted by St John of Gods on how resident finances were managed.

The use of restraint was low and in general, where used, the appropriateness of it was assessed. However, there was a discrepancy in reports as to whether a lap belt was used as support while staff were with the resident or used to keep the resident safe while staff were absent. Some staff were due training updates in the use of restrictive practices.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

implemented.

Findings:
Residents had access to the services of a general practitioner (GP) who visited the centre weekly or more frequently if required. Staff acknowledged the valuable contribution of this GP service. There was also access to out-of-hours GP services.

Residents received a medical assessment at regular intervals and healthcare needs were met in a timely manner. There was access to allied health specialist services such as speech and language therapy, occupational therapy, physiotherapy, psychology, psychiatry and dental. Residents' quality of life was enhanced by the level of input from these professionals.

However, as noted on the previous inspection there was limited access to the services of a dietician. In one instance a resident requiring dietetic services did not have this facilitated since 2014 nor was it clear if access to this service was arranged with the Health Services Executive (HSE). A number of residents accessed this service privately but it was unclear if these residents were fully enabled to explore access to community dietetic services including residents who received artificial nutrition.

There was good recording and monitoring of residents daily food and fluid intake. Resident weights were regularly recorded and residents were regularly seen by the GP.

Since the last inspection improvements were made in relation to healthcare and nursing assessments. For example, nutritional assessments, pressure risk assessments and pain risk assessments were seen to be used as residents' care needs dictated.

Residents' food was prepared in a central kitchen and delivered to the houses in insulated food containers. Residents were offered a choice of food at mealtimes and food was provided in the consistency recommended by speech and language therapists. Residents requiring assistance at mealtimes were assisted in a respectful and dignified manner. Residents were provided with drinks and snacks throughout the day. Some residents were supported to eat out in local restaurants occasionally.

Hospital appointments were facilitated as and when required. Positive mental health was also provided for and where required residents had access to psychology and psychiatry supports. Health care plans were informative of how best to manage special conditions such as epilepsy. Residents with epilepsy were reviewed by their neurologist in the local acute hospital.

Judgment:
Substantially 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were written operational policies and procedures in relation to medication management. Medications were stored appropriately. A sample of prescription and administration records were reviewed and they contained appropriate information. Plans were in place to change the format of the prescription record and the record of medicines administration. The inspectors were informed of the expected positives benefits of this change. However, there was a lack of satisfactory consultation with frontline staff who would be implementing the new system. The new system continued to be paper based. Inspectors concluded it was unlikely to address the reported primary challenge with medicines records, that being legibility. The provider informed inspectors that before a complete roll out of the new system, a review would be conducted to evaluate the effectiveness of the system. Views of stakeholders were to included in this evaluation.

Where PRN medicines (a medicine only taken as the need arises) were administered, there was a record of the monitoring of the effectiveness of the medication.

A review of incident records indicated that where medication errors occurred appropriate remedial action was taken. There was an audit of medication management completed in August 2016 and more recently in October 2016.

Non nursing staff were in the process of receiving training in the administration of emergency medicine. It was anticipated this would facilitate staff to accompany residents on outings and to day services.

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

Findings:
Systems were in place to monitor and improve practice. However, these systems did not achieve the desired outcomes. For example, a system was in place whereby risks were monitored by the risk forum. This forum was made up of senior managers and staff responsible for health and safety. The forum held regular meetings and minutes of meetings were maintained. However, risks were not always escalated to the forum. One significant incident which occurred in a house and which necessitated the house to be evacuated was recorded by staff in the incident book and reported to the line manager but that appeared to be as far as the matter went. There was no record of what measures were put in place to mitigate against this risk and medical advice given with regards to the volatility of the situation was not acted upon. The risk forum was unaware of this incident until it was brought to their notice by inspectors.

Another example of the systems not achieving the desired outcome was the lack of clarity as to how the risk forum decided on the degree of risk. For example, a risk was deemed to have been reduced even though part of the measures in place to mitigate against the risk were removed (reduction in staffing).

