

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Bliain Orga
Centre ID:	OSV-0003015
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Declan Moore
Lead inspector:	Raymond Lynch
Support inspector(s):	Conor Brady
Type of inspection	Unannounced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 03 January 2017 08:30 To: 03 January 2017 19:30

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 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to Inspection

This was an unannounced triggered inspection to inform a registration decision after the Health Information and Quality Authority (HIQA) received a number of notifications concerning allegations of peer to peer abuse and injuries to residents in this centre.

The centre was first inspected in January 2015, where major non compliances were found across the majority of outcomes assessed. A second inspection took place in January 2016 which found some improvements had been made since the first inspection. However, serious concerns were identified regarding workforce and the governance and management arrangements in place.

Since that inspection HIQA held a meeting with the provider nominee and director of service regarding the unsuitability of the living environment and future plans for this centre (and all other centres on the campus where this centre is located). During this meeting the provider presented documented plans for a significant number of residents to move to more suitable and appropriate community based

accommodation by September 2016. At that time the inspectors found evidence that consultation had taken place with residents and their representatives to facilitate this transition.

On receipt of unsolicited information received by HIQA a third inspection was carried out in May 2016. This inspection found that serious issues remained with workforce and with the governance and management of the centre. Major non compliances were also found in premises and in meeting the health care and social care needs of the residents. Moderate non compliances were found with health, safety and risk management, as well as safeguarding.

By January 2017 all residents remained on campus, no transitions to the community had been facilitated and a number of serious notifications were received by HIQA in recent months which triggered this current and fourth inspection.

How we Gathered Evidence

The inspectors met with 10 of residents briefly during the course of the inspection and spoke with one resident for a short period of time. While all staff on duty were spoken with at some stage over the inspection process, two staff nurses and two health care assistants were spoken with at length. The Person in Charge, the Director of Care and Support and the Director of Services were also spoken with over the course of the inspection.

A sample of policies and documentation were also inspected as part of the process including health and social care plans, complaints log, risk assessments, safety statement and audits.

Description of the Service

The centre comprised of four houses on a campus based setting belonging to St. John of Gods in County Louth. Twenty residents were supported across the four houses that comprised the centre.

There were a range of small villages and towns in close proximity to the centre however, due to its isolated location private transport was required to access these amenities. It was noted that the centre had transport to support the residents in accessing their surrounding facilities.

Overall Judgment of our Findings

Overall the inspectors found that the residents were in receipt of a poor quality of service, the premises were not suited for their stated purpose and the governance and management arrangements in place were not adequate to ensure residents were safe in their home.

This inspection found significant levels of 'non compliance' across the majority of outcomes assessed. Of the ten outcomes assessed eight were found to have major

non compliances including resident's rights, premises, health, safety and risk management, safeguarding, healthcare needs, governance and management, social care needs and workforce. A moderate non compliance was found in health care needs and documentation.

While inspectors found that some progress had been made to support residents to move to more suitable accommodation, sufficient systems were not in place to implement the overall plan in accordance with the timeframes and undertakings given to HIQA. Despite being informed that this centre would commence decongregation by September 2016, no residents to date had transitioned to the community.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

This inspection found that the centre was not meeting or supporting the rights, choice, privacy and dignity of the residents that lived there.

While policies and procedures were in place to inform that residents would be consulted with, and would participate in decisions about their care and about the organisation of the centre, the inspectors found that this was not the lived reality of the residents and these policies and procedures were not being implemented at ground level.

For example, the inspectors observed that three residents had no choice but to leave their home for up to 12 hours per day, every day as it was not safe for them to be there. These residents were subject to incidents of aggression and violence from other residents and the centre was managing this by keeping the residents out of their home for prolonged periods of time.

Because of this issue it was also observed that these particular residents' intimate care needs could not be supported in their own home and they had no alternative but to use a different facility (everyday) for showering and bathing.

The inspectors were also not satisfied that the personal care arrangements observed over the course of this inspection upheld residents' rights to privacy and dignity.

For example, on the morning of the inspection the inspectors noticed a resident using the bathroom with the door open, while another resident stood outside with two staff members who were chatting while preparing a bath. When this was discussed with staff

they said that the resident using the bathroom left the toilet door open 'by choice'.

