

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002905
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Claire O'Dwyer
Lead inspector:	John Greaney
Support inspector(s):	Breeda Desmond; Liam Strahan; Mairead Harrington; Margaret O'Regan
Type of inspection	Announced
Number of residents on the date of inspection:	42
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 December 2015 09:45	07 December 2015 19:00
08 December 2015 09:00	08 December 2015 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the second inspection of the centre by the Health Information and Quality Authority (the Authority). The previous inspection was completed on 11 March 2014. This was a registration inspection, it was announced and took place over two days. As part of the inspection, inspectors visited the centre and met with residents and staff members. Inspectors observed practices and reviewed documentation such as personal plans, medical records and accident and incident records.

The centre comprised eight units on the grounds of a large campus in a rural area of Co. Kerry. There were extensive grounds that were well maintained with expansive

views of the surrounding scenery. On the days of this inspection the centre was home to 42 residents with three additional beds for the purpose of respite that were used on an alternating basis by six residents. One unit accommodated eight residents, two units accommodated seven residents, three units accommodated six residents, one unit accommodated four residents and one unit accommodated one resident. There were four twin bedrooms and all of the others were single.

Overall, inspectors were satisfied that care was provided to a good standard and identified a number of areas of good practice. A number of questionnaires were sent to relatives on behalf of the Authority in advance of this inspection and seven completed questionnaires were returned. Overall the feedback from the questionnaires was complimentary of the care provided and the only suggested improvements related to insufficient numbers of staff and a request for continuity of staff, so that residents were familiar with them.

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 and for the most part, residents were supported to achieve the goals set out in the plans. Some improvements, however, were required, particularly in relation to access to activities. Many of the residents had severe to profound disabilities and required significant support to participate in activities, both within the centre and in particular within the community. However, access to these activities was limited and many residents spent considerable time within the centre and had limited access to activities in the community. Inspectors were satisfied that, in part, this was due to inadequate numbers of staff.

Improvements were also required in relation to fire safety. A fire safety survey had identified a number of required improvements on issues such compartmentalisation, fire resistant door sets, emergency lighting, fire detection system, and smoke seals on doors. A fire safety risk assessment had been carried out following an inspection of another centre on the same campus that identified the mitigation of risks by staff training, regular fire drills including deep sleep drills and the availability of an additional staff member at night. The risk assessment also identified the works to be completed on a priority basis. The schedule of works was planned to commence in early 2016 with a proposed completion time of six weeks. Reassurance was provided to the Authority from a suitably qualified person that the timeframe of the works schedule was acceptable.

Other required improvements included:

- care plans for health related issues
- policies
- staffing
- sluicing facilities located in bathrooms
- consultation with residents/relatives
- access to advocacy
- contract of care

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):

No actions were required from the previous inspection.

Findings:

There was a national policy and procedure for the management of complaints. There was also a local policy identifying the process for managing complaints within the centre. The policy identified the person responsible for managing complaints, however, it did not accurately identify the appeals process or who was responsible for ensuring that all complaints were responded to and that appropriate records were maintained. There was a notice on display identifying the complaints process in easy read format. Inspectors reviewed the complaints log and were satisfied that all complaints were fully investigated and adequate records were maintained, including whether or not the complainant was satisfied with the outcome of the complaint.

Residents were consulted through meetings with key workers when developing personal plans, which also served as a forum for consulting with relatives. Plans were in place for consulting with residents/relatives through a relatives' forum, however, this had not yet commenced. The contact details of an independent advocate were on display, however, the advocate was responsible for a large geographical area and was not readily accessible or known to residents.

Inspectors observed staff interacting with residents in a kind and respectful manner. It was apparent that residents were relaxed and comfortable in the presence of staff. Residents' privacy was respected and inspectors observed staff knock before entering bedrooms. There were a small number of twin bedrooms and portable screens were available in these rooms to support the provision of privacy during the provision of personal care. There was adequate space available for residents to meet with visitors in private, should they wish.

Many of the residents had severe to profound disabilities and were dependant on staff to support them attend activities and outings to the community. There was evidence that activities were identified based on individual assessments. Available activities included swimming, gymnasium, bowling, storytelling, walks on the grounds, trips in the car, shopping, massage and other holistic therapies. However, access to these activities was limited and was led by routine and the availability of staff rather than the needs or wishes of the residents. Staff confirmed to inspectors that residents had limited access to activities external to the centre.