On this inspection, inspectors found the person in charge was absent from her post for six weeks prior to the inspection. In her absence the post was covered by a deputy person in charge with supports from the senior management team. This deputising person also had person in charge responsibilities for two other centres. One was located adjacent to this centre and accommodated up to 45 residents. The other was a single occupancy house located approximately 12 kilometres away. In total the deputy person in charge was managing three centres which catered for 77 residents. All residents had significant and complex needs. It was not possible for the person deputising for the person in charge to know the residents and their individual support requirements. To further complicate the management structure, a key lead front line person in this centre was on leave for over three months and had not been replaced.

Gaps in the line management structure was a contributing factor to the lack of follow through on important matters. It was also a contributor to reporting systems not achieving the desired outcomes of improvements in practices.

The inspectors observed that there was an on-call system in place where staff could contact a senior manager at any time if the need arose. However, staff were uncertain about the effectiveness of this. Some comments made to inspectors indicated staff generally addressed any issues locally, which was commendable but lacked oversight.

This lack of oversight was characterised by;
- an absence of team meetings
- where meetings took place a lack of clarity as to who was to follow up with the required actions
- limited formal supervision of staff
- limited communication with staff about changes

- unclear reporting structures
- uncertainty amongst staff as to who was in charge
- a reluctance by staff to freely express their views
- an incomplete annual report on the safety and quality of the service.

These managerial arrangements did not ensure the effective governance, operational management and administration of the centre.

Other deficits in governance arrangements have been discussed elsewhere in this report and include;
- lack of adherence to the complaints policy
- delay in addressing complaints
- risk assessments not completed
- inappropriate oversight of how resident monies were managed
- poor consultation with family and residents around goal setting
- limited involvement of management staff in supporting key workers in setting resident's goals.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Based on the observations of inspectors, a review of records and discussions with staff, inspectors were not satisfied that there were sufficient numbers of staff on duty at all times to meet the needs of residents.

It was identified on the last inspection that evening time staffing levels were inadequate. Also identified was that staffing levels and skill mix curtailed residents' ability to access activities. In the interim, the whole time staffing equivalent had increased. This was in tandem with a change in the rostering system and a reduction in the level of dependency on agency staff. Since the last inspection, an extra staff member was employed on the night shift to assist in all four houses of this centre. However, the

evening needs in one of the houses was such that this extra help was not available in the evening to two other houses which also required assistance.

It was assessed in one house that a resident required one to one staffing due to a moderate risk which pertained in the house. However, this house's staffing was reduced as was its level of risk. This occurred even though there was no evidence that the issues pertaining to residents needs had changed. Staff stated that in general, residents' needs were getting more complex, thus requiring extra resources to attend to their needs adequately.

As referenced under Outcome 14, inadequate management cover was provided for periods when the person in charge was on extended leave and when another key lead member of staff was on leave.

There were a number of entries in house diaries and staff meeting minutes, indicating concerns about gaps in staffing levels.

Training records indicated that there was a comprehensive programme of training available to staff that included manual handling, fire safety, safeguarding, first aid, medication administration and management of behaviours that challenge. Based on a review of training records provided to inspectors a number of staff did not have up-to-date training in fire safety, manual handling and management of behaviours that challenge.

A sample of personnel records reviewed indicated that most of the requirements of Schedule 2 of the regulations were satisfied; however, a full employment history was not available for one member of staff.

Judgment:
Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Margaret O'Regan
Inspector of Social Services
Regulation Directorate

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Company Limited By Guarantee
Centre ID:	OSV-0003630
Date of Inspection:	10,12, and 13 January 2017
Date of response:	16 March 2017

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:
Each resident's privacy and dignity was not respected in relation to his or her personal and living space. Ten of the 31 residents shared accommodation.

1. Action Required:

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The Registered Provider is committed to the reduction of resident numbers supported within the Designated Centre over a phased period. There has been a reduction of two in the previous twelve months within the Designated Centre.