In addition, a number of residents were observed walking around the centre in a state of undress over the course of this inspection. While staff were observed in some cases to endeavour to support these residents, there was an emphasis on the collective management of residents as opposed to an individual service tailored to meet residents individual assessed needs

The premises and bathroom facilities were found to be institutional by design and layout, as stated above the practice of residents having to leave their homes to be supported with their personal care was an institutional practice that was a direct result of an inappropriate resident mix in this centre.

The inspectors observed that access to advocacy services and information about resident rights formed part of the support services that should be provided to the residents.

It was also observed that the identity and contact details of an external advocate were on display in the centre and were available to staff, the residents and/or their representatives. The complaints procedures were also prominently displayed in the centre.

However, the inspectors looked for documentation in order to ascertain if the organisation had contacted advocacy services or complained on behalf of the residents who had no alternative but to leave their home for up to 12 hours each day and found that there was no evidence of this in the centre.

It was also observed that a support plan and policy was in place to assist the residents' with managing their money. From a sample of files viewed the inspectors observed that a number of residents had previously been inappropriately charged for medical appointments and items of furniture. However, by the time of this inspection these residents had been reimbursed.

A protocol was now in place to ensure that all monies could be accurately accounted for and overall the inspectors were satisfied that there were adequate policies and systems in place to protect the residents from all forms of financial abuse.

There was a complaints policy in place which was to provide residents and family members with a platform to bring complaints to the attention of the service and to seek a satisfactory resolution. A dedicated log book for recording complaints was also to be kept in the centre.

However, the inspectors observed that complaints were not being managed appropriately in the centre. For example, a complaint had been made with regard to a house keeping issue in one unit that comprised the centre. While this complaint was logged, there was no evidence available to inform the inspectors if or how it was dealt with or how it would be resolved.

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):

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

Findings:

While the inspectors found that the assessed health and social care needs of the residents was being supported in some parts of the centre, it was also observed that for some residents a lot of activities were campus based and some residents had limited opportunities to experience or utilise their community.

The inspectors observed that some of the social care goals being identified with some residents were basic in nature and involved activities such as being brought to collect and pay for take away meals and walks on the campus.

From a sample of social care plans reviewed the inspectors observed that some residents had a review of their social care plans in August 2016. It was observed that some activities were being implemented for some residents however, the files also informed that some goals were not implemented and there was no explanation or reason as to why this was the case.

For example, one resident as part of their social care plans had requested to go to specific museums and to engage in other community based activities. These goals were not facilitated and the inspectors observed that there was no documented evidence to inform why this was the case.

It was also observed that staff knowledge of plans was found to be inadequate. For example, in exploring plans with some staff members they did not demonstrate awareness of residents' assessed needs and highlighted that only key workers would know the answers.

Social care planning and meaningful day plans were inconsistent and key worker dependant. For example, another resident had goals to complete skills teaching with the

use of an electronic device they had purchased, have a trip to the seaside and attend a Christmas pantomime. The review form for these goals was undated and there was no evidence that goals had been achieved. Staff on duty said they were not aware whether these goals were achieved or not.

Other personal plans reviewed across this centre were found to contain basic standards of goal setting that had insufficient evidence of follow up and no indications of whether goals were progressed and achieved with residents.

For example a resident had goals to dine out in a restaurant, visit his home and join a walking club. There was no evidence that these goals had been achieved or actively pursued in reviewing personal plan review forms. In discussing this plan with staff on duty they were not aware of these plans.

Another personal plan reviewed highlighted a programme for a resident to be facilitated for a daily visit to a coffee shop, a monthly meal out in a restaurant and a visit to their home town. None of these goals were marked as achieved in their social goal review form and the staff on duty did not know of these goals were achieved or not.

In reviewing the residents daily notes of a period of 4-6 months there was no evidence found that such social excursions were happening in accordance to plans. The majority of activities were highlighted as 'nature walk' and 'table top' or 'drive'. The inspectors queried this with staff and found that many activities were supported on the campus for some residents and when 'drive' was highlighted in reports that many residents would not leave the bus/car when off the campus on 'drives'

An activity sampling assessment (undated) was in place for a resident was indicated as requiring additional stimulation. This recommended activities such as 'being read to', 'swimming', 'water play'. With the exception of being asked to go for a walk, inspectors did not see any evidence of such activities being offered to this resident either on inspection or in a comprehensive review of the resident's daily notes.