There was a policy on residents' personal property and finances. Based on a sample of residents' financial records viewed by inspectors, adequate records were maintained with two staff signatures recorded for all transactions and receipts were available.

There were adequate storage facilities for residents' property and possessions, including lockable storage for valuables.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

There was a policy on communicating with residents. A large number of residents had significant communication needs and many were non-verbal. There were also a small number of residents with a visual impairment. There was a communication profile recorded in each resident's personal plan that was comprehensive and identified the most appropriate means of communicating with each resident. Inspectors observed staff members interacting with residents and it was obvious that they were aware of the different communication needs of each resident. There was evidence of the use of assistive technologies such as mobile phones and electronic tablets with communication applications. Communication boards were available in each unit containing pictures to identify for residents the proposed activities for the day. "Objects of reference" were also used to communicate with residents when no other form of communication was effective. This involved placing objects in the resident's hands to communicate a planned activity, such as using a spoon to denote that it was mealtime or a sponge to denote bath/shower. A number of residents communicated through sign language and a number of staff had undergone training in Lamh, which is Irish sign language..

Judgment: Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were no restrictions on visitors. Families were consulted when developing personal plans and residents were supported to maintain links with their families, where relevant.

As already discussed under Outcome 1, residents were supported to maintain links with the community, however, this was not always possible due to insufficient staff.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There was an admissions policy dated July 2014. Inspectors were informed that the centre was currently closed to admissions and residents were transferred internally from the unit in the main building to other units when vacancies arose.

Each resident had a signed written agreement of the terms of which they reside in the centre. While the contract outlined the services to be provided, the contract outlined a range of fees to be paid that was based on the resident's income, it did not specify the

exact fee each resident paid. Additionally, the contract did not list any fees to be paid for additional services. Inspectors were informed that a new contract was in the process of being drafted to meet the requirements of the regulations.

Judgment:

Substantially Compliant

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:

Each resident had a comprehensive assessment of their personal and social care and support needs. Based on these assessments, each resident had a personal plan developed by their keyworker in consultation with the residents and/or their relatives. The plans were person-centred and clearly set out individual needs and choices of the residents.

There was evidence of the involvement of members of the multi-disciplinary team such as nursing, healthcare/social care workers, psychology, psychiatry, physiotherapy and occupational therapy in the development of the plans. There were regular reviews of the plans for effectiveness, however, personal plans were not always available to residents in an accessible format.

While some plans identified who was responsible for supporting the resident to achieve the goals identified, others did not. Due to the degree of disability of most residents identified goals predominantly related to participation in various activities. Many of the goals identified in the plans were achieved, however, some were not. This was mainly due to insufficient numbers of staff being available to support residents achieve these goals. For example, the personal plan of one resident stated that they liked social outings, however, records indicated that they were only on one social outing in the month of November. This action has been addressed under Outcome 1.

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:

This was a designated centre for adults with a disability. The centre comprised eight units on the grounds of a large campus in a rural area of Co. Kerry. There were extensive grounds that were well maintained with expansive views of the surrounding scenery. On the days of this inspection the centre was home to 42 residents. The centre also provided a respite service for six service users on an alternating basis with no more than three respite service users being accommodated at any one time. Overall the units were bright, clean, suitably decorated and kept in a good state of repair.

The first unit was home to five residents and also provided a respite service for two service users on an alternating basis so that there were no more than six residents accommodated in the unit at any one time. This unit was located in an older building that also contained a unit from another designated centre, the main kitchen and a number of administrative offices. The unit had been recently painted and was bright and clean throughout. Bedroom accommodation in this unit comprised six single bedrooms, although one of the bedrooms contained two beds, each of which was reserved for individual respite service users. The bedrooms were personalised with resident's personal belongings and possessions and had adequate storage and wardrobe space. Communal space comprised a large sitting room, a dining room and an activities room. There was access to enclosed outdoor space through a door from the sitting room. Sanitary facilities comprised two bathrooms, each with a standard bath and assisted shower. There were five toilet cubicles. At the previous inspection in March 2014 there was no partition between the toilet and bath/shower facilities, however, a partition had recently been installed to support residents' privacy and dignity.

The second unit accommodated six residents in six single bedrooms. Although the bedrooms were relatively small they were adequate in size for the residents living in the centre on the days of the inspection. Communal space in this unit comprised a large dining room, a spacious sitting room and a second smaller sitting room. Sanitary facilities comprised two bathrooms, one of which an assisted shower and wash-hand basin and the other contained an assisted bath and wash-hand basin.

