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
Lead inspector:	Margaret O'Regan
Support inspector(s):	Mary Moore
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
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 inform a registration decision. 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:
13 November 2017 14:30	13 November 2017 22:15
14 November 2017 10:55	14 November 2017 18:30
15 November 2017 10:50	15 November 2017 18:15

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

Outcome 01: Residents Rights, Dignity and Consultation
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 was an inspection carried out to monitor compliance with the regulations and standards and to follow up on matters from the previous inspection. The last inspection was carried out in January 2017.

How evidence was gathered:
As part of the inspection, the inspectors met with 28 of the 30 residents who were residing in the centre. Inspectors observed interactions between residents and staff and noted the knowledge staff had of residents needs, likes and dislikes. The majority of residents expressed their views in a non verbal manner or with limited verbal communication.

The inspectors met with parents and family members of the people living in the centre. Relatives spoke of the many aspects of care provided in the service which they were satisfied with and the areas where they were working with the provider in bringing about improvements. Families were active advocates for the residents. Relatives engaged in the life of the centre with the aim of ensuring their family

member's voice was heard. Monies raised by families through fundraising events, were directed to enhancing the quality of life for those residing in the centre.

The inspectors noted that since the January 2017 inspection, a number of improvements had been made in relation to;
* the decoration and upkeep of the premises
* the focus on providing a meaningful day for residents and
* the increased emphasis of maintaining a regular workforce, thus ensuring disruption to attachments were kept to a minimum.

The inspectors spoke with staff who shared their views about the care provided in the centre, aspects of the service which worked well and areas which could be improved. The inspectors heard about improvements in relation to physiotherapy, occupational therapy, speech and language therapy and other therapies available to residents. Inspectors met with the staff involved in these allied health supports. Inspectors also met with visiting medical personnel and the person involved in the provision of pastoral care. The inspectors spoke with the person in charge, the clinical nurse managers and the acting programme manager and gained an insight into their roles in the operation of the centre. The provider nominee met with the inspectors. Members of the management team were present for inspectors' feedback at the end of the inspection.

Inspectors examined documentation such as care plans, risk assessments and medication records.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. This document described the centre as one which supported individuals with a range of intellectual disabilities and high physical support needs. It described the centre as having evolved from a children's to an adult service and, as such, some placements had been identified in childhood for the current population.

Accommodation was in four separate living quarters. Between six and nine residents resided in each house. All accommodation was at ground floor level and was part of campus accommodation provided by the St John of God Kerry Services.

Most bedrooms were single occupancy bedrooms. One house had two bedrooms which accommodated three residents in each room. The houses and grounds were generally well maintained.

Male and female residents were accommodated in this service.

Overall judgement of our findings:
Residents in this centre had complex medical, physical and social care needs. Staff and the person in charge were aware of these needs and were working towards supporting each resident achieve as good a quality of life as possible. Many residents had lived in the centre for several years. There was evidence that, year on year, residents' quality of life had improved. This was primarily due to the increased focus

on establishing what a meaningful day meant for each resident. What was particularly noticeable was the increased awareness by staff around facilitating a social model of care. Inspectors also noted the improved lines of communication between frontline staff and the management team and between the management team and family members. These were positive developments.

The centre provided well for the healthcare needs of residents, maintained each house to a good decorative standard and significant progress had been made in retaining a regular cohort of staff in each house thus minimising a disruption to attachments. However, for many residents there remained significant gaps between their identified goals and the actual fulfilment of these. Goals for greater involvement in the community and goals for on-campus activities were curtailed due to staff skill mix and the number of frontline staff available. For some residents, their living arrangements impacted on their quality of life. For example, living in multioccupancy rooms and sharing with residents who had altered sleeping patterns.

While progress was made in addressing actions from previous reports, overall this progress was insufficient in addressing all the requirements made by previous HIQA reports to comply with regulations. For example, actions identified on the last inspection around staffing skill mix, provision of meaningful activities and providing appropriate placements to meet the needs of residents, remained as actions on this inspection. In addition, actions remained in place around the manner in which complaints were managed. These ongoing issues were a reflection on the effectiveness of the governance and management of the centre. Overall, inspectors concluded the leadership struggled to direct sufficient resources to meet the needs of residents.

The inspection findings are detailed in the body of this report and required actions outlined in an 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, 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:
Improvements were noted since the last inspection in the manner in which multioccupancy bedrooms were arranged. For example, screens were in place between beds and efforts had been made to make the bedrooms personal. However, it remained that each resident did not have adequate privacy and dignity due to the shared bedroom room arrangements. For some, this shared accommodation was in a three bed, ward type bedroom. While every effort was made by staff to ensure residents personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information was respected, the physical design and layout impeded this.

