

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | A designated centre for people with disabilities operated by St John of God Community Services Limited |
| Centre ID: | OSV-0003630 |
| 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; Vincent Kearns; Liam Strahan |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 33 |
| 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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

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|-----------------------|-----------------------|
| From: | To: |
| 06 October 2015 09:45 | 06 October 2015 18:30 |
| 07 October 2015 08:30 | 07 October 2015 18:30 |

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

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

Summary of findings from this inspection

This was the first inspection of the centre by the Health Information and Quality Authority (the Authority). 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, visitors and staff members. Inspectors observed practices and reviewed documentation such as personal plans, medical records and accident and incident records.

The centre comprised four 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 33 residents. Three of the units accommodated 22 residents in two 8-bedded units and one 6-bedded unit comprising 20 single bedrooms and one twin bedroom. The fourth unit accommodated 11 residents in one 4-bedded room, two 3-bedded rooms and one single bedroom.

Overall, inspectors identified a number of areas of good practice. Staff members were seen to interact with residents in a kind and caring manner and residents appeared to be comfortable in their presence. Personal plans were person-centred and for the most part, residents were supported to achieve the goals set out in the plans. Some improvements, however, were required, most notably in the unit that was home to 11 residents in three multi-occupancy rooms and one single bedroom. This unit was not suited for its stated purpose due to multi-occupancy bedrooms with inadequate screening between beds that did not support the privacy and dignity of residents. This unit also had significant deficits in relation to fire safety due to an inadequate fire detection system, inadequate emergency lighting and inadequate compartmentalization. A fire safety survey completed in 2014 had recommended a number of improvements in this unit, however, on the days of inspection this work had not been completed. Many of the residents in this unit had high physical and psychological needs and records of fire evacuation drills indicated that residents required significant assistance to evacuate, particularly at night time. An immediate action plan was issued on the first day of the inspection in relation to fire safety. In response to the action plan an additional staff member was rostered on duty at night while awaiting the outcome of a fire safety risk assessment.

Inspectors were not satisfied that there were adequate numbers of staff on duty at all times to meet the needs of residents. For example, access to activities/day services had been curtailed for some residents due to the withdrawal of personal assistants and there were insufficient staff available in the centre to provide the same level of support on an individual basis. In addition, there were inadequate numbers of staff on night duty, taking into account the significant physical and psychological needs of the residents living there.

Additional required improvements included:

- access to allied health/specialist services such as dietetics
- assessment of nutritional status
- contracts of care
- risk management
- staff training

The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

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

Findings:

There was a policy and procedure for the management of complaints. The policy was a national policy, however, and did not identify, by name, the person responsible for managing complaints, the independent appeals process or who was responsible for ensuring that all complaints were adequately addressed. The complaints procedure was on public display, was written in an accessible format and included a photograph of the complaints officer. However, the procedure outlined in the notice was also generic and did not include the contact details of the complaints officer or identify the appeals process. Inspectors reviewed the complaints log that contained four complaints and were satisfied that complaints were fully investigated and adequate records were maintained.

Plans were in place for consulting with residents/relatives through a relative's 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 to residents.

Inspectors observed staff interacting with resident's in a respectful manner. It was apparent that residents were relaxed and comfortable in the presence of staff. Residents' privacy was respected insofar as the premises would allow and inspectors observed staff knock before entering bedrooms. However, bedroom accommodation in one of the units was primarily in three and five-bedded multi-occupancy rooms with inadequate screening to support residents' privacy and dignity. Communal accommodation in this unit comprised two large sitting rooms for eleven residents with significant psychological and physical needs. At times it became quite noisy in these

rooms through residents shouting which had a negative impact on other residents within the unit. There was inadequate space in this unit for residents to meet with visitors in private or to spend some time alone, where appropriate. In another unit there was a twin bedroom that also had inadequate screening to support residents' privacy. These issues are further discussed under Outcome 6, Premises.

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 tailored to the needs of residents identified on assessment. A range of activities were available based on individual needs and preferences. For example, residents had access to massage, a swimming pool, bowling, story telling, walks on the grounds and other holistic therapies. Some residents attended day services either on the grounds of the centres or in local towns. However, participation in these activities were dependent on the availability of staff and there was not always sufficient staff available. For example, at least one resident that had previously attended a day service was no longer able to attend following the withdrawal of funding for a personal assistant. Additionally, some residents' access to day services were restricted due to lack of capacity within the day service. These actions are addressed under Outcome 17, Workforce.

There was a policy on residents' personal property and finances. Where the provider was responsible for residents' monies there were adequate records maintained demonstrating that the money was used appropriately for the benefit of the resident. However, some improvements were required. For example, while each resident had an account for the purpose of managing money, it was not in the name of the resident to which the money belonged. Residents' finances will be further discussed under Outcome 8, Safeguarding and Safety.

Most bedrooms had suitable storage facilities for residents' property and possessions, however, in one of the units there was inadequate wardrobe space for residents clothing.

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):

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

Findings:

There was a policy on communicating with residents. Many of the residents had

significant communication needs and were non-verbal and some had 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 and there was evidence of good practice. For example, there was evidence of the use of "objects of reference" where objects were 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 armbands to denote swimming, a spoon to denote that it was mealtime or a sponge to denote bath/shower.

Judgment:

Compliant

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

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

Theme:

Individualised Supports and Care

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

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

Findings:

There were no restrictions on visitors. Families were consulted when developing personal plans and in advance of any changes, such as transferring to another unit. Residents were supported to maintain links with their families. For example, one resident was supported to remain in contact with her family through Skype as they lived a considerable distance from the centre.

Residents were able to meet with visitors in private in some units, however, due to the limitations of the premises, this was not always the case. 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:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

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. There was evidence of consultation with a resident and relatives prior to internal transfer from one unit to another, however, there was no evidence of consultation with residents already living in the unit to which the resident was transferred, to determine if they were agreeable to a new resident coming to live with them. This action is addressed under Outcome 1.