In the event of a vacancy arising in the second unit identified within the body of the Report the residents currently in twin room in this location will be allocated individual rooms.

The campus is closed to admissions; any vacancies will be allocated to residents in multi occupancy rooms where the placement is assessed as appropriate to their needs and the needs of the other residents in the proposed location.

• Multi occupancy bedrooms are no longer reallocated to another resident in the event of a vacancy arising.
Proposed Timescale: Completed

• The main building is closed to admissions and this is agreed with HSE and documented in Statement of Purpose.
Proposed Timescale: Completed

• Unit two identified in the body of the Report will reduce to seven residents when a vacancy arises in that location. The Statement of Purpose will be amended to reflect this commitment.

• A review of the existing screens will be completed in multi occupancy rooms and twin room to identify an alternative to the existing free standing screening.
Proposed Timescale: 26/05/17

Proposed Timescale: 26/05/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have adequate access to advocacy services and information about his or her rights.

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

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

The Service operates a Human Rights Committee with both external and internal members. Referrals to the Human Rights Committee can be made directly by all staff, residents or family members.

Each resident is allocated a Keyworker who can support the resident to make a Complaint. Planning meetings are scheduled with residents and their family member on an annual basis to support family advocacy in the development of plans.

• Information on the role and function of the Human Rights Committee will be rolled out to keyworkers, residents and family members to support advocacy for residents.
Proposed Timescale: 30/08/17

• Staff will be provided with training in:
o Keyworking
o Advocacy
o Rights Promotion

The PIC will ensure each resident has an annual planning meeting schedule and facilitated with their family as appropriate in the current year.
Proposed Timescale: 28/02/2018

As part of the annual review each family/resident's representative will be furnished with a copy of the following procedures:
• Local Complaints Policy and Procedure
• Details of the National Advocacy Service
• The Confidential Recipient within the HSE
Proposed Timescale: 30/06/17

• The Person in Charge has met with the National Advocacy Service on 21/11/2016 to explore the options of extending the Service for the residents in DC1 and identify potential models of advocacy that could be developed within the Service.
• The Person in Charge in consultation with the Clinical Nurse Managers will ensure a referral to the National Advocacy Service will be made where this has been identified as an assessed need in the resident's plan.
Proposed Timescale: 30/09/2017

Proposed Timescale: 28/02/2018

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inadequate support was given to ensuring each resident was helped to manage their financial affairs.

3. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and

possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
• An Internal Audit will be completed on all residents' finances to identify any expenditure eligible for refund.
Proposed Timescale: 28/02/2017

• Residents will be reimbursed for any expenditure identified as eligible for refund as part of the Internal Audit.
Proposed Timescale:30/04/2017

• A schedule of Internal Audits will be in place in the Designated Centre to audit:
o The quality of accuracy of records
o The nature and appropriateness of expenditure
o The consent process in place
Proposed Timescale: 30/09/2017

• Each resident's Private Property List will accurately detail their personal property and be retained on their plan.
Proposed Timescale: 30/09/2017

• Residents and family requests to use private healthcare as opposed to wait listing on the public service will be clearly documented on each resident's plan.
Proposed Timescale: 31/05/2017

• The Designated Centre will be included in an External Audit being commissioned by the Service Provider nationally.
Proposed Timescale: 30/03/2017

• The local Policies and Procedures in relation to residents' finances will be updated based on recommendations from above Audits and in consultation with the local Policies, Procedures Group.
Proposed Timescale: 30/06/2017

• The PIC in collaboration with Unit Managers will roll out the updated Policies and Procedures to staff teams within the Designated Centre to ensure compliance.
Proposed Timescale: 31/07/2017

Proposed Timescale: 30/09/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Each resident was not provided with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

4. Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
• Resident not fully attending day service at time of the Report with another service provider will be supported to re-engage in this service.