There were shortcomings in the effectiveness of the complaints procedure. For example;
* One documented complaint was not recorded on the electronic complaints log where the all such complaints were meant to be recorded
* There was lack of clarity as to who was the complaints officer
* There was no recorded follow up to a documented complaint
* The approach to verbal complaints was to invite the complainant to put the matter in writing. This impeded the accessibility of the complaints process.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Staff spoken with had a good understanding on what constituted a meaningful day and meaningful engagement for residents both on and off the main campus. Staff said that they had received support from the project manager in enhancing their understanding and enriching the process of agreeing and progressing residents personal goals and objectives.

There was evidence that some residents had good opportunity for social and community involvement and ongoing support and contact with family, including home visits and holidays. However, staff also recorded that other residents had limited opportunity to;
* access structured day services
* partake in social participation
* engage in community activities.

It was clear from individual resident assessments, that residents' general welfare and development would benefit from the above mentioned opportunities. For example, personal objectives for one resident included;
* increased opportunity for community access
* their own bedroom
* daily one-to-one activity.
Records maintained by staff and seen by the inspector, indicated that the resident had one community outing in September 2017 and two community outings in both October and November 2017.

The barriers to residents achieving their personal goals and objectives were primarily compromised by the available staffing resources and skill-mix. For example, records seen indicated and staff spoken with confirmed, that a proposed holiday for residents in 2017 had not materialised due to inadequate staffing resources. Staff had reverted to securing a full "day-out" for residents as a substitute. Another record seen dated October 2017, stated that 12 days of staff shortages in the previous month had resulted in a reduction in social outings for residents.

There was evidence of increased family involvement in the planning of residents personal goals. However, not all residents had an annual review of their personal plan. Some reviews was overdue by five months. The reviews that had taken place had not adequately assessed the effectiveness of the plan. For example, one resident had a goal of going to the swimming pool at least weekly. This was particularly important for this resident. However, the swimming log indicated the resident attended less that once a month for the previous 10 months. Reviews of the progress of the goals had not been documented. Nor was there any documented record outlining the barriers to achieving the gaol or evaluating the effectiveness of the plan.

The centre was not suitable for the purposes of meeting the assessed needs of each resident. For example, residents in shared bedrooms had different sleeping patterns, such as one resident waking several times a night while the other two residents were happy to sleep the night through if not disturbed.

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

Findings:
Inspectors saw that refurbishment works had been completed. Wardrobes had been re-positioned and this enhanced independent access for residents to their personal items. A resident demonstrated this to the inspector and said that they were very happy with the change.

A programme of maintenance works was ongoing in the centre. This included painting and redecorating. These improvements added to the overall well kept appearance of the houses and addressed one of the actions from the previous report.

This was an unannounced inspection and inspectors noted the houses were clean, tidy and generally well organised. The large landscaped grounds were generally well attended to. Plans were underway to improve the driveways and pathways. The upkeep of the premises was a collaboration between the provider and the families of those living in the centre. Families spoke of their work in fundraising to help to maintain and improve the standard of accommodation in the centre. It was clear this, amongst other

issues, was something families took pride in and put considerable energy into.

The number of residents in the centre reduced by one since the previous inspection which facilitated two other residents to have single occupancy rooms. However, the design and lay out of parts of the premises did not meet the aims and objectives of the service, in terms of providing privacy and appropriate bedroom space for the number and needs of residents.

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:
Inspectors saw a more comprehensive range of risk assessments compared to what had been in place at the time of the last inspection. Improvement was noted in the identification and management of risks.

Some staff spoken with had a good understanding of how risks were identified, reviewed and assessed so that there was learning to prevent reoccurrence. Staff were seen to have signed as having read and understood the risk register. There were risk assessments pertinent to the safety of individual residents and the scope of the assessments was seen to evolve in line with incidents as described by staff. For example, appropriate assessments put in place in response to an incident of behaviours of concern. Staff described and maintained a record of the review of these risk assessments and the required controls.

A range of work related risk assessments had been completed by health and safety personnel in consultation with staff. For example, for the risk of fire, manual handling, infection prevention and control. However, all risk management practice did not provide assurance that it promoted and protected resident safety. For example, there was one identified risk of residents falling due to uneven ground at the rear of a house. The control of the risk required the repair of the surface and was stated to be funding dependent. When asked why residents could not access the vehicle at the front of the house to reduce the risk of falling, staff said that they were not allowed to park the vehicle to the front as it may obstruct an ambulance.