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 residents' 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.

Judgment:

Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

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 key worker 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 and how these goals would be met. 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. Some

improvements, however, were required as all plans were not always available to residents in an accessible format.

For the most part, personal plans were implemented, however, as discussed elsewhere in this report, the achievement of some goals was hindered by insufficient staff numbers. In addition, due to the significant needs of some residents, particularly those residing in the unit in the main building, inspectors were not satisfied that the designated centre was suitable for the purposes of meeting the assessed needs of each resident. This was supported by the findings that there were inadequate numbers of staff and the limited access to activities outside of the centre.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

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

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

Findings:

This was a designated centre for adults with a disability. The centre comprised four 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 33 residents.

The first unit was home to eight residents. Sleeping accommodation in this unit comprised eight single bedrooms. While all of the bedrooms were adequate in size to meet the needs of the residents living there on the days of the inspection, the provider was requested to monitor the changing needs of two residents in particular, in relation to their bedroom accommodation. Should the dependency levels of these residents increase, their bedrooms may be insufficient in size, for example to manoeuvre assistive equipment such as hoists and large specialised chairs. Communal space in this unit comprised a large sitting room that was minimally furnished with a 3-seater couch, an armchair and a ball-pool that provided a safe environment for one resident to play. There was a large dining room with two dining tables and a kitchen. Sanitary facilities comprised two bathrooms, one with an assisted shower and one with a bath. There were four toilets for use by residents and one staff toilet. There was a sluicing area in one of the bathrooms that contained a sluice sink but was also used to store equipment. Inspectors were not satisfied that the sluicing area was suitable for its stated purpose and posed a risk of cross contamination and infection.

The second unit adjoined the first unit and had its own separate entrance but was also accessible through a door from the first unit. This unit was also home to eight residents. Sleeping accommodation in this unit comprised six single bedrooms and one twin bedroom. All of the single bedrooms were adequate in size to meet the needs of the residents living there. The twin bedroom, however, did not support the provision of privacy and dignity to residents due to inadequate screening between beds and inadequate wardrobe space for residents to store their clothing. Communal space comprised a kitchen/dining area, an activity room, a sitting room and a relaxation/multi-sensory room. Sanitary facilities comprised two bathrooms, one with a shower and assisted bath and the other with a shower. Similar to the first unit, there was a sluicing area in one of the bathrooms that was not suitable for its stated purpose. There were three toilets for use by residents. One of the toilets had a commode chair placed over the toilet bowl with a lap belt secured to the commode. Inspectors were informed that this was used to support the resident when using the toilet. Inspectors were not satisfied that this was supported by a written protocol, was risk assessed or that it complied with good infection prevention and control practice.

The third unit was located in a separate part of the campus to the first two units. It was home to six residents with sleeping accommodation in six single bedrooms and also a staff bedroom. All of the bedrooms were small in size but, based on inspectors' observations, they were suitable for the needs of the residents living there on the days on inspection. The provider was requested to keep the needs of the residents under review as a small increase in dependency level may mean that the bedrooms would not be adequate in size to meet their needs, for example, should they require the use of assistive equipment. Communal space comprised a sitting room and a sunroom/dining room. Sanitary facilities comprised a bathroom with an assisted shower and a standard bath. There were three toilets for use by residents.

The fourth unit was located in an older building that also contained a unit from another designated centre and a number of administrative offices. This was a two-storey building, however, all residents' accommodation and facilities were on the ground floor. This unit was home to 11 residents on the days on inspection. Bedroom accommodation comprised one 5-bedded room, two 3-bedded rooms and one single bedroom. The fifth bed in the five-bedded room was unoccupied due to the transfer of one resident to another unit in the weeks prior to this inspection. Once the resident had settled in the new unit it was proposed to decommission and remove the fifth bed. Inspectors were not satisfied that multi-occupancy bedrooms adequately supported the privacy and dignity of residents. Communal space comprised a large sitting room that also served as a dining room and a large activation room. There were bags of clothes, that had recently been returned from the laundry, stored on the floor of the sitting/dining room and there was also trolleys of folded clothes stored here. Inspectors were informed that the clothes would be removed from the bags and folded by night staff. Inspectors were not satisfied that this was a suitable place for storing laundry. Sanitary facilities comprised 2 spacious bathrooms, each of which contained a bath, a shower and two toilets. The bathrooms were bright, clean and had recently been redecorated. There was a sluice room in one of the bathrooms that was used to clean bedpans. The sluice room was small and did not have shelves for storing the bedpans. There were mops that were stored with the mop heads sitting in the mop buckets. Based on discussions with staff

members and the observations of inspectors, there was an inadequate protocol around the cleaning of bedpans and the storage of cleaning equipment to support good infection prevention and control practice.

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

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

There was a risk management policy, a safety statement and an emergency plan. There was a risk register in each unit that identified risks from an individual resident perspective and there were also risk assessments for individual residents. The process of risk management could be enhanced by the identification and inclusion of general risks in the risk register. Some risks were identified by inspectors during the initial walk around of the units that warranted a risk assessment to ensure that residents were not exposed to risk. These included:

- latex gloves were stored in toilets that could pose a risk of choking
- there were chords for hanging loosely from window blinds that could pose a risk of strangulation
- staff personal bags were stored unsecured and it was possible that the contents could pose a risk to residents with an intellectual disability
- there were a large amount of electrical cables in use in one resident's bedroom
- there was unsecured access to the kitchen

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. It was proposed that 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, however, this had not yet occurred.

