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A designated centre for people with disabilities operated by St John of God Community Services Limited, Louth

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Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003013
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Ciara McShane
Support inspector(s):	Carol Grogan;
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
08 April 2015 09:30	08 April 2015 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management

Summary of findings from this inspection

This inspection was unannounced and took place over one day with two inspectors. The purpose of the inspection was to focus on health-care and safeguarding.

The designated centre consisted of two units. In one unit personal plans, and the care plans within, were found to be reflective of the care and support required by residents. The documentation was up-to-date and relevant to the specific needs of residents. In the other unit the personal plans and care plans within required improvements. For example where a review occurred and recommendations were made as a result, these did not inform the plan of care. Personal plans contained a significant amount of information which was conflicting and contradictory in places therefore posing a risk to the care to be delivered. Care for residents was not always timely or apparent. Observations such as neurological observations were not completed as required.

The governance arrangements required significant improvement to ensure compliance with the Regulations. There was little evidence of autonomy regarding decision making and care delivery. Staffing was inadequate; the person in charge was not full time in the centre and had responsibilities for a number of designated centres. She was supported by a clinical nurse manager. However, these arrangements were found to be inappropriate in ensuring oversight and accountability. Reviews of incidents and accidents were not appropriate in ensuring best possible care.

The inspectors found there were systems in place to safeguard residents from abuse.

However, improvements were required to ensure that residents who had behaviours that challenged were supported to alleviate the causes of the behaviour. Improvements were required regarding resident's behavioural support plans to ensure they addressed the actual behaviours, providing clear and concise guidance to staff to deliver consistent care to the resident. These findings are further outlined in the body of the report and at the action plan at the end.

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):

Findings:
The inspectors reviewed the complaints log. The inspectors found a number of complaints which had been logged by staff on behalf of a resident regarding aspects of normal service delivery expectations. For example the complaints related to the wish for a day care placement, psychotherapy or general upkeep of the premises. The inspectors found that individual residents were being named as complainants on the form however they had not necessarily actually made the complaint. In general the inspectors found that complaints were not actually complaints they were normal expectations of service delivery. A system was required to ensure that service delivery requirements and general issues such as premises deficits were escalated to management via a more appropriate forum. This is actioned under Outcome 14.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
Each resident had a personal plan in place which was securely stored. The inspectors reviewed a sample of resident's personal plans from both units of the designated centre. While there were care plans in place for residents, in the first unit inspected, to meet their assessed needs, it was difficult to decipher and get an overall of view of how the care was to be delivered to meet the resident's needs. This was partially due to the large volumes of documentation for each resident but also due to the contradictions and inconsistencies of the information within. The inspectors found documentation was inconsistent in a number of areas throughout the personal plans reviewed. For example speech and language recommendations were not consistent across resident's personal plan and were contradictory. Information regarding health-care needs was also found to be recorded in multiple locations which presents an additional risk as the centre relies on agency staff.

From a review of a resident's personal plan in the same unit the inspectors saw that a resident had recently been admitted to hospital. At the time of inspection they had been discharged. It was unclear why the resident was admitted to hospital as the reason/diagnosis differed throughout the personal plan and notes within the personal plan. The person in charge told the inspectors this was due to incorrect information which was communicated to staff, from external stakeholders, however the personal plan was not amended, in all areas, to reflect the most to date diagnosis. The inspectors acknowledge that the finalised plan of care reflected the most up to date diagnosis.

Care plans were not at all reviewed as required or updated post review. For example the inspectors reviewed a care plan for a resident who had been reviewed by a speech and language however this was not reflected in their eating and drinking plan. Information pertaining to observations such as resident's weights were not being critically reviewed or analysed to determine best possible care.

The personal plan reviewed in the second unit was easily deciphered, organised and the care provided met the actual needs of residents. Where a review occurred it was linked to the care plans which were updated accordingly.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
From a review of the accident and incident log for one of the units it was evident that there were a high number of incidents. During the past five and a half months one resident alone had 44 incidents of behaviours that challenge culminating in self injurious behaviour.

The inspectors reviewed the behaviour support plan for this resident and found that it failed to address the dominant behaviours as recorded in the accidents and incidents reports; that of self injurious behaviours.

The behaviour support plan that was in place for the resident, for an alternative behaviour, was found to be extremely detailed. The person in charge told the inspectors, that the number of incidents had decreased significantly over the last number of months. However the inspectors were not assured that all possible action was being taken to support the resident with their behaviour that challenged or that staff were aware of same. For example the resident did not have a behaviour support plan for self injurious behaviour. Also from a review of the accident/incident log staff recorded that incidents lasted at times for ten minutes. The actions from staff were often recorded as ‘given a cup of tea and offered reassurance to good effect’.

In addition the inspectors from a review of a resident's personal plan found that the high levels of noise and activity on one of the units upset that particular resident. However this was found not to be appropriately addressed by management.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
From a review of personal plans it was evident that residents had access to allied health professionals such as speech and language therapist, psychiatry and dieticians.