The third, fourth and fifth units were similar in design and layout and each unit contained six bedrooms, however, one of the units had two twin bedrooms whereas the other two units had one twin bedroom each. There were portable screens in the twin

bedrooms to support the privacy and dignity of the residents sharing these rooms. These residents had shared the bedrooms for many years and based on discussions with staff and a review of residents records, the residents were happy to continue sharing these rooms. It would, however, be inappropriate to continue using these rooms as shared bedrooms for any new residents. Communal space in these units comprised a large combined sitting/dining room and one of the units had an additional communal room in the form of a conservatory. Given that two of these units accommodated seven residents and the other accommodated eight residents, many of whom spent most of the day within the units, inspectors were not satisfied that there was sufficient communal space to meet the needs of the residents. A small number of residents could at times become quite verbal and there was not always alternative communal space available for other residents to have some quiet time other than in their bedrooms.

The sixth unit accommodated four residents in four single rooms. There was a spacious dining room, a sitting room and an activity room. Sanitary facilities comprised two bathrooms, one of which had a bath and the other had a shower. There were also two toilets for use by residents.

The seventh unit accommodated five residents and one respite service user in six single bedrooms and was adjoined to the sixth unit. Communal space comprised a dining room, a sitting room and an activity room. Sanitary facilities comprised of two bathrooms, one of which contained a shower and the other contained a bath. There were three toilets.

The eighth unit was a single bedroom apartment that accommodated one resident. This was originally part of the seventh unit but was partitioned and converted to an apartment to meet the needs of the resident living there. The apartment consisted of a bedroom, living room, a kitchen and a shower/toilet area.

While the centre was clean and bright, some improvements were required. For example, in some areas the bathrooms also housed sluicing facilities and housekeeping equipment and inspectors were not satisfied that these areas were in compliance with standards for the prevention and control of healthcare associated infections. The location of sluicing facilities in a bathroom can pose a risk of cross contamination. This action is addressed under Outcome 7. As already stated, many of the residents exhibited varying degrees of behaviour that challenges, which frequently presented as shouting. At times the units could become noisy, which in turn impacted negatively on the behaviour of other residents. A contributing factor to this behaviour was the number of residents living in the units together with limited communal space and limited access to activities outside of the units. Additionally, residents in one unit could not access their bedrooms as the doors were locked in order to protect their personal possessions from the behaviour of another resident living in the unit. While electronic locking mechanisms were installed, many of the residents were unable to use these due to the nature of their disability. This action was addressed under Outcome 1.

A number of beds were old and did not appear to be comfortable, however, prior to the end of the inspection the provider/person in charge had arranged for a survey of beds and a number were identified for replacement. Records were available demonstrating the preventive maintenance of equipment such as hoists and beds.

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 risk management policy addressed the items specified in the regulations. However, a small number of risks were identified by inspectors, which included access to a kettle with hot water and access to fluid thickener by residents without an adequate risk assessment to identify if this was safe.

There was an incident management policy and a serious incident management policy. Inspectors reviewed a sample of incident records and found that each incident was reviewed and issues that could minimise the risk of recurrence were identified. Data from the incident log were submitted to a national database for collation. A safety committee had recently been established and minutes of these meetings were available. The process whereby accident and incident data would be audited locally to identify trends, where relevant, for the purpose of learning, feedback to staff and to minimise the risk of reoccurrence had commenced.

Records were available to demonstrate that vehicles used to transport residents were maintained and roadworthy.

As already stated under Outcome 6, some improvements were required in relation to infection prevention and control practices, which included the storage of housekeeping equipment in bathrooms and sluicing facilities being located in bathrooms. This is not in compliance with standards for the prevention and control of healthcare associated infections.

Records were available to demonstrate that fire safety equipment was serviced annually and the fire alarm system was serviced quarterly. Records indicated there were daily checks of the fire alarm panel and to verify that escape routes were free from obstruction.