• The Person in Charge has agreed with the service provider a planned return to the service for the resident based on their assessed needs.
• Resident has commenced attendance at her day service on a weekly basis.
Proposed Timescale: Completed

• Non nursing staff are currently being trained in the Safe Administration of medication to support this resident on transportation in order to prevent any unnecessary disruption to her attendance based on staff skill mix.
Proposed Timescale: 22/12/2017

• SAM's training will be rolled out on a phased basis across each unit to non-nursing staff.
Proposed Timescale: 22/12/2017

• The rollout of SAM's training will support residents on activities in order to prevent any unnecessary disruption to residents on activities based on skill mix. Some staff supporting residents identified in the body of this Report will be prioritised for training in 2017.
Proposed Timescale:22/12/2017

Proposed Timescale: 22/12/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have adequate access to advocacy services for the purposes of making a complaint.

5. Action Required:
Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

Please state the actions you have taken or are planning to take:
Each resident is allocated a Keyworker who can support the resident to make a Complaint. Planning meetings are scheduled with residents and their family member on an annual basis to support family advocacy in the development of plans.

The PIC will ensure each resident has an annual planning meeting schedule and

facilitated with their family as appropriate in the current year.
Proposed Timescale: 22/12/2017

The Person in Charge in consultation with the Clinical Nurse Managers will provide additional information to each team in relation to supporting residents in making a complaint.
Proposed Timescale: 30/09/2017

Proposed Timescale: 22/12/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All complaints were not investigated promptly.

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

Please state the actions you have taken or are planning to take:
Complaints will be responded to in accordance with the Complaints Procedure. The timeline for each complaint will be recorded on the Complaints Log.

Proposed Timescale: 30/03/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complainants were not informed promptly of the outcome of their complaints and details of the appeals process.

7. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
• Complainants will be responded to in accordance with the Complaints Procedure. The timeline for each response to a complaint will be recorded on the Complaints Log.

• All complainants will receive a written outcome to their complaint which will include details of the appeals process.

Proposed Timescale: 30/03/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of evidence to show that measures were taken for improvement in response to a complaint.

8. Action Required:
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
• The Registered Provider will review the process of management of complaints within the Designated Centre to enhance the current structure.
Proposed Timescale: 31/05/2017

An initial Audit of Complaints has been carried out in January 2017.
• Audit of Complaints will form part of the annual schedule of Audits within the Designated Centre.
Proposed Timescale: 22/12/2017

Proposed Timescale: 22/12/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A record was not maintained of all complaints.

9. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
• Each Unit Manager along with the PIC will have access to the Complaints Log to ensure all complaints from each location is accurately reflected on the Log.
• An annual Audit of Com-plaints will take place to monitor the implementation of the Complaints Policy.

Proposed Timescale: 31/10/2017

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:
The agreement for the provision of services did not adequately detail the services to be provided for that resident and where appropriate, the fees to be charged. For example, charges for furnishings were not detailed. Neither did the contract detail the exact fee each resident paid.

10. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
• Details of costs not covered by the Registered Provider in the event of a resident or family choosing to incur these expenses.
• The Registered Provider will complete a review of the implementation of Residential Support Services maintenance and accommodation contributions.

Proposed Timescale: 30/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre's admissions process did not adequately considers the wishes, needs and safety of other residents currently living in the services. For example, the resident mix in one house posed a significant restriction on the occupants of that house.

11. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
• All future transfers will have a record maintained of the consultation process undertaken with existing residents in the event of a new resident being identified to move into the residential area. The Designated Centre is closed to new admissions.
• A review of the Risk Assessment in relation to the resident identified in the body of the Report will be completed by PIC and the Unit team.
Proposed Timescale: 12/02/2017

• The Risk Assessment will be escalated to the Multi-Disciplinary Risk Forum for review.
Proposed Timescale: Completed 08/03/2017

Proposed Timescale: 08/03/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements in place did not meet the assessed needs of each resident. For example, a resident's goal to go on a trip to a local amenity had not progressed in over 12 months. In other instances residents assessed needs to go on regular drives had not materialised due to a lack of trained staff to accompany them.