Residents also had access to a general practitioner. However, residents were not always referred when required. For example a resident who, on frequent occasions, engaged in self injurious behaviour involving potential head injury was not referred to the general practitioner following this behaviour. This resident had nineteen incidents over a nine week period, ten of which involved potential head injuries.

Neurological observations were not consistently completed post head injury for residents reviewed.

Judgment:
Non Compliant - Moderate

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):

Findings:
While some governance arrangements at centre level were evident, for example clear reporting lines for front-line staff, improvements were required to ensure compliance with the Regulations.

The designated centre consists of two units each with their own separate teams of care staff and nursing staff. However, there is also a recurrent need for agency staff in each unit. The provider has made attempts, at all times when possible, to avail of the same agency staff ensuring continuity of care for residents. There is a Clinical Nurse Manager, with twelve supernumerary hours, who has responsibilities within both units. This was found to be inadequate as the person in charge is not full time. The centre is managed as two distinct units and the clinical nurse manager spends a greater amount of their time allocated to one specific unit. The unit with the greater presence of the clinical nurse manger addressed resident needs more effectively. For example the personal plans and care plans within were maintained to a satisfactory standard. These care plans offered clear guidance and clearly met the needs of residents. The person in charge had responsibilities for more than one designated centre. Based on the cumulative findings the inspectors were not satisfied that the governance arrangements of the person in charge managing more than one designated centre were effective and appropriate. This required a review.

There was no management oversight/follow through on action required to mitigate risk to residents following incidents of self injurious behaviour.

The inspectors reviewed documentation in which a resident indicated a wish to move into the community from the congregated setting. However there was little evidence of management action to support the resident in his goal, even though the atmosphere, in one of the units in particular, was unsuitable for this residents needs. The person in charge told the inspectors this had been escalated to management however there was no formal plan in place to address the goal from a governance and management perspective.

It was evident that management decisions were directly impacting on the ability of staff to describe and deliver care. For example there was a requirement for staff to document resident's daily activities in four locations. It was also found that staff/management within the designated centre had little autonomy in the model of care that was used to support residents. The current model of care did not meet some of the current resident's individual needs. The person in charge advised that she had no input into the development or ongoing review of the model of care.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ciara McShane
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003013
Date of Inspection:	08 April 2015
Date of response:	18 May 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 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 reviewed, on all occasions, to take into account changes in circumstances for example recommendations made by a speech and language therapist post review.

Action Required:

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

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

Please state the actions you have taken or are planning to take:
1. Person in Charge to discuss the importance of updating the critical information sheets for resident post any changes following a review. This critical information must update within 24hrs following any changes recommended following a review.
2. All personal plans to be reviewed by the Keyworker. Keyworker will ensure that all relevant information is updated from any multi-disciplinary review.
3. Audits to be carried out on personal plan bi monthly
4. Audit schedules of Individual Personal Plans to be developed and spot checks to be carried out

Proposed Timescale:
1. 30th April 2015
2. 30th June 15
3. 31st May 15
4. 30th April 15

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of personal plans did not take into consideration the effectiveness of the plan as demonstrated on multiple occasions. For example;

- Information within personal plans was contradictory.

-The plan of care was not clearly identified ensuring consistent care was delivered to meet the residents actual assessed need.

- Information obtained from observations was not anyalsed to inform the best possible plan of care.

Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
1. Clinical Nurse Manager 1 and the Quality advisor will develop a tracking system for assessments and review dates.
2. Quality advisor will provide training in smart goal setting for keyworkers.
3. Quality advisor will provide training in reviewing and evaluating the effectiveness of plans for keyworkers.
4. Clinical Nurse Specialist in Health to provide training in best practice in observation

recording and effective plan of response established from same from findings developed.
5. Person in charge and clinical nurse manager1 to discuss the importance of reviews and evaluating goals at team meeting
6. Audits will be carried out on personal plans

Proposed Timescale: 30/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Behavioural support plans were not in place to address the needs of specific behaviours that challenged.

Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
1. Residents Behaviour Support Plan are been currently reviewed with staff and positive behaviour support group on a weekly basis, includes all challenging behaviour.
2. All Adverse Incident Report forms are being reviewed on a weekly basis by management team. This information is being communicated to the frontline staff at team meeting, by the Person in charge and clinical nurse manager. This information can be brought to the positive behavioural support group on a weekly basis for the individual behaviour support to plan and review of these if necessary. Also the Adverse Incident Report forms reviewed on a weekly basis by management team during the designated centre meeting. The Person in Charge, the Director of Nursing, Care and Support and Staff from the designated centre will attend this meeting. If immediate changes are required to ensure the safety, health & wellbeing of residents this will be communicate to staff during handover.