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. These included:

- inadequate sluicing facilities and practices
- lack of storage facilities for bedpans to dry appropriately
- unsuitable storage of mops
- medicated cream was found in one bathroom that was not labelled for individual use
- shaving creams not identified for individual use

Records were available to demonstrate that fire safety equipment was serviced annually and the fire alarm system was serviced quarterly. A fire safety survey had been carried out in February 2014 resulting in a significant number of recommendations for improvements. In response to the survey, a fire safety upgrade had been completed in the first second and third units, and the provider was requested to submit evidence that these units were now in compliance with fire safety recommendations. However, significant work recommended in the survey remained outstanding in relation to fire safety for the fourth unit. These included the creation of compartments through the installation of fire resisting door sets in bedrooms, the activity room and along escape corridors. The survey also identified that the fire alarm detection system required enhancement and the emergency lighting did not meet the required standard. There were records that emergency lighting was tested, however, the certificate stated that the emergency lighting in the fourth unit could not be tested as some of it was on the same circuit as other important services and it would cause too much disruption. There were regular fire drills that included the fourth unit and another adjacent unit from another designated centre. Some of these drills were carried out at night when residents were in bed. Records indicated that evacuation of residents ranged from 14 to 20 minutes. Based on the outstanding fire safety works and the fire drill response times, an immediate action plan was issued to the provider in relation to fire safety. In response to the action plan, the provider put in place an additional staff member at night in the fourth unit, commencing on the night of the inspection. In addition a risk assessment was commissioned to identify what additional measures were to be put in place in the interim until the fire safety upgrade was completed.

Records indicated there were daily checks of the fire alarm panel and to verify that escape routes were free from obstruction. Training records indicated that most, but not all, staff had up-to-date training in fire safety.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

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 policy in place for the provision of intimate care to residents. Most, but not all, staff had received up-to-date training on abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of an allegation of abuse. 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. Residents with whom inspectors could communicate stated that they felt safe.

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. However, the provider did not have access to financial records for all residents living in the centre and it was therefore not possible for them to ascertain that all residents' finances were managed appropriately and in the best interest of the resident.

There was a policy in place for the provision of behavioural support. A significant number of staff did not have up-to-date training in behavioural support. Based on a review of a sample of residents' records, efforts were made to identify and alleviate the underlying causes of behaviour that challenge. There was evidence of the use of restrictive practice in the form of bedrails, speciality beds, splints and chemical restraint. Records indicated that efforts were being made to minimise the use of restrictive interventions and there was evidence of the involvement of the multi-disciplinary team in the development of behaviour plans. Improvements, however, were required in relation to risk assessments for the use of bedrails and identifying the level of monitoring required. While approval for the use of bedrails was given in the form of a signature from a member of the multi-disciplinary team, there was no assessment of the risks associated with the use of bedrails to determine if the use of bedrails posed a greater risk than the absence of bedrails.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where

required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
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):
This was the centre's first inspection by the Authority.

Findings:
As already stated in this report, many of the residents had a severe to profound disability. A number of residents attended day services either on the grounds of the campus or in nearby towns. However, not all residents had access to day services, either due to lack of capacity within the day service or through insufficient numbers of staff to support residents to attend.

Judgment:
Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

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

Findings:

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, occupational therapy, physiotherapy, psychology, psychiatry and dental. However, there was limited access to the services of a dietician.

Residents received comprehensive social care assessments, however, improvements were required in relation to healthcare/nursing assessments. For example, there was minimal evidence of the use of evidence-based assessment tools for issues such as assessing the risk of malnutrition or the risk of developing pressure sores. Of a small sample of personal plans reviewed, inspectors noted that two residents had lost a significant amount of weight in the previous 12 to 18 months. While one resident had been prescribed a nutritional supplement, a review of recorded weights did not indicate any increase in the resident's weight. Neither resident had been reviewed by a dietician and there was not always evidence of the use of laboratory values to assess nutritional status, even for residents that were being fed artificially.

There were care plans in place for healthcare issues identified on assessments and most were comprehensive, however, some required improvement. For example, there were comprehensive care plans in place for issues such as epilepsy, constipation, skin integrity and increased body weight. However there was not an adequate care plan in place to guide practice for a resident being fed artificially or for residents that were losing weight.

Residents' food was prepared in a central kitchen and delivered to the units 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 therapy, where relevant. Residents requiring assistance at mealtimes were assisted in a respectful and dignified manner. Residents were provided with drinks and snacks throughout the day. Some residents were supported to eat out in local restaurants occasionally.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

There were written operational policies and procedures in relation to medication management. Medications were stored appropriately and there were records to indicate that the stock of medication was checked weekly. Records indicated that where healthcare assistants administered medications they had attended appropriate training.

A sample of prescription and administration records were reviewed and most contained appropriate information. However, a small number did not contain details of the resident's GP, the route of administration or date of birth. Where PRN (as required) medications were administered there was a record of the monitoring of the effectiveness of the medication. Other areas of good practice included the development of a protocol to support the administration of medication to a resident that often refused his medication.

A review of incident records indicated that where medication errors occurred appropriate remedial action was taken. There was an audit of medication management completed in January 2014 and more recently in July 2015.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

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):

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

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 two CNM 2s. Staffing in each of the units comprised a combination of nurses and social care/healthcare workers or social care/healthcare workers only. Staffing is discussed in more detail under Outcome 18.

There was a programme of audits that included a medication audit, an infection prevention and control audit, an audit of financial records and an unannounced visit carried out on behalf of the provider nominee. There was an annual review of the quality and safety of care and support needs which was 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 programme of audits and annual review could be enhanced through the addition of other audits from high risk areas, for example, an audit of accidents and incidents. The process for consultation with residents/relatives could also be enhanced through the proposed relatives' forum. A report of the annual review was made available to inspectors, however, it was not available to residents.

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:

Substantially 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 centre during his/her absence.

Theme:

Leadership, Governance and Management

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

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

Findings:

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.

Judgment:

Compliant

Outcome 16: Use of Resources

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

Theme:

Use of Resources

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

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

Findings:

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, when funding was no longer available for some residents to have a personal assistant, there was a negative impact on the quality of life of these residents due to the inability to attend day services due to insufficient staff.

Recommended fire safety work in one of the units was not completed due to lack of resources. Inspectors also found that there was insufficient staff on duty at all times to meet the needs of residents, which impacted on residents attendance at activities. This is further discussed under Outcome 17.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

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.