A fire safety survey had been carried out in February 2014 on a number of designated

centres that were under the auspices of this provider resulting in a significant number of recommendations for improvements. Some of the works had been completed in another designated centre on the same campus, however, most of the recommended improvements for this centre had not been carried out. The required improvements included:

- the installation of automated fire door closers
- the replacement of glazing
- the fitting of fire resistant door sets
- the fitting of smoke seals on doors
- the removal of storage from evacuation corridors
- the sub-compartmentalisation of units for evacuation purposes
- the upgrading of the fire alarm/fire detection system
- the upgrade of emergency lighting
- the installation of fire breaks in attics

Following an inspection by the Authority of the other designated centre on this campus in October 2015, the provider was requested to carry out a risk assessment of fire safety across the campus to identify what measures were required to mitigate fire safety risks. The risk assessment identified the works to be completed on a priority basis, and in response to this a schedule of works was developed to commence in January 2016 and to be completed over a six week period. In the interim, to mitigate the risks identified, an additional staff member was rostered on night duty to support the evacuation of residents in the event of a fire. Records indicated that there were regular fire drills, including deep sleep drills. While records indicated that evacuation in some fire drills took up to 14 minutes, the fire safety officer indicated that this was because at times he quizzed staff during the evacuation which added time to the evacuation process.

All residents had a personal evacuation plans identifying how they were likely to respond in the event of a fire and the optimal mode of evacuation. Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire and were able to describe the evacuation procedure in the area in which they worked. Training records indicated that all staff had received 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):

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

Findings:

Based on the observations of inspectors, staff were courteous and kind to residents and residents appeared to be comfortable and relaxed in the presence of staff.

There was a policy and procedure in place for the prevention and response to abuse, however, it was a national policy and did not reference most recent national guidance. There was a local procedure that had recently been developed which referenced the most recent guidance, however, it remained a work in progress and did not describe in detail the process for responding to allegations of abuse. There was a policy in place for the provision of personal intimate care to residents, however, it was dated 2009. Based on records viewed by inspectors, most staff had received up-to-date training on abuse but training was scheduled for the only member of staff without up-to-date training. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of an allegation of abuse.

The provider and person in charge stated that they monitored systems in place to protect residents by interacting with staff, relatives and residents on a regular basis. There have been no reported allegations of abuse.

There were adequate systems in place for the management of residents' finances and appropriate records were maintained.

There was a policy in place for the provision of behavioural support. Records indicated that training on positive behavioural support, in the form of multi-element behavioural support (MEBS) training, was ongoing, however, a significant number of staff had not yet attended this training. Training records indicated that a small number of staff required training in the management of aggression and violence, however, they were scheduled to attend this training in the week following this inspection.

Based on a review of a sample of residents' records, efforts were made to identify and alleviate the underlying causes of behaviours that challenge. Each resident had a comprehensive assessment under the heading of MEBS and there were care plans identifying antecedents to this behaviour and measures were identified to alleviate the behaviour. Referrals were made to a positive behavioural support committee that was composed of multidisciplinary team members. Records were maintained of any incidents of behaviour that challenges and scatter plots were used to chart improvements or otherwise in behaviour. Records indicated the use of chemical restraint in the form of the administration of PRN (as required) medication. There was a protocol in place for the use of chemical restraint and efforts were made to minimise its use. Records also indicated that resident were periodically restrained by staff when their behaviour escalated to a level where it posed a risk to other residents, however, staff were trained in this technique and records indicated that it was used for the shortest time possible.

Judgment:

Substantially Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

No actions were required from the previous inspection.

Findings:

A record of incidents occurring in the centre was maintained. Based on records reviewed inspectors were satisfied that Authority was notified of incidents in accordance with regulations.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

As already stated in this report, many of the residents had a severe to profound disability. As discussed elsewhere in this report, access to activities and in particular activities external to the centre were limited due to inadequate resources, for example staffing. This action is addressed under Outcome 1.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents had access to the services of a general practitioner (GP) who visited the centre once each week and when required. 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, dietetics, occupational therapy, physiotherapy, psychology, psychiatry and dental. There was evidence of referral and review to these services. For example, where one resident presented with an episode of choking, records indicated that this resident was reviewed by a speech and language therapist and resulting recommendations were addressed. However, one record viewed indicated that a resident had been referred for a physiotherapist assessment but records indicated that this had not happened. An explanation for why the resident was not reviewed was not available.

Residents received comprehensive health assessments under the activities of daily living model. Based on a sample of records viewed by inspectors, residents were assessed using evidence-based assessment tools for issues such as assessing the risk of malnutrition and the risk of falling. Where health related issues were identified, care plans were developed to guide care provision for most, but not all, issues. For example, there was a care plan in place for a resident with epilepsy and for a resident with respiratory illness, however, there was no care plan in place for a resident that had oedema of the lower extremities. This action is addressed under Outcome 5.