Proposed Timescale:
1. Commenced
2. Commenced on 14th April 2015

Proposed Timescale: 14/04/2015

Theme: Safe Services

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

From a review of staffs actions to behaviour that challenge and the duration of behavioural outbursts, the inspectors were not assured staff had the appropriate skills to respond to the behaviour that is challenging and support residents.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
1. All staff have received TMAV training
2. We will develop a training programme where are all staff will receive training in supporting resident's with challenging behaviour
3. Multi Element Behavioural Support training - currently one staff member currently being trained by The Callan Institute.
4. Person in Charge and Clinical Nurse Manager 1 to discuss the importance Behaviour support plans with all staff to ensure they have read and understood the contents of plan and how they are to be implemented.
5. All staff are aware of the details of residents behavioural support plans both the proactive and reactive procedures. If any change occurs in behaviour support plans or if the positive behavioural support group require data to be collected, the shift leader at handover meeting will inform all staff of this. Also a daily input folder for data collection has being set up in the centre and all staff are made aware of this at hand over meetings by the shift leader.
6. Shift leader are aware of their responsibility to ensure that all staff adhere to behaviour support plans.
7. Review of proactive and reactive measures will be discussed at positive behaviour support group.

Proposed Timescale:
1. Complete
2. 30th July 2015
3. Commenced

Proposed Timescale: 30/07/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident who had expressed a desire not to live in a noisy and busy environment had not been appropriately addressed or managed.

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:
1. Individual case conference to be scheduled for this resident focussing specifically on

appropriateness placement. The case conference will include, resident, next of kin/representatives, key worker, Person in Charge of the centre, Clinical Nurse Manager 1, representative from the De-congregation Planning Committee Phase 2 and Director of Nursing, Care and Support.
The outcome of the case conference will be communicated, to the De-congregation Planning Committee Phase 2, by their representative at the case conference.
2. The De-congregation Planning Committee Phase 2 will be established and meetings will commence on 27/04/15. The scope of the committee will be to put in place action plans for the transitioning of residents. This will be based on priorities identified by Supports Committee. Each residents individual needs will considered during this process. The Development Plan Phase 2 will highlight the risks and barriers to transitioning. It is envisaged that Phase 2 will identify temporary arrangements while the individuals transitioning plans can be completed.

Proposed Timescale:
1. 31st August 2015
2. Commenced 27th April 2015

Proposed Timescale: 31/08/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required to ensure that resident's health care needs were met:

- Referrals to general practitioners where not facilitated at all time as required.

- Neurological observations were not completed where required or consistently post head injury.

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

Please state the actions you have taken or are planning to take:
1. Clinical Nurse Specialist to provide refresher training to all staff in completion of the neurological observations and in developing plans of care in relation to health.
2. Standardised operational procedure to be done in relation to carrying out neurological observations.
3. Review with General Practitioner for resident in relation to reviewing resident's health plan in relation to head injury and self-injurious behaviour involving hitting his head.

Proposed Timescale:
1. 30th May 15
2. 30th June 15

3. 30th April 15

Proposed Timescale: 30/06/2015

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 role of the person was not full time and was found to be insufficient in ensuring oversight and accountability of the centre.

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

Please state the actions you have taken or are planning to take:
1. Recruitment process has commenced to identify a full time in person in charge for this designated centre.
2. Current person in charge will stay in situ to ensure there is a measured handover to the new person in charge

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of autonomy locally in the designated centre.

There was little evidence of how management decisions were devolved to the centre.

Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
1. A recruitment process has commenced to identify a new full time Person in Charge for this designated centre. The current Person in Charge will stay in situ until there is a smooth handover done.
2. A new arrangement has been put in place in relation to strengthen the governance and management. There is a designated centre weekly team meeting chaired by Person

in Charge with Director of Nursing Care and Support and representative of staff team to review the quality enhancement plan for designated centre.
3. There is a weekly implementation team meeting with Person in Charge and quality team with registered provider this will be chaired by Director of Nursing Care and Support. Person in Charge/Clinical Nurse Manager 1 is meeting with Director of Nursing Care and Support on a weekly basis
4. There is a weekly strategic management team meeting with registered provider.

Proposed Timescale:
1. 30th July 2015
2. 3. and 4. immediate

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems are not in place to ensure the service provided is appropriate to residents, consistent and effectively monitored.

Deficits in service delivery, which were highlighted incorrectly through the complaints process, have not been addressed by management and the mechanisms used to escalate these deficits required a review. For example:

- review of incident/accident forms
- the model of care used
- requirements of staff to duplicate documentation

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1. A weekly meeting with Person in Charge/ Clinical Nurse Manager 1 and Director of Nursing Care and Support will take place to review all incidents, complaints and safeguarding issues. Relevant multi-disciplinary team members will be contacted where needed.
2. A review is going to take place re implementation of the complaints process. Systems not in place to address service deficit will be addressed through the new structure in relation to governance as follows. There is a designated centre weekly team meeting chaired by Person in Charge with Director of Nursing Care and Support and representative of staff team to review the quality enhancement plan for designated centre.
3. There is a weekly implementation team meeting with Person in Charge and quality team with registered provider this will be chaired by Director of Nursing Care and Support. Person in Charge/Clinical Nurse Manager 1 is meeting with director of nursing

care and support on a weekly basis. There is a weekly strategic management team meeting with registered provider.
4. A review will be carried out in relation to duplication of documentation at a corporate level.

Proposed Timescale:
1. Immediate
2. Immediate
3. Immediate
4. 30th July 2015.

Proposed Timescale: 30/07/2015