Staffing in the first unit usually comprised five staff from 08:00hrs to 18:00hrs, three staff from 18:00hrs to 20:00hrs, two staff from 20:00hrs to 22:00hrs and one staff from 22:00hrs to 08:00hrs. There were eight residents living in this unit, most of whom had an epilepsy diagnosis and a small number presented with behaviours that challenge. The second unit was adjacent to the first unit, could be accessed from the first unit through an adjoining door and also had eight residents. Staffing in this unit comprised five staff from 08:00hrs to 13:00hrs, four staff until 18:00hrs, four staff until 20:00hrs, three staff until 21:00hrs, two staff until 22:00hrs, and one staff from 22:00hrs to 08:00hrs. There was also a CNM 2 that worked between these two units on a variety of shifts throughout the week, including weekends. If assistance was required at night time in one of the units the staff member from the other unit would come to assistance, thereby leaving the other unit without a staff member, however, the door between the units would be left open.

Staffing in the third unit comprised one staff from 07:00hrs to 10:00hrs, one staff from 08:00hrs to 17:00hrs, two staff from 17:00hrs to 21:00hrs, and one staff from 21:00hrs until 23:00hrs. The staff member that worked the shift from 21:00hrs to 23:00hrs remained in the unit as sleepover staff and also worked the early morning shift.

Staffing in the fourth unit comprised five staff from 08:00hrs to 18:00hrs, three staff from 18:00hrs to 22:00hrs and one staff from 22:00hrs to 08:00hrs. There were 11 residents residing in this unit, all of whom had a severe to profound disability and most also had significant physical disabilities. Inspectors were informed that should the member of staff on night duty require assistance it would be provided by the night supervisor, however, she/he was responsible for the whole campus that included another designated centre. There was also a night porter that worked on alternate weeks.

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

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

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

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 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013. Similarly most records were kept in compliance with Schedule 3 of these Regulations, however, the Directory of Residents required expansion to include the name and address of any authority, organisation or other body, which arranged the resident's admission to the centre, as required by 3 (f) of Schedule 3. Clarification was also required in relation to the status of residents that were transferred to acute care. Inspectors were informed that these residents were discharged and readmitted when care was complete, however, this was not reflected in the directory of residents.

Inspectors reviewed policies and procedures and found that not all were centre-specific and not all were up-to-date, this primarily related to national policies. Inspectors found that many were generic to the provider's wider service and some required review and up-dating. Examples of these included the policy on the provision of intimate care and the policy on the provision of behavioural support. Additionally the policy on Access to Education, Training and Development was under development at the time of the inspection.

National policies were supported by a suite of local policies that were centre-specific and up-to-date.

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:

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-0003630 |
| Date of Inspection: | 06 October 2015 |
| Date of response: | 15 December 2015 |

Requirements

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

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Residents were not always consulted in relation to with whom they shared accommodation.

1. Action Required:

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

Under Regulation 09 (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:

- Internal Transfers of residents to shared bedroom accommodation is no longer facilitated within the Designated Centre.
- All future transfers will document evidence of the consultation process undertaken with the resident and or their representative in the Residents plan
- The resident will have a documented transition plan for any proposed move to an alternative residential service
- The transition plan will involve the residents family/ representative as part of the resident`s Circle of Support
- All future transfers will have a record maintained of the consultation process undertaken with existing residents in the event of a new resident being identified to move into the residential area.
- The record of consultation will be maintained in the residents plan

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

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

The design and layout of the premises did not support residents' privacy, due to:

- multi-occupancy bedrooms with inadequate screening to support residents privacy and dignity
- there was inadequate space in one unit for residents to meet with visitors in private or to spend some time alone, where appropriate
- communal space in one unit was inadequate

2. Action Required:

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

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

The following actions are in place to progress de-congregation which will address the issues relating to multi occupancy rooms/large groups and the associated issues for residents.

A separate comprehensive action plan in relation to the planned implementation of Phase1 for St Fidelis has been submitted to the regulator in December 2015. The initial focus of this plan is to address the privacy issues arising from the multi occupancy in bedrooms.

- Multi occupancy bedrooms are no longer re- allocated to another resident in the event

of a vacancy arising

- The main building is closed to admissions and this is agreed with HSE and documented in statement of purpose and function
- Consultation and agreement with the HSE to set up National Joint Task Group to progress the de-congregation of Saint Mary of The Angels as a national pilot site - St Fidelis in DC 1 is prioritised for phase one of this plan in agreement with HSE.
- Local decongregation implementation committee is in place working with HSE, Kerry County Council and service to plan phase 1 of decongregation

Additional actions

- Complete transition assessments and plans for all residents in St Fidelis in preparation to move in phase 1 of de- congregation.

Proposed Timescale:28.02.16

- Source alternative types of screens or curtains to improve resident privacy while awaiting de- congregation.

Proposed Timescale: 31.12.15

The Service will identify additional locations within the Designated Centre to facilitate residents meet visitors in private

- Staff sitting room to be converted to a Visitors room to provide an alternative location for meetings with visitors.
- The main dining room will also be made available to facilitate visitor meetings.
- Residents can avail of the activation room located between St Fidelis and St Brendan's unit if they require time alone. This room is also available as a communal space and is now being used for this purpose.
- The Spraoi Lios an Phuca Activation room will also be available for residents and their family members to visit in private.

Proposed Timescale: 30.11.15

Proposed Timescale: 28/02/2016

Theme: Individualised Supports and Care

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

While each resident had an account for the purpose of managing money, it was not in the name of the resident to which the money belonged.

3. Action Required:

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

- A bank has been provided with all the necessary paperwork to open new accounts for

all Residents whose accounts were in the name of St John of God Kerry Services.

- New accounts will be open for Residents by the Bank

Proposed Timescale: 15/12/2015

Theme: Individualised Supports and Care

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

Most bedrooms had suitable storage facilities for residents' property and possessions, however, in one of the units there was inadequate wardrobe space for residents clothing.