Overall, residents' goals had not been achieved in a number of plans reviewed and the monitoring and review of the progress of these plans was ineffective. In all personal plans reviewed by the inspectors there were examples of incomplete and undated personal plans. Some staff were not familiar with plans. Plans were not accessible to residents and while one resident's bedroom had a board on the wall highlighting 'my personal goals' this board was found to be empty.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

As with all previous inspections of this centre, the physical layout and design of the centre continued to provide significant challenges to providing a quality based service to the residents.

Bedrooms were small (approximately five to seven square metres gross floor area) and the windows in each bedroom were not suitable as residents could not access them or view the outside from them due to their institutional design.

It was also observed that storage space for personal belongings was inadequate and the layout of the bathrooms continued to compromise the dignity and privacy of individual residents.

For example, and as found in the last inspection, some bathrooms comprised of communal facilities and required modernisation so as to ensure the privacy and dignity of each resident living in the centre.

The inspectors also observed that in one house that comprised the centre that communal rooms were large and furniture was sparse which impacted negatively on creating a homely environment.

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):

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

Findings:

While risk management policies were in place, the inappropriate resident mix, design and layout of the premises and institutional practices observed in this centre were

seriously and substantially impacting on residents' rights, safety and quality of life in this centre.

The system of risk management in this centre was ineffective and did not keep the residents safe from harm. There were 234 reported accidents and incidents in a one year period (2016) in this designated centre.

These incidents included peer to peer assault, physical and verbal abuse, violence and aggression, exposure to bodily fluids, falls, self injurious behaviour, bruising/body mark (unknown causation) and absconsion/missing persons.

The inspectors observed that risk was not being effectively managed in this centre. On the day of the inspection, the centre could not provide inspectors with basic information about the numbers and types of incidents occurring and there was a level of uncertainty regarding the frequency of such incidents. Incident reporting was also found to be inconsistent and not appropriately categorized in terms of the level of risk.

On the day of inspection the inspectors also requested the most up-to-date information pertaining to a risk assessment related to a resident who had been described as 'medically fragile'.

This resident had experienced a number of falls recently, resulting in injuries and was also susceptible to peer to peer assault. There were falls risk assessments in place however, the inspector observed that they were not adequately informative of how to best to mitigate the risk of falling.

While staff spoken with could verbalise how best to support this resident, the centre was unable to provide the most recent and up-to-date risk documentation on how to manage the level of risk this resident was exposed to.

Staff members also informed inspectors that they felt residents were not safe when they were questioned about the risks and resident safety in the centre. Both management and staff informed inspectors that they knew the centre was not meeting the resident's needs. This gravely concerned inspectors as they were not assured that risk was being managed appropriately or adequately throughout the centre.

With regard to infection control, some staff were observed not adhering to best practice. On arrival inspectors reviewed a number of residents' bedrooms and found two bedrooms required cleaning and replacement of bed linen and duvet.

A staff member informed inspectors that as some residents did not keep duvet covers on their bed they were 'impossible to keep clean'. On the day of this inspection, faecal matter was observed on one duvet that was visibly dirty. This was replaced following the inspectors observing same and a new duvet was provided on the day of inspection.

A resident who displayed significant complex behaviours required a lot of staff support particularly with personal care needs and hand hygiene. The inspectors observed that at times, when this resident required staff intervention and support with hand hygiene it was not being adequately provided for and instead the resident spent a lot of time in the

dining room which concerned inspectors.

The fire register was checked in one unit that comprises the centre. It was observed that fire drills were being carried out as required, daily checks were being facilitated on the fire panel and to ensure that escape routes were unobstructed. Weekly checks were also being carried out on manual call points, emergency lighting and fire extinguishers.