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

Please state the actions you have taken or are planning to take:
• Three non-nursing staff are currently being trained in the Safe Administration of medication in the location identified to improve residents access to social activities and ensure activities are not prevented due to skill mix.
Proposed Timescale: Completed 10/03/2017

• SAM's Training will continue to be rolled out to non-nursing staff across the Designated Centre in 2017.
Proposed Timescale: 21/12/2017

Proposed Timescale: 21/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not clear that personal plan reviews were conducted in a manner that ensured the maximum participation of each resident, and where appropriate his or her representative.

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

Please state the actions you have taken or are planning to take:
• The PIC has arranged mentoring sessions on an individual basis for keyworkers to support them develop plans in accordance with residents' wishes. These sessions have commenced since January 2017 and will be available to all keyworkers in the Designated Centre where required.
Proposed Timescale: 31/10/2017

• Group Key-working training has been included in the annual training plan.

Proposed Timescale: 22/12/2017

• The PIC will request a schedule to outline planning meetings scheduled within the Designated Centre from each unit Manager.
Proposed Timescale: 22/12/2017

• The PIC will ensure each resident has an annual planning meeting facilitated to include the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.
Proposed Timescale: 21/12/2017
• Keyworker will invite principal Multi-Disciplinary team member to attend Planning Meeting in accordance with resident's wishes.

• Each resident's Plan will clearly reference the input from Multi-Disciplinary Team and location of documentation in Medical files.
Proposed Timescale: 31/10/2017

Proposed Timescale: 22/12/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the premises were unsuitable due to:
- multi-occupancy bedrooms
- inadequate sluicing facilities
- inadequate storage.

14. 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:
Multi occupancy bedrooms:
• The bedroom identified is prioritised for single occupancy in the event of a suitable vacancy arising.

Inadequate Sluicing facilities:
• The PIC will complete an Audit of existing sluice areas within the Registered Centre in accordance with HSE Infection Prevention and Control measures.
Proposed Timescale: 28/03/2017

• Arising from the Audit agreed Action Plan will be developed by the Clinical Nurse Management team and PIC.

Proposed Timescale: 26/04/2017

• Local Protocols will be updated in each area in Designated Centre.
Proposed Timescale: 30/06/2017

• Suitable storage of mops and protocol will be put in place in consultation with the Household Supervisor in line with Infection Prevention and Control Measures.
Proposed Timescale: 26/04/2017

Inadequate storage:
• The storage facilities in the room identified in the body of the Report had been enhanced since last inspection.
• The shortage of facilities will be reviewed to assess if any alternatives are available to improve storage.
Proposed Timescale: 31/05/2017

Proposed Timescale: 30/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the centre required redecoration due to damaged and chipped paintwork on walls and doors.

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

Please state the actions you have taken or are planning to take:
• A planned schedule of maintenance will be put in place in consultation with the maintenance team to include painting within the Designated Centre.
Proposed Timescale: Completed

• Painting has commenced in the Designated Centre and will be phased for completion during the year.
Proposed Timescale: 01/09/2017

Proposed Timescale: 01/09/2017

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 include hazard identification and assessment of

risks throughout the designated centre.

16. 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:
• The current Risk Register will be reviewed and extended to include Clinical, Occupational and General Risks.
Proposed Timescale: 31/12/2017

• The Registered Provider will review the Risk Management Policy under Section 7 to include General Risks.
Proposed Timescale: 31/10/2017

• Information on the role of the Risk Forum will be disseminated to each area through the Infoshare meetings and individual team meetings.
Proposed Timescale: 09/05/2017

Proposed Timescale: 31/12/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While systems were in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies, these systems did not always achieve their objective.