Residents' food was prepared in a central kitchen and delivered to the units in insulated food containers. Lunch was usually delivered at 12:00hrs, however, residents were facilitated to eat at a time of their choosing. Residents were offered a choice of food at mealtimes and food was provided in the consistency recommended by speech and language therapy, where relevant. Residents requiring assistance at mealtimes were assisted by staff 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.

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):

No actions were required from the previous inspection.

Findings:

There were written operational policies and procedures in relation to medication management. There was a national policy which was supported by a local policy identifying the procedure for medication management within the centre. Medications were stored appropriately and there were records to indicate that the stock of medication was checked weekly.

A sample of prescription and administration records were reviewed and the sample viewed contained appropriate information. Where PRN (as required) medications were administered there was a record of the monitoring of the effectiveness of the medication. There was a PRN protocol for residents that were in receipt of PRN medications. Other areas of good practice included a guide for each resident identifying how best to support the resident to take their medications, such as what drinks to give to help them swallow their medications.

There was a comprehensive audit of medication management completed in October 2015 and there was evidence that where improvements were required, these were implemented.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The statement of purpose set out a statement of the aims and objectives of the service and contained all the items required by the regulations.

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):

No actions were required from the previous inspection.

Findings:

There was a clearly defined management structure that identified the lines of authority and accountability. The person in charge was a clinical nurse manager 3 (CNM 3) who reported to the programme manager, who in turn reported to the provider nominee, who was a general manager. The provider nominee reported to a regional director, who in turn reported to the chief executive officer (CEO). The person in charge was supported by three CNM 2s. Staffing in each of the units comprised a combination of nurses and social care/healthcare workers or social care/healthcare workers only.

There was a programme of audits that included a medication audit, an infection prevention and control audit, an audit of financial records and unannounced visits carried out on behalf of the provider nominee. There was a Quality Enhancement Plan (QEP), which was developed at the beginning of each year and was based on the results of the various audits, inspections and unannounced visits. This plan identified who was responsible for carrying out the required actions and also identified progress against each of the actions. There was an annual review of the quality and safety of care and support needs, which was in development and was also informed by audits, unannounced visits by the provider, inspections by the Authority, monitoring visits from the HSE, and feedback from residents and their representatives at annual review meetings. The first annual review was scheduled to be published in early 2016. The process for consultation with residents/relatives could also be enhanced through a proposed relatives' forum. This action was addressed under Outcome1. A draft report of the annual review was made available to inspectors.

The person in charge worked full-time and had the required qualifications and experience. She demonstrated adequate knowledge of legislation and her statutory responsibilities. There was evidence that she was involved in the day-to-day governance and operational management of the centre.

Judgment:

Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated

<i>centre during his/her absence.</i>
<p>Theme: Leadership, Governance and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There was no period when the person in charge was absent for a period that required notification to the Authority. There were adequate arrangements in place for when the person in charge is absent from the centre.</p>
<p>Judgment: Compliant</p>

<p>Outcome 16: Use of Resources <i>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</i></p>
<p>Theme: Use of Resources</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The findings of this inspection indicated that adequate resources were not at all times available to support residents achieve their individual personal plans. For example, the personal plan of one resident identified that she had limited access to activities in the community even though her assessment indicated that she "loved outings in the community". Additionally the goal for another resident was to go on holiday, however, this had not been achieved. These actions are addressed under Outcome 1.</p>
<p>Judgment: Compliant</p>

<p>Outcome 17: Workforce <i>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.</i></p>
<p>Theme:</p>

Responsive Workforce

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

The action(s) required from the previous inspection were 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. This is supported by the limited access to activities by residents outside of the centre and the number of residents that spent long periods each day within the various units.

Training records indicated that there was a comprehensive programme of training available to staff that included manual handling, fire safety, safeguarding, multi-element behavioural support training, defensive driving, first aid, medication administration, risk assessments, and infection prevention and control. Based on a review of training records provided to inspectors all staff had up-to-date training in fire safety. There was one member of staff that required training in safeguarding vulnerable adults. There were two staff that required training in manual handling but this had been scheduled for the weeks following this inspection.

A sample of personnel records reviewed indicated that all of the requirements of Schedule 2 of the regulations were satisfied.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

A review of documentation within the centre found that records were kept in the designated centre in respect of each resident, as required by Schedule 4 and 4 of the

Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013.