The last fire drill carried out was in December 2016 where no issues were identified. From a sample of files viewed it was also found that residents had a personal emergency evacuation plan on their files.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The inspectors found that residents were not safe or adequately protected from harm in this centre. The inspectors reviewed 88 safeguarding notifications made to the HIQA in advance of this inspection regarding this centre.

In addition to the high volume and frequency of accidents and incidents (239), inspectors reviewed a folder containing 70 'allegations of abuse forms' from periods in 2015 and another folder with 23 preliminary screening forms completed for periods in 2016.

These reports included instances of peer to peer assault and instances of violence and aggression predominantly. It was also observed that in a recent notification to HIQA a resident had reported an assault on another resident as staff did not witness it.

The person in charge informed the inspectors that six residents in the centre required safeguarding plans. However when looking at one resident with very complex needs who had six safeguarding referrals and preliminary screening reports, the person in charge stated that they had not completed a safeguarding plan for this resident to date.

The inspectors reviewed two safeguarding plans and found that they were reactive by design and did not necessarily safeguard the respective resident. For example and as identified earlier in this report, three residents were moved out of their homes for up to 12 hours per day to safeguard them from other persons they were living with.

One resident's safeguarding preliminary screening clearly highlighted "There is on-going risk to the resident living in this environment and it is not suitable to his current needs".

In reviewing safeguarding incidents the inspectors found a number of incidents whereby residents had marks and/or scratches from unknown causation and instances whereby peer to peer assaults were not being observed by staff and were reported to staff by other residents.

A sample of staff training records informed the inspectors that staff had up to date training in the management of problematic behaviours. From speaking to staff on the day of the inspection the inspectors were satisfied that they knew how to support a resident with behaviours of concern.

However, regarding positive behavioural support, the inspectors were not satisfied that residents behaviours were managed in line with behavioural support plans in place.

For example, a positive behavioural support plan dated 13 July 2016 prescribed that specific behaviours be clearly documented to inform this resident's development to include antecedents, behaviours and consequences of specific behaviours. This requirement had not been fulfilled by the time of this inspection.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The inspectors observed that the practice in relation to notifications of incidents was not satisfactory and required review.

While the person in charge were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents occurring in the centre it was observed that

two serious incidents occurring in September 2016, which required a resident to seek medical interventions, were not reported to HIQA as per legal requirements.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

While the inspectors found that arrangements were in place so that the residents' healthcare needs were being provided for, it was also identified that the centre did not follow through on a recommendation made by an occupational therapist for one of the residents living there.

The inspectors found that arrangements were in place to ensure that residents health care needs were being regularly reviewed with appropriate input from allied health care professionals where and when required.

From viewing a sample of documentation the inspectors observed that healthcare plans were informative of how each resident would be supported to experience best possible health regarding personal hygiene, dental care, mobility, and positive mental health.

The inspectors found that monitoring documents were also being maintained in the centre. From viewing this documentation, the inspectors were satisfied that GP check-ups were being facilitated as and when required and clinical observations and treatments were being provided for.

From viewing a small sample of healthcare plans the inspectors found that residents had access to a GP as and when required, hospital appointments were facilitated, medication was reviewed regularly and dental visits were facilitated as and when required.

It was also observed that input from other allied healthcare professions was being sourced, such as speech and language therapy, dieticians, physiotherapy and reflexology as and when required.

However, an occupational therapist made a recommendation in July 2016 for one resident regarding the management of behaviours of concern. There was no evidence

available on the day of inspection to inform if this recommendation had been implemented.

Residents' health care plans were informative of how best to manage special conditions such as epilepsy. Where a resident had epilepsy a support plan was in place to support the resident and staff to manage the condition.

The inspectors also found that arrangements were in place to ensure residents' nutritional needs would be met and where required weights were being recorded and monitored on a regular basis.

However, while it was observed that meals were nutritious, they were being provided by a centralised kitchen and residents were not being supported to have any input into preparing and/or making their own meals.

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):

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

Findings:

This inspection found that the management structure in place in this centre required review as the service being provided to the residents was of poor quality, unsafe, undignified and inappropriate.

It was observed over the course of this inspection that the senior management of the service were aware of the unacceptable living conditions that some residents had to endure each day in this centre. While the provider had given assurances to HIQA that this centre would be prioritised for de-congregation and residents would be supported to transition to new homes no later than September 2016, this had not happened. All residents remained on campus by the time of this inspection in January 2017.