A staff spoken with advised inspectors that decision making to inform a medicines

related practice was supported by the assessment of the associated risk. The practice related to the reported unavailability to residents, of a prescribed emergency medicine while residents were in the community. Given the potential risk to resident health and safety, inspectors sought to review the cited risk assessments so as to establish the safety of the reported practice. It was of concern to inspectors to be advised that the risk assessments were not available, that they were historical rather than current and had potentially been archived.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
The provider had commissioned audits of the management of residents' personal monies personal property and finances. These audits were completed. The overall findings were of financial procedures and practices that were insufficient to safeguard residents' personal monies and property. The findings and the requirement for change were accepted by staff spoken with. Further to these audit findings inspectors saw a revised draft policy dated October 2017, on the management of residents' private property and finances. Inspectors saw guidelines outlining clarification for staff on what was appropriate expenditure for residents. Inspectors were told that while queries were still arising, the guidelines were implemented in practice.

Inspectors were advised by members of the multidisciplinary team that residents were now supported to have timely access to goods and services to which they had a statutory entitlement. Inspectors reviewed a small random sample of residents' records and saw that monies had been reimbursed to residents and there was no evidence of residents being charged for goods and services that they were not personally liable for.

Staff spoken with were aware of the recent audit and the broad changes required to ensure the appropriate management and safeguarding of residents' personal monies and property. A key recommendation of the commissioned report was to
* carry out audits of new procedures

* provide training for staff and
* further investigate where necessary, some of the expenses that were reimbursed.
However, inspectors found that there was still some confusion amongst frontline staff as to what residents could and could not be charged for; for example, in relation to therapeutic activities and personal toiletries. Some staff spoken with said that they had not seen the guidelines developed to support financial practice though inspectors were advised at verbal feedback that all contracted staff had received a copy of them. While there was evidence to support financial oversight in each house, and no evidence to indicate ongoing inappropriate practice, an formal campus-wide audit of the implementation of the revised financial procedures and practice had not been completed. The further investigation of expenses had not taken place up to the time of this inspection.

Internal audits completed in March and June 2017 had identified deficits in staff knowledge of safeguarding procedures and that the safeguarding training provided to staff had not encompassed the most recent safeguarding policy and procedures that the provider was obliged to implement. Inspectors were advised that training was being delivered to address this deficit. However, records seen indicated that while all staff had received safeguarding training only six staff had had refresher training to date in 2017.

Training records indicated that there were gaps in both baseline and refresher training for staff in de-escalation and intervention techniques. Eight staff had no recorded attendance and 18 staff were overdue refresher training.

Staff also received training on multi-element behaviour support planning. Training records seen indicated that approximately 50% of staff had received such training. Inspectors were advised that this training was provided once only as part of the induction programme. However, an internal audit in March 2017 had allocated a moderate non-compliance for the failure to ensure that all staff had completed this training.

Staff spoke with had a good understanding of residents and their needs including behaviours of concerns. Staff said that they and residents received good support from behaviour support personnel. Staff had a good understanding of behaviour management guidelines such as potential triggers and therapeutic interventions to implement so as to prevent escalation. For example, staff described how they would offer a resident a diversion such as a walk or a chat and a cup of tea or sufficient occupation so as to avoid boredom. Staff also described how they had recently successfully supported a resident to have a dental examination and how the dentist had supported the staff, the resident and the therapeutic plan.

Procedures for the oversight and review of restrictive practices did not ensure practice was implemented in line with agreed protocols or that resident rights were protected in the use of restrictive procedures. Inspectors saw a clear protocol for staff supported by photographic guidance for one such procedure identified as restrictive. There was an associated risk assessment dated as reviewed in August and no change was identified as required to the control measures in place. However, a procedure observed by inspectors was not as outlined in the explicit protocol.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were 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.

Since the previous inspection a greater emphasis was placed on accessing, where possible, community support services. This included community dietetic services, occupational therapy aids for residents and orthotics. Requests for specialised equipment were discussed at local Health Services Executive level and responded to according to priority.

Nutritional risk assessments, pressure risk assessments and pain risk assessments were seen to be used as residents' care needs dictated. It was also acknowledged within the service that as residents got older, their health care needs had increased. This in turn impacted on the level of care required and the staffing levels needed to meet these increasing care needs.