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

Please state the actions you have taken or are planning to take:
• The current final sign off on adverse incidents will be reviewed to ensure PIC's review all incidents.
Proposed Timescale: 15/03/2017

• The Risk Register will be reviewed by the Residential Manager, in consultation with PIC, to identify any current risks that require escalating to the Risk Forum.
Proposed Timescale: 12/04/2017

• The risk identified in the body of this Report will be escalated to the Risk Forum for review.
Proposed Timescale: Completed 08/03/2017

Proposed Timescale: 12/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The standards for the prevention and control of healthcare associated infections were inadequate.

18. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
• The PIC will complete an Infection Control Audit within the Designated Centre in accordance with the HSE Infection Prevention and Control measures.
Proposed Timescale: 28/03/2017

• Arising from the Audit agreed Action Plan will be developed by the Clinical Nurse Management Team and PIC.
Proposed Timescale: 26/04/2017

Proposed Timescale: 26/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had received suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Please state the actions you have taken or are planning to take:
• Fire Training is part of Training Calendar and all staff will be included in this training.
Proposed Timescale: 31/12/2017

• Training Log will reflect staff who are on long-term absence and not available for training.

Proposed Timescale: 30/06/2017

Proposed Timescale: 31/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date training in managing behaviours that challenge.

20. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
• Training in de-escalation and intervention techniques is scheduled for remaining two staff in the high priority residential unit highlighted in the body of Report.
Proposed Timescale: 30/06/2017

• The PIC in consultation with unit managers will facilitate staff to attend training in behaviours that challenge for areas the PIC has identified as a priority for this training within the Designated Centre.
Proposed Timescale: 31/12/2017

Proposed Timescale: 31/12/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear if therapeutic interventions were implemented as per the personal planning process. For example, there was a discrepancy in reports as to whether a lap belt was used as support while staff were with the resident or used to keep the resident safe while staff were absent.

21. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
• Protocol is in place for use of the lap belt identified in body of this Report. This protocol has been updated by the Unit Manager to reflect the staff support and residents privacy.

Proposed Timescale: Completed 28/02/2017
• All staff will sign off on Protocol as having read same to ensure use of lap straps is in line with the prescription issued by the Occupational Therapist.

• Occupational Therapist has confirmed the use of this lap belt is to support the resident as part of their intimate care needs.

• All staff on unit to be educated on the correct use of this Protocol through team meetings.
Proposed Timescale: 31/03/2017

Proposed Timescale: 31/03/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practices indicated residents were inaccurately charged for services provided.

22. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
• Residents and family requests to use private healthcare as opposed to waitlisting on the Public Service will be clearly documented on the resident's plan.
Proposed Timescale: 31/05/2017

• All residents will be supported to access funding available to them through the HSE Public System for aids and appliances which they are entitled to avail of under the Medical Card scheme.
• The PIC will ensure there are clear records on residents' files in relation to the Applications submitted to the HSE KRAG (Kerry Resource Allocation Group) for the purpose of funding for specialist equipment covered within the HSE Policy available to Medical Card holders.
• The PIC will ensure each resident's and family member's request to opt out of the Public funding procedure for specialist equipment will be clearly recorded on each resident's file.
• The PIC in consultation with the Policy/Procedure/Protocols Group will update the local Policies and Procedures to include a clear outline to reflect this process.
Proposed Timescale: 30/06/2017

Proposed Timescale: 30/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident requiring dietetic services did not have this facilitated since 2014 nor was it clear access if access to this service was arranged with the Health Services Executive.

23. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
The resident identified in the Report will be referred to Dietetic support.

Proposed Timescale: 10/03/2017

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:
The effectiveness of the revised practices relating to the prescribing and administration of medicines needed to be evaluated to ensure it achieved the desired outcome.