There was no permanent person in charge in this centre and it was being managed by a

person deputising in this role. The deputising person in charge had responsibility for the management of four houses supporting twenty residents that comprised this centre. (The provider did notify HIQA with regard to this change of person in charge arrangement).

Many residents had significant individual and complex medical needs and at times during the course of this inspection, staff members were unable to provide inspectors with important information and documentation pertaining to the management of risk and assessed needs of some of the residents.

For example, the inspectors were not assured by the lack of information pertaining to how a specific risk was being managed concerning one resident and the strategies in place to mitigate that risk.

While staff could verbalise to good effect how best to support this resident, the centre was not able to produce any documentary evidence to the inspectors regarding this resident's most recent risk assessment and in particular the strategies in place to mitigate that risk. It was also observed that some staff were not familiar with some of the assessed social care needs of the residents they were supporting.

The inspectors noted that no internal audits had taken place in the centre since February 2016. It was also observed that the person in charge was not being adequately supported in their role as the provider nominee made no provisions for an annual audit of the safety and quality of care in the centre for 2016. This meant that the service was not being adequately monitored, which in turn meant it was not being managed appropriately.

For example, issues were found regarding to how complaints were being managed, how risk was being documented and how staff were being supervised. (This was further discussed in outcome 17 workforce). Because audits were not being carried out, the deputising person in charge was unaware of some of these issues and no actions had been identified to address them.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Inspectors spoke to all staff on duty and found that there was a mix of staff who had worked in the centre for considerable periods of time and some newly appointed staff. However, there was not a sufficient skill mix of staff in this centre based on deficits in some staff knowledge regarding the residents in their care and the absence of implementation of residents care plans.

There was only one nurse on duty in a part of the designated centre that according to rosters required more than this. This nurse was providing oversight to 13 residents with the support of eight care workers. All residents had complex individual support requirements.

In reviewing staffing rosters over the previous six months inspectors noted agency staff were utilised on most shifts in the centre which did not support the consistent provision of staffing.

Staff highlighted that some residents, due to the complexity of their needs would only engage in activities when certain staff were on duty. This emphasised the need for residents to have consistent staffing to support them.

Agency staff spoken to could provide very limited information when questioned by inspectors regarding residents' personal plans, assessed needs and residents' financial safeguards.

When discussed with the person in charge it was clear that the supervision and performance management of staff required improvement. The person in charge informed inspectors that they had not reviewed staff files and were not aware if agency staff were adequately trained to work in the centre.

Inspectors had to request that this information be submitted to HIQA the day following inspection. From viewing a sample of that documentation the inspectors found that staff had completed mandatory training such as fire safety and safeguarding.

However, inspectors were still concerned regarding the provision of training in order to best support the residents as some staff had little knowledge of their assessed social care needs or indeed their personal plans (as identified above).

In one unit in the centre whereby a resident with high levels of clinical support needs was allocated a 2:1 staff ratio during the day, this ratio was reduced during the evening and at night time. This meant that at times during the night, one staff member was responsible for the supervision of 5 residents. The provider stated that this had been risk assessed. Post that risk assessment it was decided that it was safe to reduce the staffing levels at night time in the centre.

However, in discussing one recent incident that occurred over the Christmas period

whereby a resident was injured by another resident, this incident occurred when the staff member was supporting another resident with intimate care, hence leaving four residents unsupervised. It was also observed that in one part of the centre a resident informed staff of an incident of alleged peer to peer abuse as staff did not witness this and were not aware that it had occurred.

As outlined in outcomes 7 and 8, given the levels and frequency of risk and safeguarding matters in this centre inspectors observed that such an absence of supervision arrangements were not safe, appropriate or adequate.

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):

No actions were required from the previous inspection.

Findings:

The inspectors found that the systems in place to maintain complete and accurate records in the centre were not adequate and required information for regulatory purposes was not easily retrievable.

Over the course of the inspection it was found that required records and information for the purpose of regulatory business was either not available or could not be located on the day of inspection.