4. Action Required:

Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

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

Additional storage space to be installed in the relevant bedroom

Proposed Timescale: 15/12/2015

Theme: Individualised Supports and Care

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

Some residents attended day services either on the grounds of the centres or in local towns. However, participation in these activities were dependent on the availability of staff and there was not always sufficient staff available. For example, at least one resident that had previously attended a day service was no longer able to attend following the withdrawal of funding for a personal assistant. Additionally, some residents' access to day services were restricted due to lack of capacity within the day service.

5. Action Required:

Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

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

- All residents' plans to be reviewed to define meaningful day for each resident based on their assessed needs and this information will be outlined in their plan.
- External therapist will be identified to provide additional activities based on the residents needs
- The service has a group of activity co-ordinators with representation from each residential area to plan activities within the designated centre. The PIC will meet with the activities co-ordinators to plan a schedule of events for each quarter

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

Proposed Timescale: 31/05/2016

Theme: Individualised Supports and Care

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

Many of the residents had severe to profound disabilities and were dependant on staff to support them attend activities and outings to the community and there were not always sufficient staff available.

6. 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 completed a business plan which has reviewed in full the current staffing roster for DC1. As a result of this review a new proposed roster is currently being negotiated with staff and there Union Officials.

- The Registered Provider has submitted a business case to the HSE supporting the need for additional staffing. As result of this business case a review of the WTE has taken place across the Kerry Residential Services.

Proposed Timescale: Completed 13/11/15

- Recruitment has commenced in relation to posts being allocated to residential areas
- Proposed Timescale: Completed 30/03/16

- The Registered Provider has introduced a new Volunteer drive which is currently introducing additional supports to individuals attending activities and outings in the community.

Proposed Timescale: Completed 30/06/16

- Existing interns within the Kerry services will be relocated to the campus as part of increasing staffing levels with the Centre

Proposed Timescale: Completed 30/01/16

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 was a national policy and did not identify, by name, the person

responsible for managing complaints.

7. Action Required:

Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

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

- The Complaints Poster has been up-dated with Complaint Officers details and contact numbers listed on the poster
- The Complaints Poster is displayed in all areas of DC1

Proposed Timescale: Completed

- The local Policy and Procedure for Complaints will detail the person by name who is responsible for managing complaints
- The local procedure will identify a named individual not involved in the matters subject of a complaint is nominated to deal with complaints by or on behalf of residents.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

The complaints policy did not adequately identify the independent appeals process.

8. 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 Service has identified the nominated person outside of the Complaints Officer available to residents in the event of appeal
- The nominated person for appeals relating to complaints is available in an accessible format and displayed in all areas of DC1 with the persons contact details

Proposed Timescale: completed 31/10/15

- The Local Complaints Policy and Procedure will be amended to include the name of the Complaints Appeals Officer

Proposed Timescale: 31/12/15

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

The complaints policy did not identify who was responsible for ensuring that all complaints were adequately addressed.

9. 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:

- Complaints data will be forwarded to the Quality and Safety Committee for analysis
- An annual audit of Complaints will take place across the Kerry Services incorporating DC1 by the local service to oversee that the Complaints Officer maintains a record of complaints in accordance with regulation 34 (2) F and responds appropriately to complaints

Proposed Timescale: 28/02/2016

Theme: Individualised Supports and Care

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

The complaints procedure was on public display, was written in an accessible format and included a photograph of the complaints officer. However, the procedure outlined was generic and did not include the contact details of the complaints officer or identify the appeals process.

10. Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

- The public display of the Complaints procedure has been updated to include the contact details of the Complaints Officers
- The public display of the Complaints Procedure has been updated to include the contact details of the Complaints Appeals Officer
- This information is displayed in each area in the DC1

Proposed Timescale: 31/10/2015

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 to residents.

11. Action Required:

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

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

External advocacy services are currently provided through the National Advocacy Service. Saint John of God Services has been working with the local advocate from the national advocacy service to progress the advocacy services involvement within Saint Mary of the Angels Campus.

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

Each family/ Residents representative will be re-advised of the

- Local Complaints Policy and Procedure
- Details of the national advocacy Service
- The Confidential Recipient within the HSE

Proposed Timescale: 31/01/16

- The Service will request a meeting with the National Advocacy Service to explore the options of extending the Service for the residents in DC1 and identify potential models of advocacy that could be developed within the Service.

Proposed Timescale: 31/05/16

Proposed Timescale: 31/05/2016

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

Theme: Individualised Supports and Care

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

There were not adequate facilities for all residents to receive visitors in private.

12. Action Required:

Under Regulation 11 (3) (a) you are required to: Provide suitable communal facilities for each resident to receive visitors.

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

Additional Locations identified within the Designated Centre to facilitate residents to meet visitors in private. Actions identified in Outcome 1, No. 2 action required

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

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

Due to insufficient staff numbers residents access to the community was at times limited.

13. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

- The Registered Provider has submitted a business case to the HSE supporting the need for additional staffing. As result of this business case a review of the WTE has taken place across the Kerry Residential Services.

Proposed Timescale: Completed 13/11/15

- Recruitment has commenced in relation to posts being allocated to residential areas

Proposed Timescale: Completed 30/03/16

- The Registered Provider has introduced a new Volunteer drive which is currently introducing additional supports to individuals attending activities and outings in the community.

Proposed Timescale: Completed 30/06/16

- Existing interns within the Kerry services will be relocated to the campus as part of increasing staffing levels with the Centre

Proposed Timescale: Completed 30/01/16

Proposed Timescale: 30/06/2016

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:

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 outline a range of fees to be paid that was based on the residents' 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.

14. 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 to be attached to the Support Agreement to specify the exact fee each resident paid, and will list any fees to be paid for additional services.