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 seen by inspectors being 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 and coffee shops.

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 provided detail as to how best manage special conditions, such as epilepsy. Residents with epilepsy were reviewed by their neurologist in the local acute hospital.

End-of-life care was well managed in the centre. The centre had the required skills to care for people as they approached this stage of their lives. Since the last inspection, the centre benefited by having full time pastoral care support and spiritual care support. Staff reported this to be of immense benefit to both residents and staff. Residents confirmed to the inspectors their involvement with spiritual and religious services and indicated this involvement was important to them.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
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. Consultation with frontline staff took place around the implementation of the new medication management system. This was an action that had been addressed since the previous inspection.

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. Medication audits took place on a regular basis and the incidents of medication errors was low.

Judgment:
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:
The residential service had made strides to govern in a manner that supported the active participation of people living in the service. To augment this active participation, families had been facilitated to meet with the management team on a monthly basis to discuss issues of concern for them and work together to enhance the quality of life for those residing in this service.

The management arrangements were in the process of being restructured. Responsibility for the day-to-day running of each house was being devolved to nurse managers working in the individual houses. It was generally accepted that this was, and would continue to be, a positive development. Such arrangements, once embedded, were likely to be appropriate to the size, ethos, and purpose and function of the service. However, it was unclear at the time of inspection, if these new arrangements were going to necessitate a review of the roles and responsibilities of other layers of management. Given the deficits noted in frontline staffing (Outcome 17), the need to manage prudently the staff resources available was a priority. This was to ensure residents enjoyed the best quality of life possible.

The service demonstrated an understanding of the levels of need within the service by the findings of its own six monthly unannounced inspections. However, these findings had limited impact on informing the planning and allocation of resources. For example, as discussed under Outcome 5, many residents had deficits in achieving their goals for a meaningful day. Inspectors concluded the resources available were either inadequate and/or ineffectively deployed to ensure the provision of a desired level of effective person-centred care and support.

The processes for reviewing the quality and safety of the care, support and services provided to residents included audits of residents' personal plans and audits of medicines management practices. A review had been conducted of each of the four houses in the centre. These reviews were completed in March and June 2017. Inspectors reviewed the reports that issued from these reviews and formed the view that the provider continued to identify failings in areas, including residents' personal goals and objectives, the suitability of resident placements to meet these personal goals, the inadequacy of staffing numbers and skill mix to meet the needs of the residents in terms of promoting independence, activity and social engagement. These reviews

informed the "quality enhancement plan". Work was ongoing in carrying out the actions identified in the quality enhancement plan. At the time of this inspection 28 actions were stated to be complete and 72 actions in progress.

Staff spoken with said that regular team meetings were held and that there was an identified person responsible for escalating, with senior management, matters raised at these. Staff also described the centralised system used by senior management to share information with staff. Inspectors reviewed some of these records and saw that issues such as training, health and safety and policy developments were shared with staff. However, inspectors found lack of clarity around complaints management (Outcome1), risk management (Outcome 7), financial processes (Outcome 8) and the precise work location of the night supervisor. These suggest further improvements are required in how matters are communicated.

Judgment:
Non Compliant - Moderate

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:
Overall, since the previous inspection (January 2017), the level of community based activities had increased. This was due to increased emphasis placed by staff on engaging residents with their community. However, staff enthusiasm for an enhanced social model of care further identified the deficits there were in the system, such as insufficient staff numbers and lack of staff skill mix to adequately assist residents to fulfil their social roles. Staff confirmed to inspectors that staffing levels impacted on how much time they had to engage in meaningful activities with residents.

A review of staffing also highlighted the need for a solution to the situation whereby, some residents could only go on community outings in the company of nursing staff. Given that there were significant challenges in recruiting nurses and that many residents were at a low risk of needing specialised nursing care whilst out in the community, the skill mix of staff warranted a review as to how this staffing challenge could be resolved.

The number of staff employed increased since the previous inspection; however, some of this increase was negated by staff leave. Notwithstanding the increase in staff numbers in 2017, inspectors concluded there continued to be insufficient staff with the required skills, qualifications and experience to meet the assessed needs of residents at all times. The impact of this was the deficits noted elsewhere in this report around residents not achieving their goals for a meaningful day.

There was a staff rota. It was displayed in the centre. The inspectors saw that residents received assistance, interventions and care in a respectful, timely and safe manner. The dependency on agency staff had reduced since previous inspections resulting in staff becoming more familiar with residents and vice versa. This was of positive benefit to residents.