For example, records of how some complaints were being managed in the centre were not being kept and/or updated. (This was discussed and actioned under outcome 1: residents' rights, dignity and consultation).

The inspectors also observed that internal audits and systems for monitoring the centre were not in place and there was no record of this information made available for inspection. (This was discussed and actioned under outcome 14: governance and management).

An updated important risk assessment pertaining to one resident and how to ensure their safety, health and well being could not be retrieved over the course of the inspection. (This was discussed and actioned under outcome 7: health, safety and risk management).

It was also observed that one resident did not have a copy of their personal belongings on their file as required by the Regulations.

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:

Raymond Lynch
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-0003015
Date of Inspection:	03 January 2017
Date of response:	21 February 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Some residents were not being supported to have freedom or to exercise choice and control in their daily lives. Three residents had no alternative but to leave their home for prolonged periods of time every day as they were subject to peer to peer assaults from other residents.

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

1. Action Required:

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

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

1. To date 10 residents are actively engaging in the transition process to their new homes. 2 residents will be successfully transitioned by end of March 17 and the remaining 8 residents will move subject to environmental assessments, successful transitioning and HIQA registration. The outcome of the above transition is that the 3 residents will no longer have to leave their current homes.

2. Referrals on behalf of the 3 residents have been sent to the National Advocacy Service.

3. A Rights committee has been established and the inaugural meeting takes place on the 09/02/17. Referrals on behalf of the 3 residents will be made following clarification of the committee's referral process.

Proposed Timescale:

1. 05/04/2017
2. 06/02/2017
3. 28/02/2017

Proposed Timescale: 05/04/2017

Theme: Individualised Supports and Care

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

Residents' privacy and dignity was not upheld in this designated centre. Some residents' privacy and dignity was being seriously compromised as they had no option but to use the bathing and showering facilities of another house for their intimate care needs

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:

To date 10 residents are actively engaging in the transition process to their new homes. 2 residents will be successfully transitioned by end of March 17 and the remaining 8 residents will move subject to environmental assessments, successful transitioning and HIQA registration. The outcome of the above transition is that the 3 residents will no longer have to leave their current homes.

Proposed Timescale: 05/04/2017

Theme: Individualised Supports and Care

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

While information was available on advocacy services in the centre, it was observed that such advocacy services had not been utilised on behalf of the residents who had no alternative but to leave their home for up to 12 hours everyday because of on-going safety issues.

3. Action Required:

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

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

1. Referrals on behalf of the 3 residents have been sent to the National Advocacy Service.
2. A Rights committee has been established and the inaugural meeting takes place on the 09/02/17. Referrals on behalf of the 3 residents will be made following clarification of the committee's referral process.
3. Each resident's rights awareness checklist is in place. Checklists will be reviewed and updated for each resident with a priority given to the 3 residents.

Proposed Timescale:

1. Completed 06/02/2017
2. 28/02/2017
3. 06/03/2017

Proposed Timescale: 06/03/2017

Theme: Individualised Supports and Care

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

Some residents were not being provided with appropriate care and support in accordance with evidence-based practice.

4. Action Required:

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

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

1. Decongregation plan is being accelerated with a view to providing appropriate and suitable accommodation based on compatibility of residents.
2. A staff team meeting took place on the 02/02/2017 to informally assess the compatibility of residents living together in the future.

Proposed Timescale:

1. 05/04/2017
2. Completed 02/02/2017

Proposed Timescale: 05/04/2017

Theme: Individualised Supports and Care

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

Complaints were not being adequately investigated or brought to an appropriate resolution

5. Action Required:

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

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

1. 1 centralised Complaints Folder is in place in Bliain Orga
2. Complaints information is displayed on noticeboards in each house in the DC.
3. The PIC maintains an electronic Complaints Log for the DC.

Proposed Timescale:

1. Completed 02/02/2017
2. Completed 06/02/2017
3. Completed 06/02/2017

Proposed Timescale: 06/02/2017

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 comprehensive and were inconsistently maintained and

implemented.

6. Action Required:

Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

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

1. The PIC will coordinate an audit of each resident's Personal Plan identifying actions required.
2. Based on the above audit each keyworker will update and complete each resident's personal plan based on their assessed needs and individual choices involving the resident or their representative.
3. The PIC/PPIM will monitor personal plans quarterly.