Proposed Timescale: 31/01/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

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

15. 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:

- Each resident has had a comprehensive assessment completed.
- Elements of the plan are communicated by objects of reference / photos in accordance with resident`s communication skills
- A communication passport is in place for each resident. The resident is supported to access this information with support from his/her family member, Keyworker and unit staff.
- A summary of three main priority goals will be completed in accessible format to support residents understanding of same. The format used will be documented in the individuals plan and as part of planning meetings

Proposed Timescale: 30/03/2016

Theme: Effective Services

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

Due to the significant needs of some residents, particularly those residing in the unit in the main building, inspectors were not satisfied that the designated centre was suitable for the purposes of meeting the assessed needs of each resident. This is supported by the findings that there were inadequate numbers of staff and the limited access to activities outside of the centre.

16. 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:

Consultation and agreement with the HSE to set up National Joint Task Group to progress the de-congregation of Saint Mary of The Angels as a national pilot site - St Fidelis in DC 1 is prioritised for phase one of this plan in agreement with HSE.

The Registered Provider has submitted a separate costed plan with timescales to the Regulator in Dec 2015 in relation to recruitment.

- The Registered Provider has submitted a business case to the HSE supporting the need for additional staffing. As result of this business case a review of the WTE has taken place across the Kerry Residential Services.

Proposed Timescale: Completed 13/11/15

- Recruitment has commenced in relation to posts being allocated to residential areas

Proposed Timescale: Completed 30/03/16

- The Registered Provider has introduced a new Volunteer drive which is currently introducing additional supports to individuals attending activities and outings in the community.

Proposed Timescale: Completed 30/06/16

- Existing interns within the Kerry services will be relocated to the campus as part of increasing staffing levels with the Centre

Proposed Timescale: Completed 30/01/16

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

There was minimal evidence of the use of evidence-based assessment tools for health related issues such as assessing the risk of malnutrition or the risk of developing pressure sores.

17. 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:

- Malnutrition Universal Screening Tool (MUST) has been completed for all residents in DC1 to determine resident`s risk of malnutrition

Proposed Timescale: Completed : 31/10/15

- Health goals are identified in each resident`s plan based on the individual resident`s

MUST assessment where required
Proposed Timescale: Completed: 31/10/15

- A system is in place and documented in the residents plan for those who require monitoring of fluid and diet intake based on their individual MUST assessment

Proposed Timescale: Completed: 31/10/15

- Waterlow Assessments have been undertaken in all areas of DC1
- The Waterlow assessment verified no mattress change required for any resident at this time
- The Waterlow assessment will form part of the annual assessment review

Proposed Timescale: Completed: 31/10/15

Proposed Timescale: 31/10/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Parts of the premises were unsuitable due to:

- multi-occupancy bedrooms
- inadequate sluicing facilities
- inadequate storage

18. 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:

Actions to Date

- As space becomes available the service prioritises the transfer of residents from multi occupancy rooms to single occupancy rooms if appropriate.
- Resident numbers in St fidelis have reduced to 11 in the last month
- Transition plans are being completed for all residents in St Fidelis unit as part of the services de-congregation plan. St Fidelis is prioritised to in phase 1 of de-congregation process.
- HSE have agreed to prioritise the de-congregation of St Mary of the Angels, and the residential units in the main building have been included in Phase 1 of this plan.

Additional Actions

- Meeting held with HSE Infection Control Nurse on the 14/10/15 re sluicing facilities to identify alternative arrangements to be put in place.
- Infection Control nurse is due to submit a report to the Person in Charge with

recommendations on how to revamp current facilities within the designated Centre

- An implementation plan with time lines will be put in place within the service based on the Infection Control nurses report

Proposed Timescale:31/01/ 2016

- Additional storage facilities is being arranged in all areas where this was highlighted as a concern within the report

Proposed Timescale:31/12/15

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Parts of the centre required redecoration due to damaged and chipped paintwork on walls and doors.

19. Action Required:

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

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

Quarterly maintenance programme will address areas highlighted as requiring redecoration due to damaged and chipped paintwork on walls and doors.

Proposed Timescale: 28/02/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Some risks were identified by inspectors during the initial walk around of the units that warranted a risk assessment to ensure that residents were not exposed to risk. These included:

- latex gloves were stored in toilets that could pose a risk of choking
- there were chords for hanging loosely from window blinds that could pose a risk of strangulation
- staff personal bags were stored unsecured and it was possible that the contents could pose a risk to residents with an intellectual disability
- there were a large amount of electrical cables in use in one resident's bedroom
- there was unsecured access to the kitchen
- there was a lap belt secured to a commode chair in one toilet that was not supported by a written protocol

20. 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 for latex gloves has been completed across the Designated Centre.
Proposed Timescale: Completed 12/11/15

- Corrective action has been taken to secure chords hanging loosely from blinds,

Proposed Timescale: Completed 10/10/15

- Additional lockers will be provided for all staff to store their belongings securely. The PIC will ensure all staff will be advised of same by their local supervisor .

Proposed Timescale: 30/11/15

- A new socket was put in place to make electrical cables safer

Proposed Time Scale: completed 13/10/15

- OT review completed of the commode Protocol has been completed for the lap strap on the commode

Proposed Timescale: Completed 23/10/15

The service has a risk management policy and risk assessment process in place. The service will further develop this system to include

- An environmental risk assessment process to be developed based on each residential location and residents

- A template will be sourced in consultation with Occupational Health and Safety to carry out the environmental assessments

- An environmental risk assessment will be completed in each area of DC1

- All resulting risks will be logged on the register

Proposed Timescale: 30/4/16

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

The risk register could be enhanced by the inclusion of general risks throughout the centre.

21. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated

centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

- The risk Register will be expanded to include General risks as identified from environmental risk assessments
- The Risk register to be expanded to include current assessments with ratings of Yellow.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

There was an inadequate system in place for auditing and learning from incidents.