Inspectors reviewed policies and procedures and found that most were centre-specific and up-to-date. However, the policy on the provision of personal intimate care was dated 2009 and there was no evidence that it had been reviewed since then. Most national policies were supported by a suite of local policies that were centre-specific and up-to-date.

Judgment:

Substantially Compliant

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002905
Date of Inspection:	07 December 2015
Date of response:	25 January 2016

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:

Plans were in place for consulting with residents/relatives through a relative's forum, however, this had not yet commenced.

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 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

In order to encourage resident and family participation/consultation in the organisation of the designated centre, a schedule of quarterly resident and family forums has been devised, the first of which will take place in March 2016.

Proposed Timescale: 30/03/2016

Theme: Individualised Supports and Care

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

The contact details of an independent advocate were on display, however, the advocate was responsible for a large geographical area and was not readily accessible or known to residents.

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:

Families and resident representatives have been advised of:-

- Details of the national advocacy Service
- The confidential recipient within the HSE
- Local complaints policy and procedure.

Completed

Each resident has a keyworker in place and this allocation has been updated in December 2015 to ensure each resident has an appropriate keyworker to advocate on the residents behalf

Completed

St John of God community service is consulting with the National Advocacy Service (NAS), in order to progress advocacy services involvement within the designated centre. A follow up meeting is scheduled with the service in the first quarter of the year to further explore options.

The services of an external advocate are available to residents within the designated centre currently.

Proposed Timescale: 30/06/2016

Theme: Individualised Supports and Care

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

While electronic locking mechanisms were installed, many of the residents were unable to use these due to the nature of their disability.

3. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

An alternative 'fob' system is to be installed. The system has been researched with input from the Senior Occupational Therapist and Senior Clinical psychologist, in order to provide a user friendly system based upon resident abilities.

Procurement and installation expected completion date of June 2016

Proposed Timescale: 15/06/2016

Theme: Individualised Supports and Care

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

Access to activities was limited and was led by routine and the availability of staff rather than the needs or wishes of the residents.

4. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

The registered provider has secured additional resources through consultation with the HSE in relation to the designated centre. This will support the ongoing management of risk and the support activities within the designated centre

Recruitment of additional posts to the designated centre is currently being complete

Proposed timescale : 30/03/2016

The Person in Charge in consultation with each unit manager will review the allocation times of new staff within the roster to ensure posts are not routinely assigned within the current rostering system and these posts are targeted at reducing risk and supporting residents choice and activities

Proposed timescale:31/03/2016

The Registered Provider has introduced a new Volunteer drive aimed at introducing additional supports to individuals attending activities and outings in the community.

Proposed timescale: 30/06/2016

Proposed Timescale: 30/06/2016

Theme: Individualised Supports and Care

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

The complaints policy identified the person responsible for managing complaints, however, it did not identify who was responsible for ensuring that all complaints were responded to and that appropriate records were maintained.

5. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

The complaints poster is displayed in all areas of the designated centre and identifies the Appeals Officer with contact details and photograph.

Completed

The local Policy and Procedure for complaints has been amended to include details of the person by name who is responsible for management of appeals of complaints
Complaints data will be forwarded to the Quality and Safety Committee for analysis
Completed

The service has identified a nominated person outside of the Complaints Officers, to complete an annual audit of all complaints within the designated centre, to oversee that the Complaints Officer maintains records of complaints and responds appropriately to complaints, in accordance with the regulations stated.

Proposed Timescale: 30/04/2016

Theme: Individualised Supports and Care

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

The complaints policy identified the person responsible for managing complaints, however, it did not accurately identify the appeals process.

6. 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 Complaints policy has been amended to provide a clear and concise flowchart detailing how to make a complaint and the process to be undertaken in the event of an appeal.

Proposed Timescale: 30/03/2016

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 contract of care outlined a range of fees to be paid that was based on the residents' income, however, it did not specify the exact fee each resident paid. Additionally, the contract did not list any fees to be paid for additional services.

7. 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:

An appendix will be added to the Resident Support Agreement to detail exact fees each resident pays and will list any fees incurred for additional services.

Proposed Timescale: 30/06/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Some personal plans identified who was responsible for supporting the resident to achieve the goals, others did not.

8. 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 allocation of the resident's keyworkers has been reviewed and a named person allocated to each resident to support in the achievement of individuals goals.