Proposed Timescale:

1. 06/03/2017
2. 06/03/2017
3. 31/03/2017

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

Personal plans were not accessible to residents.

7. 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:

1. Accessible personal plans are being developed for each resident in the DC.
2. Accessible activity schedules are under development and will be displayed on the resident's noticeboard in the DC.

Proposed Timescale:

1. 28/02/2017
2. 28/02/2017

Proposed Timescale: 28/02/2017

Theme: Effective Services

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

The effectiveness of plans was not reviewed to an appropriate standard.

8. 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. The PIC/PPIM will monitor the effectiveness of each resident's personal plan quarterly reflecting changing in need and circumstances.

Proposed Timescale:

1. 31/03/2017

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

There was an inconsistent standard and implementation of plans. Accountability was absent for the pursuit of plans and staff knowledge of plans was absent in many plans reviewed. Plans were not appropriately dated and reviewed. There was not appropriate review and follow up to ensure goals and objectives set to enhance residents quality of life were being completed.

9. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

1. The Programmes Facilitator for social goals has been allocated to the DC one day per week to support staff in social goal planning and reviews.
2. Social goal planning will be discussed at resident's weekly meetings.

Proposed Timescale:

1. 07/03/2017
2. 28/02/2017

Proposed Timescale: 07/03/2017

Theme: Effective Services

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

The assessed needs of residents were not being met.

10. Action Required:

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

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

The PIC is reviewing the roster to ensure there is an adequate number of staff to meet the assessed needs of the residents in the DC.

Proposed Timescale: 28/02/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The premises were not fit for purpose and did not meet the aims and objectives of the service or the needs of residents.

11. 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:

1. 3 houses have been sourced in the local community in order to accelerate the de-congregation plan and meet the required needs of the residents.

2. New soft furnishings will be purchased to create a more homely environment for house two of this DC.

Proposed Timescale:

1. 05/04/2017
2. Completed. 18/02/17

Proposed Timescale: 05/04/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Risk in this centre was not being appropriately or effectively managed.

12. 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:

1. Up to date Risk Management policy is in place.
2. The Risk Register is in place and has been reviewed by the PIC/PPIM.
3. The pager and alarms have been serviced, labelled and placed in House 2, 5 and Ashling House for responding to emergencies. The pager and alarms are tested daily.

Proposed Timescale:

1. Completed 03/02/2017
2. Completed 06/02/2017
3. Completed 02/02/2017

Proposed Timescale: 06/02/2017

Theme: Effective Services

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

Infection control practices observed were not adequate in respect of the support needs of residents.

13. 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:

1. A deep clean will take place in House 2 (commenced on 07/02/17) and House 5
2. The PIC will coordinate a schedule of Hygiene audits and complete audits in each house in the DC.
3. The cleaning schedule has been reviewed for House 2 & 5.

Proposed Timescale:

1. Completed 21/02/2017
2. 31/03/2017
3. Completed 03/02/2017

Proposed Timescale: 31/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Recommended therapeutic interventions were not being implemented.

14. Action Required:

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

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

Sensory assessment appointment rescheduled with community occupational therapist on 07/03/2017.

Proposed Timescale: 07/03/2017

Theme: Safe Services

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

Residents were not appropriately protected in this centre.

15. 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. The PIC is reviewing the roster to ensure there is an adequate number of staff to supervise and protect all residents from all forms of abuse.
2. The compatibility of residents living together has been reviewed and residents have been identified who should not live together as part of the decongregation plan.

3. Decongregation plan is being accelerated to transfer all residents to community based houses.
4. HSE safeguarding policy is in place. An interim Designated Safeguarding Officer has been appointed to the campus.
5. The PIC /PPIM will develop a Safeguarding tracking system to monitor incidents.