Education and training updates were provided. Staff mandatory training was generally up to date. Some gaps were noted in behavioural support training, as discussed under Outcome 8. Staff were scheduled for this training.

Staff had a good awareness of the regulations and standards. A copy of the regulations and standards were available in the centre.

Staff were supervised appropriate to their role. There were effective recruitment procedures in place. A small representative sample of staff files was requested and reviewed by inspectors. The sample was found to be well presented and each file reviewed contained all of the required information including full employment history, references and Garda Siochana vetting.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Margaret O'Regan
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[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:	13, 14 & 15 November 2017
Date of response:	22 January 2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Each resident did not have adequate privacy and dignity due to the shared bedroom room arrangements.

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:
•One resident is currently transitioning to a single room in one unit resulting in all residents in both locations having single rooms. Proposed Timescale - 28th January 2018

•Numbers in the units above are restricted to maintain single occupancy rooms. Completed

The unit in the main building is closed to admissions and resident numbers have reduced to 9.

•Residents from this location are prioritised for transfer in the event of a single occupancy placement becoming available.

•The parents and relatives group, in consultation with the registered provider, have completed feasibility Drawings with a view to providing single room occupancy for residents in shared dormitories. Completed

•The parents and relatives group, in consultation with the registered provider, are currently pursuing funding options in relation to the above works. 30/03/2018

•The registered provider, in consultation with the parents and relatives group, will review progressing this project pending the outcome of funding application 30/09/2018

Proposed Timescale: 30/09/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were shortcomings in the effectiveness of the complaints procedure.
* One documented complaint was not recorded on the electronic complaints log where the all such complaints were meant to be recorded.
* There was lack of clarity as to who was the complaints officer.
* There was no recorded follow up to a documented complaint.
* The approach to verbal complaints was to invite the complainant to put the matter in writing. This impeded the accessibility of the complaints process.

2. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
•The documented complaint referred to in this report has been inputted to the Complaints Log.
Completed

•The CNM2 Managers will provide clarity to frontline staff in relation to the Complaints Officer through Team Meetings which will be evidenced through minutes of meetings (Complaints Policy).
28/02/2018

•An updated Complaints Poster will be distributed to each location within the Designated Centre and all older posters withdrawn from locations.
30/01/2018

•PIC will complete an Audit of all Complaints in the Designated Centre.
30/03/2018

•The PIC will discuss complaints as a standard agenda item in meetings with managers in each location to ensure all complaints are logged.
28/02/2018

Proposed Timescale: 30/03/2018

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were inadequate arrangements in place to meet the assessed needs of each resident.

3. 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:
•The PIC, in consultation with the CNM2 management, will review and quantify the number of residents whose activities are restricted due to requiring nursing support outside of the Designated Centre.
•Each resident identified will be assessed through risk assessment process to ensure the requirement of a nursing staff is based on a valid degree of risk and is not a restriction on the resident's right.
•Each resident's Epilepsy Plan and Risk Management Plan will be updated to reflect the skill-mix required to support activities.

Proposed Timescale: 30/06/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' personal plans were not reviewed annually.

4. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
•PIC and Unit Heads will phase introduction of quarterly review of personal goals for each resident within the Designated Centre.
•Project Manager, in consultation with PIC and CNM2 managers, will support with staff training in the review process.
•A schedule of review dates will be planned for each resident within the Designated Centre.

Proposed Timescale: 31/12/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessment of the health, personal and social care needs of each resident was not carried out at least annually.

5. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
•All staff are being supported by the Project Manager and the CNM2 to review and update all residents Personal Plans.

• The PIC, in conjunction with the CNM2's, has put a schedule of Personal Outcomes meetings in place in the DC for the current year in consultation with residents and their families.

•The PIC will monitor that these POMs meetings are taking place in line with the Schedule and ensure residents plans are reviewed annually.

Proposed Timescale: 31/07/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre was not suitable for the purposes of meeting the assessed needs of each resident. For example, residents in shared bedrooms had different sleeping patterns.

6. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
•One resident identified by the PIC and manager as having his sleep pattern disturbed due to the sleeping pattern of another resident in a shared room is currently transitioning to single room.
28/01/2018

•The Registered Provider is currently in consultation with the Parents Representative Group to identify and progress options in relation to accommodation within the Designated Centre (ref Outcome 1, Action 1 in this plan).

Proposed Timescale: 30/09/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The reviews of each personal plan did not adequately assess the effectiveness of the plan.

7. 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:
•The PIC will implement a monitoring report from each CNM2 manager to monitor the status of each residents plan within the Designated Centre.