22. 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:

- Incidents data will be forwarded to the Quality and Safety Committee for analysis and Trends
- Incidents are reviewed within unit at staff Team meetings and handover same will be documented in meeting minutes
- A bi-monthly report will be generated for each location and distributed to the manager illustrating the nature of adverse incidents reported
- Incidents will be reviewed at unit manager/person in charge meetings to identify actions to reduce re-occurrence

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

Some improvements were required in relation to infection prevention and control practices. These included:

- inadequate sluicing facilities and practices
- a lap belt was secured to a commode chair in one toilet
- unsuitable storage of mops
- medicated cream was found in one bathroom that was not labelled for individual use
- shaving creams not identified for individual use

23. 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:

Sluicing facilities and infection control actions identified in action 17 of action plan.

OT review completed of the commode, the Following actions complete

- o Vertical & horizontal rails removed
- o Commode removed – new seating in place over toilet
- o Protocol in place in relation to use of lap strap
- o Small sink removed

Proposed Timescale: Completed 23/10/15

- Storage and supply of mops reviewed with Household Supervisor and appropriate storage in place

Proposed Timescale: Completed : 23/10/15

- All creams to be individually marked for residents and verified to the PIC that this system is in place by unit manager

Proposed Timescale: Completed : 15/12/15

Proposed Timescale: 15/12/2015

Theme: Effective Services

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

Results of a fire safety survey indicated there was inadequate fire detection system.

24. Action Required:

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

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

A separate comprehensive action plan in relation to a schedule of planned works to address fire safety issues including fire detection systems has been submitted to the regulator in November 2015. These works are planned to commence in January 2016 following procurement process and will take 6 weeks to complete

Fire Detection works are due to commence on January 26th 2016

Proposed Timescale: 15/03/2016

Theme: Effective Services

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

Results of a fire safety survey indicated there was inadequate emergency lighting.

25. Action Required:

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

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

A separate comprehensive action plan in relation to a schedule of planned works to address fire safety issues including Emergency Lighting systems has been submitted to the regulator in November 2015. These works are planned to commence in January 2016 following procurement process and will take 6 weeks to complete
Fire Detection works are due to commence on January 26th 2016

Proposed Timescale: 15/03/2016

Theme: Effective Services

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

Not all members of staff had up-to-date fire safety training.

26. Action Required:

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

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

In the absence of statutory requirement that dictates the frequency of fire safety training within Designated centres the service had the following arrangements in place to ensure all staff in the Designated centre had appropriate training in place

- All staff are required to complete Fire safety training every 2 years.
- On that basis all staff in DC1 had completed the relevant training on the date of the inspection.
- Fire Drills are in place to ensure staff and residents are familiar with evacuation procedures
- Daily Fire register in place in each residential area

Following Registration visit

- The service have now commenced a programme to refresh the fire safety training in DC1 for all our staff on an annual basis to reflect recommendation in this report.
- Our Health and Safety Officer has signed up for a FETAC approved Training Delivery Course, which will mean we will have a trainer on site to provide fire safety training.
- All Staff will have completed refresher training within DC1 as part of revised schedule

Proposed Timescale: 31/10/2015

Theme: Effective Services

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

Significant works identified from a fire safety survey were outstanding on the days of inspection.

27. 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 has been submitted to the regulator in November 2015. The works are planned to commence in January 2016 following procurement process, and will take 6 weeks to complete

Proposed Timescale: 15/03/2016

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:

A significant number of staff require training in behaviour that challenging.

28. 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:

- Positive Behaviour Support clinics are being run for staff on monthly basis from 14.00-16.30 to mentor staff in the implementation of behaviour support plan within the Designated Centre
- Behaviour support Training will form part of the annual training calendar within the service

Proposed Timescale: 13/01/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

There were inadequate risk assessments and monitoring record where bedrails were in use.

29. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

All existing Bedrails have been prescribed by the Senior Physiotherapist. The process relating to this will be enhance as follows:

- Bedrails to be included in planned postural supports record in each residents plan
 - Monitoring sheet for the use of bed-rails to be put in place for each resident
- Proposed Timescale :30/11/15
- Risk Assessment to be completed for each resident prescribed bedrails with in-put from the Physiotherapist as part of the prescribing process

Proposed Timescale: 28/2/16

Proposed Timescale: 28/02/2016

Theme: Safe Services

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

The provider did not have access to financial records for all residents living in the centre and it was therefore not possible for them to ascertain that all residents' finances were managed appropriately and in the best interest of the resident.

30. Action Required:

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

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

- The individual Residents who don't have an account have been identified by the Service.
- The registered provider will arrange for contact is be made with the parents/guardians who currently control the relevant bank account for Residents in the Designated.
- Each individual parent/guardian will be advised of the regulation and the need for the account to be in the name of the resident and managed through the Designated Centre.
- The service will provide Support to parents/Guardians to facilitate this process.

Proposed Timescale: 30/03/2016

Theme: Safe Services

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

Not all staff had up-to-date training in the prevention and response to abuse.

31. 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:

- Having reviewed our training records for DC1 in relation to Prevention and Response to Abuse all staff are currently up-date with their training. The 5 staff queried on the days of the Inspection - 3 had their up-date training, 1 is on a career break and the remaining staff member is not attached to DC1.
- An accurate training log will be available in the Designated Centre for the PIC and the Regulator
- The PIC will review the training log on a quarterly basis to ensure all staff are in date and any new staffs are scheduled for training immediately prior to commencement of employment.

Proposed Timescale: 30/01/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Not all residents had access to day services, either due to lack of capacity within the day service or through insufficient numbers of staff to support residents to attend.

32. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

- All residents' plans to be reviewed to define meaningful day for each resident based on their assessed needs and this information will be outlined in their plan.
- External therapist will be identified to provide additional activities based on the residents' needs
- The service has a group of activity co-ordinators with representation from each residential area to plan activities within the designated centre. The PIC will meet with the activities co-ordinators to plan a schedule of events for each quarter
- The Registered Provider has introduced a new Volunteer drive which is aimed at introducing additional supports to individuals attending activities and outings in the community

Proposed Timescale: 31/05/2016

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:

Residents were not always reviewed by a dietician when clinically indicated.