24. 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 PIC has requested and received written feedback from all frontline staff nurses on proposed new Kardex system.
Proposed Timescale: 12/03/2017

• The proposed new system for Kardex will be reviewed by PIC's in consultation with Clinical Nurse Manager and include the feedback received from frontline staff teams prior to implementation.
Proposed Timescale: 30/05/2017

Proposed Timescale: 30/05/2017

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 arrangement whereby a person in charge covered three centres did not satisfy inspectors that there was effective governance, operational management and administration of the designated centres concerned.

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

Please state the actions you have taken or are planning to take:
Registered Provider will complete a review of the Designated Centred on Campus to review and refine existing PIC to support governance.

Proposed Timescale: 31/07/2017

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 in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

26. 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:
• CNM2 Manager has been assigned to Areas 1 and 2 to address any gaps in management.
Proposed Timescale: Completed

• CNM2 Manager is off line to support PIC in management of Designated Centre pending completion of recruitment to fill long term absence of an existing manager.
• Recruitment is at an advanced stage to fill long term absence of an existing manager within the Designated Centre.
• The allocated CNM2 will put structure in place to ensure:
o Regular team meetings that will include identified actions, time scales and will allocate responsibility.
o Team based Performance developed and reviews will be set up within the team in this area.
Proposed Timescale: 30/04/2017

• Provider Nominee has quarterly meetings in place with frontline staff to support and encourage open communication, information sharing, from teams within the Designated

Centre and the Provider Nominee.
Proposed Timescale: Completed

Proposed Timescale: 30/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review of the quality and safety of care and support in the designated centre was incomplete.

27. 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:
Annual report will be completed including circulating to all family members.

Proposed Timescale: 30/06/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were ineffective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

28. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
• Team based performance management will be introduced in each unit.
• Each team based PDR will include the individual training needs of each team mentor.
• Schedule of Training to be incorporated.
• Team building, training, will be arranged for groups – refer to units.

Proposed Timescale: 20/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were limited arrangements to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

29. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
• Team meeting will take place on a monthly basis and standard agenda items will include any concerns regarding residents.
Proposed Timescale: 30/03/2017

• Provider Nominee has quarterly meetings in place with frontline staff to support and encourage open communication, information sharing, from teams within the Designated Centre and the Provider Nominee.
Proposed Timescale: Completed

Proposed Timescale: 30/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number, qualifications and skill mix of staff was not appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

30. 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:
• The PIC will review the location of night supervisor post to support needs in higher priority areas in the Designated Centre.
Proposed Timescale: 28/02/2017

• The Registered Provider will provide training programme in Safe Administration of Medication, on a phased basis, to up-skill teams in supporting residents in a range of activities.
Proposed Timescale: 28/12/2017
• The Registered Provider will allocate Volunteers to enhance provision of activities to residents.
Proposed Timescale: 30/06/2017

• Senior staff nurses and unit mangers will be provided to participate in the LEO programme to develop and hone their management skills.
Proposed Timescale: 31/10/2017

Proposed Timescale: 28/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A full employment history was not available for one staff member.

31. 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:
Human Resources Dept. will review personnel file to ensure full employment history is on file for the employee concerned.

Proposed Timescale: 31/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were gaps in staff access to appropriate training, including refresher training, as part of a continuous professional development programme.

32. 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 PIC will review Training Log and ensure training gaps are included in the Training Calendar for 2017.
Proposed Timescale: 30/04/2017

• The PIC will ensure each unit manager within the Designated Centre will allocate staff to available dates throughout the year.

Proposed Timescale: 22/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised. For example, line managers were not replaced when on extended leave, staff meetings were irregular, formal staff supervision was not always carried out.

33. 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:
• The PIC will ensure the Night Supervisor will be relocated to a more effective base to support staff and residents.
Proposed Timescale: 28/02/2017

• The PIC has relocated a CNM2 post to replace manager on extended leave.
Proposed Timescale: 21/02/2017

• Recruitment of CNM2 post is at an advanced stage. Interviews completed to restore the Unit Manager whole time equivalent to full complement within the Designated Centre.
Proposed Timescale: 0104/2017

Proposed Timescale: 01/04/2017