Proposed Timescale: 04/02/2016

Theme: Effective Services

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

Many of the goals identified in personal plans were achieved, however, others were not.

For example, the record of one resident stated that she liked social outings, however, records indicated that she was only on one social outing in the month of November.

9. 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 registered provider has completed a business plan which has reviewed in full the current staffing roster for DC2. As a result of this review a new proposed roster is currently being negotiated with staff and their Union Officials.

The Registered provider has completed a business case to the HSE which has reviewed in full the current staffing allocation the designated centre.

As a result of the business case a review of the WTE has taken place across the Kerry Residential Services.

Completed: 13/11/2015

Recruitment has commenced in relation to posts being allocated to the residential areas in DC2.

Proposed timescale : 30/03/2016

The Registered Provider has introduced a new Volunteer drive aimed at introducing additional supports to individuals attending activities and outings in the community.

Proposed timescale: 30/06/2016

Four additional staff members have been relocated from within the Kerry Service, increasing staff levels within the designated centres.

Proposed Timescale: 21/01/2016

Theme: Effective Services

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

Personal plans were not always available to residents in an accessible format.

10. Action Required:

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

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

Utilizing the information available from the resident communication assessment, the resident will be supported to access their personal plan by their keyworker focusing on the Residents Priority Goals. Information will be summarised in the format relevant to

the individual and form the basis of planning meetings.

Each resident will be afforded the opportunity to ensure their family or representative can attend their planning meetings.

Proposed Timescale: 30/05/2016

Theme: Effective Services

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

There was not always a care plan in place for all issues identified on assessment.

11. Action Required:

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

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

Care plans have been completed for all areas of resident support as identified within the body of the report.

Proposed Timescale: 04/02/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Inspectors were not satisfied that the premises were designed and laid out to meet the aims and objectives of the service and the number and needs of residents, due to:

- the number of residents with complex behavioural needs in each of the units
- the inadequate communal space for the number of residents living in the units
- the extended period of time that residents spent in each unit due to inadequate access to activities external to the centre
- some residents did not have access to their bedrooms with the assistance of staff.

12. 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:

St John of God Kerry Services is part of a Joint Task Group with the HSE to progress the de-congregation of Residents within St Mary of The Angels. The service is currently progressing phase 1 of the de-congregation plan for the campus which primary focus is

on the older building on campus.

The registered provider has put the following measures in place:

The designated centre is currently closed to admissions, as vacancies arise the service prioritises the transfer of residents from multi-occupancy rooms to single occupancy rooms.

Completed

A review of staffing levels has been completed to increase the number of frontline staff in each residential area in the designated centre - see Action 9.

Plan for residents to have more independent access to their bedrooms - Reference Action 2

Proposed Timescale: 15/06/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

A small number of risks were identified which included access to a kettle with hot water and access to fluid thickener by residents without an adequate risk assessment to identify if this was safe.

13. Action Required:

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

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

Risk assessment has been completed on areas detailed above in relation to access to the kettle with hot water and fluid thickeners

Completed

A Risk forum has been established which includes Multi- disciplinary team members, Residential programme manager, person in charge and unit staff for the assessment and management of ongoing review of risk within the designated centre.

Completed

A Local protocol for responding to emergencies is in place within the designated centre

Completed

Proposed Timescale: 04/02/2016

Theme: Effective Services

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

In some areas the bathrooms also housed sluicing facilities and housekeeping equipment and inspectors were not satisfied that these areas were in compliance with standards for the prevention and control of healthcare associated infections.

14. 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:

Following consultation with household supervisor alternative storage of cleaning materials and equipment has been sourced to comply with the prevention and control of healthcare associated infections.

Completed

A review of the bathrooms areas which also house sluicing facilities has been complete in consultation with the infection control Nurse from the HSE.

The review identified the appropriate re-modelling required to the sluicing areas to ensure compliance with the standards for the prevention and control of healthcare associated infections published by the Authority.

Completed

The Registered provider has received Indicative quotations for the completion of works.
Completed

An application for funding of works is currently being prepared for submission to the HSE for approval of capital expenditure.