•The PIC, through the CNM2 managers and Keyworkers, will review each resident's goals to ensure they are reflective and appropriate to each resident's needs.

•Quarterly reviews of each resident's goals to be phased in across the Designated Centre in 2018.

Proposed Timescale: 31/10/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The design and lay out of the premises did not meet the aims and objectives of the service in terms of providing privacy and appropriate bedroom space for the number and needs of residents.

8. 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:
•The Registered Provider is currently in consultation with the Parents Representative Group to identify and progress options in relation to accommodation within the Designated Centre.
(ref Outcome 1, Action 1 in this plan).

Proposed Timescale: 30/09/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
All risk management practice did not provide assurance that it promoted and protected resident safety. For example, there was one identified risk of residents falling due to uneven ground at the rear of a house. The control of the risk required the repair of the surface and was stated to be funding dependent. When asked why residents could not access the vehicle at the front of the house to reduce the risk of falling, staff said that they were not allowed to park the vehicle to the front as it may obstruct an ambulance.

9. 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 Risk Management Policy was updated on the 8th January 2018 to include the risk to residents due to uneven surface.
Completed

•Parking arrangements at the front of the house have been amended to allow parking.
Completed

•A quote has been obtained by Maintenance staff to level the uneven surface at the back of the house- work to be completed by the 28th February 2018.

Proposed Timescale: 28/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Risk assessments were not in place in relation to a medicines related practice. This practice related to the unavailability to residents, of a prescribed emergency medicine while in the community.

10. 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:
•Future planning for Staff recruitment in place to maintain staffing levels/skill mix.

•Review of staff complement/skill mix to support residents' risk assessed and identified as not requiring nursing support in order to engage in community based activity outside the Designated Centre.

•An agreed protocol to be put in place to ensure residents can access their emergency medication by suitably qualified staff in line with the Organisations Policy.

Proposed Timescale: 30/06/2018

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:
Internal audits in March 2017 identified deficits in staff knowledge of safeguarding procedures. Inspectors were advised that training was being delivered to address this deficit. However, records seen indicated that while all staff had received safeguarding training only six staff had refresher training to date in 2017.

11. 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:
•The guidelines agreed in consultation with the HSE in relation to residents' finances have been distributed to all staff electronically.
Completed

•Financial Guidelines to be clarified with staff through Team Meetings by the CNM2

•All staff are currently completing the Childrens `First Training on line through HSE LAND.

•A schedule of training dates has been put in place for 2018 by the Social Worker in connection with the HSE Safeguarding Vulnerable Persons at Risk of Abuse Policy.

•Behaviour Support Specialist is providing MEBs training to staff in the Designated Centre.

•The training log will be updated to monitor and track attendance levels of training by the PIC and CNM2 managers on a quarterly basis.

Proposed Timescale: 31/12/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A procedure observed was not as outlined in the agreed protocol.

12. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
•The Registered Provider completed a review of the procedure and the implementation of same as referenced in the body of this report.
Completed

•The PIC met with all staff to re-educate them in relation to the implementation of the residents' protocol which was signed and dated by all staff in the relevant area.

•The PIC has carried out observations to ensure that the aforementioned Protocol is adhered to by staff.

Proposed Timescale: 22/11/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management systems in place did not adequately ensure that the service provided was appropriate to residents' needs.

13. 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:
•Registered Provider completed a business case in 2017 relating to the CNM2 management structure.

•The Registered Provider is currently engaged with an Industrial Relations process to negotiate changes to the CNM2 structure within the Designated Centre.

•The Registered Provider will progress these negotiations in 2018 pending the outcome of negotiations and will implement changes to the governance structure to enhance the Leadership, Governance and Management process.

Proposed Timescale: 30/08/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There continued to be insufficient staff with the required skills, qualifications and experience to meet the assessed needs of residents at all times. The impact of this was the deficits noted around residents not achieving their goals for a meaningful day.

14. 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:
•Future planning for Staff recruitment in place to maintain staffing levels/skill mix in advance of vacancies arising e.g. Retirements, Maternity Leaves.

•Review of staff complement/skill mix to support residents' risks assessed and identified as not requiring nursing support in order to engage in community based activity outside the designated centre.

•The PIC and CNM2 Managers to review use of staff across the Designated Centre as opposed to each unit individually seeking to increase community activity. The aim is to ensure that available staff and skill-mix are utilised to enhance the quality of life for each resident.
Proposed Timescale: 30/05/2018