33. Action Required:

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

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

- The service has identified private access to a dietician as an interim measure for residents identified as requiring review .Meeting held with Private Dietician on the 22/10/15
- Recommendations from Dietician have been implemented based on Dietician review on 5/11/15 for both residents highlighted in report.
- GP is forwarding a request to HSE for Dietician Services through generic Services
- The Service will inform HSE that residents from St Mary of the Angels will require access to Dietician Services through the HSE by referral through GP
- The Service will plan in conjunction with the HSE as part of local service planning meeting the progression of access to Dietician services for residents through the executive

Proposed Timescale: 30/03/2016

Theme: Health and Development

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

Care plans were not always in place for issues identified on assessment, such as nutrition for residents losing weight.

34. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

- Malnutrition Universal Screening Tool (MUST) has been completed for all residents in DC1 to determine resident`s risk of malnutrition

Proposed Timescale: Completed :31/10/15

- Health goals are identified in each resident`s plan based on the individual resident`s MUST assessment where required

Proposed Timescale: Completed: 31/10/15

- Monthly weights charts are in place for Residents

Proposed Timescale: Completed 31/10/15

- Residents Care Plans have been updated as required to reflect issues identified in the assessment

Proposed Timescale: Completed: 31/10/15

Proposed Timescale: 31/10/2015

Theme: Health and Development

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

Not all residents that had lost weight had been reviewed by a dietician and there was not always evidence of the use of laboratory values to assess nutritional status, even for residents that were being fed artificially.

35. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

- The service has identified private access to a dietician as an interim measure for residents identified as requiring review .Meeting held with Private Dietician on the 22/10/15
- Resident with PEG feed was reviewed by the Dietician on the 22/10/15. Next review will be in January 2016
- Monthly weights are in place for Residents
- Laboratory Values complete for resident on PEG Feed through GP 21/10/15

Proposed Timescale: 22/10/2015

Outcome 12. Medication Management

Theme: Health and Development

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

A small number of prescriptions did not contain details of the resident's GP, the route of administration or date of birth.

36. Action Required:

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

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

- Corrective action has been completed on the Kardex identified in the report
- A Re-check has been completed on all Kardex in DC1 to ensure all essential information is present
Proposed Timescale: Completed 31/10/15
- An medication management audit will form part of the annual audit schedule for DC1 which will incorporate a review of Kardex to support compliance

Proposed Timescale: 30/08/16

Proposed Timescale: 31/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The annual review of quality and safety of care and supports was not made available to residents.

37. Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

- An annual review of safety and quality support provided by the DC will be completed.
- A Policy and Procedure will be developed to reflect the annual review process.
- An agreed format of the Annual Review will be identified and populated.
- The information from the annual review will be circulated to residents and family.

Proposed Timescale: 30/07/2016

Theme: Leadership, Governance and Management

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

The annual review could be enhanced to include high risk areas relative to safety.

38. 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:

The programme of audits will incorporate an audit of incidents and accidents within the Designated centre to be included in the annual review

Proposed Timescale: 30/07/2016

Theme: Leadership, Governance and Management

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

The annual review did not adequately incorporate the consultation of residents/relatives.

39. Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

- The service will provide residents/families with an opportunity to contribute to the annual review process
- The annual review will be available to residents and their representatives

Proposed Timescale: 30/07/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was inadequate resources as evidenced by:

- inadequate staff numbers
- the outstanding fire safety work.

40. 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:

A separate comprehensive action plan in relation to the staffing for DC1 has been

submitted to the regulator in December 2015.

- The Registered Provider has submitted a business case to the HSE supporting the need for additional staffing. As result of this business case a review of the WTE has taken place across the Kerry Residential Services.

Proposed Timescale: Completed 13/11/15

- Recruitment has commenced in relation to posts being allocated to residential areas

Proposed Timescale: Completed 30/03/16

- The Registered Provider has introduced a new Volunteer drive which is currently introducing additional supports to individuals attending activities and outings in the community.

Proposed Timescale: Completed 30/06/16

- Existing interns within the Kerry services will be relocated to the campus as part of increasing staffing levels with the Centre

Proposed Timescale: Completed 30/01/16

- Planned fire safety work is scheduled to commence January 26 2016

Proposed Timescale:28/02/15

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:

There were insufficient numbers of staff to meet the needs of residents at all times, including:

- to support residents to attend activities/day services
- to adequately care for residents at night time

41. 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 submitted a business case to the HSE supporting the need for additional staffing.
- The Registered Provider has introduced a new Volunteer drive which is currently introducing additional supports to individuals attending activities and outings in the community.

- The Registered Provider has increased its staffing levels at night time within the designated centre
- Recruitment has commenced in relation to posts allocated to residential areas

Proposed Timescale: 30/03/2016

Theme: Responsive Workforce

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

A full employment history was not available for one staff member.

42. Action Required:

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

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

- Staff member in question has been requested to submit updated Curriculum Vitae by 30th November 2015.
- The Human Resources Officer has completed an audit of 20% of DC1 Staff HR files and can confirm that those audited are up to date.

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

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

Not all members of staff had up-to-date training in:

- fire safety
- manual handling
- safeguarding

43. 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:

- An up to date log of training completed will be available in the DC1.
- All staff are up to date in Fire Safety Training based on two year cycle.
- All staff are up to date in Safeguarding Training and this is now reflected on the training log
- One staff member who is currently on Career Break from work will be provided with training on her return
- 1 Staff member is currently out of date for Manual Handling since 18th September 2015 is schedule for refresher training on the 17th November 2015.

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Not all policies were centre-specific or reviewed at a minimum within the last three years.

44. 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:

Registered provider will develop a suite of Local policies and Procedures specific to the centre in line with Schedule five of the regulation

Proposed Timescale: 30/04/2016

Theme: Use of Information

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

Not all the requirements of the regulations were included in the Directory of Residents.

45. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 Directory of residents will be reviewed to include the requirements of the regulations

Proposed Timescale: 28/02/2016