28/02/2016

A Planned schedule of works will be developed based on the outcome of the application to the HSE.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

A fire safety survey had been carried out in February 2014 on a number of designated centres that were under the auspices of this provider resulting in a significant number of recommendations for improvements. Some of the works had been completed in another designated centre on the same campus, however, most of the recommended improvements for this centre had not been carried out. The required improvements included:

- the installation of automated fire door closers
- the replacement of glazing

- the fitting of fire resistant door sets
- the fitting of smoke seals on doors
- the removal of storage from evacuation corridors
- the sub-compartmentalisation of units for evacuation purposes
- the upgrading of the fire alarm/fire detection system
- the upgrade of emergency lighting
- the installation of fire breaks in attics

15. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

A separate comprehensive action plan in relation to a schedule of planned works to address fire safety issues as listed above has been submitted to the regulator in November 2015

- Tendering process for above works currently being complete and contractor to be appointed by end of January 2016.
Proposed Timescale: 28/02/2016
- Revised start date is May 9th 2016 and works estimated to be completed across the designated centre by end of July 2016.

Proposed Timescale: 31/07/2016

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:

Records indicated that training on positive behavioural support, in the form of multi-element behavioural support (MEBS) training, was ongoing, however, a significant number of staff had not yet attended this training.

16. 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:

Multi Element Behavioural support training is on-going across the designated centre, training is now incorporated within the training schedule for 2016.

Completed

Positive Behaviour Support clinics have commenced on a monthly basis in order to support staff with the implementation of behaviour support plans.

Completed

CPI/MAPA training including refresher is included on the annual training schedule to

educate staff in methods of safe intervention and de-escalation of behaviours that challenge.

Completed

Staff identified within the body of report requiring training in management of aggression and violence have now completed this training

Completed

Staff currently outstanding for multi-element behaviour support training will be facilitated to complete this training within the designated centre

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

Based on records viewed by inspectors, most staff had received up-to-date training on abuse but training was scheduled for the only member of staff without up-to-date training.

17. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

All staff have completed training in the safeguarding of residents and the prevention, detection and response to abuse.

Proposed Timescale: 04/02/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

One record viewed indicated that a resident had been referred for a physiotherapist assessment but evidence was not available demonstrating that this had been done.

18. 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:

All referrals to Allied Health professionals have been reviewed and are now complete

with corresponding documentation to support process.

Proposed Timescale: 04/02/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

The findings of this inspection indicated that adequate resources were not at all times available to support residents achieve their individual personal plans.

19. Action Required:

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

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

The Registered provider has engaged with the Health service Executive in relation to securing adequate resources to support residents within the Congregated setting in St Mary of The angels incorporating designated Centre 2.

The Registered provider has completed a business case to the HSE which has reviewed in full the current staffing allocation the designated centre.

As a result of the business case a review of the WTE has taken place across the Kerry Residential Services.

Completed: 13/11/2015

Recruitment has commenced in relation to posts being allocated to the residential areas in DC2.

Proposed timescale : 30/03/2016

The Registered Provider has introduced a new Volunteer drive aimed at introducing additional supports to individuals attending activities and outings in the community.

Proposed timescale: 30/06/2016

Four additional staff members have been relocated from within the Kerry Service, increasing staff levels within the designated centres.

Proposed Timescale: 30/06/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

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. This is supported by the limited access to activities by residents outside of the centre and the number of residents that spent long periods each day within the various units.

20. 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 registered provider has engaged with the Health Service Executive in relation to securing additional resources to support Residents within the designated centre.

Reference: Action 9

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

There were two staff that required training in manual handling but this had been scheduled for the weeks following this inspection.

21. Action Required:

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

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

The staff members reflected in the inspection report have now completed manual handling training.

Manual handling training, including refresher courses, are incorporated into the service's training schedule for 2016.

An up to date log of completed training is available in the designated centre.

Proposed Timescale: 04/02/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

There was a policy and procedure in place for the prevention and response to abuse, however, it was a national policy and did not reference most recent national guidance. There was a local procedure that had recently been developed which referenced the most recent guidance, however, it remained a work in process and did not describe in detail the process for responding to allegations of abuse.

22. Action Required:

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

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

The organisations policy and procedure for the Prevention and Response to Abuse has been reviewed to include reference to updated national guidance.

The Local policy and procedure will be reviewed to describe in detail the process for responding to allegations of abuse in line with National guidelines.

Proposed Timescale: 30/06/2016

Theme: Use of Information

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

The policy on personal intimate care was dated 2009.

23. Action Required:

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

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

The national policy on Personal and intimate care is currently under review by St John of God Services. A draft of this policy has been circulated to allow the consultation process to take place across the organisation prior to final document being developed.

Proposed Timescale: 30/11/2016