Proposed Timescale:

1. 28/02/2017
2. Completed 02/02/2017
3. 05/04/2017
4. Completed 30/01/2017
5. 20/02/2017

Proposed Timescale: 05/04/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

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

HIQA was not notified within 3 working days of some adverse incidents occurring in the centre that required medical intervention

16. Action Required:

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

1. Two notifications were submitted late to the Authority.

Proposed Timescale:

1. Notices were submitted on 26/10/17

Proposed Timescale: 26/10/2016

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:

A treatment recommended by an occupational therapist had not been followed through on and was not implemented.

17. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

Sensory assessment appointment rescheduled with community occupational therapist on 07/03/2017.

Proposed Timescale: 07/03/2017

Theme: Health and Development

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

Residents were not being supported to buy, cook or prepare their own meals.

18. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

1. A system has commenced within the DC for residents to plan a home cooked meal each Friday. It is discussed at the residents meeting on a Sunday to decide on menu. The residents are supported to purchase ingredients and prepare the meal.

2. A schedule for the preparation Sunday lunches going forward will be developed and agreed at the next residents meeting.

Proposed Timescale:

1. Commenced 27/01/2017.

2. 06/03/2017

Proposed Timescale: 06/03/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

the following respect:

It was observed that the person in charge was deputising in the role and was responsible for the management of four houses supporting twenty residents that comprised this centre. The residents had significant complex and medical individual needs. This inspection found that the deputising person in charge was not being adequately supported in the role to carry out the duties and functions of the person in charge adequately.

19. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

1. A new Person in Charge (PIC) with required qualifications has been appointed to the DC on a full time basis from 23/01/2017.
2. The CNM1 has been allocated fulltime to House 5 in the DC.
3. The Senior Staff Nurse has been given additional supervision hours specifically to support residents in House 2.

Proposed Timescale:

1. Completed 23/01/2017
2. Completed 13/02/2017
3. Completed 13/02/2017

Proposed Timescale: 13/02/2017**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were no provisions in place for an annual review of the safety and quality of care to be carried out in this centre.

20. 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:

1. The PIC/PPIM will post satisfaction questionnaires to resident's representatives.
2. An annual review of the quality and safety of care and support for 2016 will be

completed for the DC.

Proposed Timescale:

1. Completed 10/02/2017
2. 10/03/2017

Proposed Timescale: 10/03/2017

Theme: Leadership, Governance and Management

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

Systems were not in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent or effectively monitored.

21. 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:

Each home within the DC will have its own identified support team with named keyworkers for the residents in that house.

A shift leader will be identified and will report to the PIC/CN

Each house will be monitored & supported throughout the week by the Director of Care and Support/Assistant Director of Nursing, Care & Support.

Proposed Timescale:

1. Completed 13/02/2017
2. Completed 13/02/2017
3. Completed 13/02/2017

Proposed Timescale: 13/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The numbers and skill mix of staff in this centre required review as they did not ensure

that residents needs were met at all times.

22. 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:

1. The PIC is reviewing the roster to ensure there is an adequate number of staff to meet the assessed needs of the residents in the DC.
2. Stabilise the workforce by reducing the reliance on agency staff subsequently providing a knowledgeable workforce to support the residents.

Proposed Timescale:

1. 28/02/2017
2. 05/05/2017

Proposed Timescale: 05/05/2017

Theme: Responsive Workforce

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

Staff were not adequately supervised.

23. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

The PIC/PPIM will develop a schedule for staff supervision with a plan to have bi-monthly 1: 1 supervision meetings with each staff member in the DC.

Proposed Timescale:

Completed 10/02/2017

Proposed Timescale: 10/02/2017

Theme: Responsive Workforce

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

Some staff required training as they were not familiar with some of the assessed social

care needs of the residents or indeed their personal plans.

24. 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:

1. Staff have been consulted to identify gaps in training needs. The PIC/PPIM will develop a training schedule for the DC.
2. An external lecturer is scheduled to facilitate staff training on a weekly basis.

Proposed Timescale:

1. 02/03/2017
2. 24/02/2016

Proposed Timescale: 02/03/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

One resident did not have a record of their personal belongings on file

25. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

1. Residents inventory of personal belongings have been audited and gaps identified.
2. Keyworkers will update and maintain inventory lists as identified.

Proposed Timescale:

1. Completed 03/02/2017
2. 03/03/2017

Proposed Timescale: 03/03/2017

Theme: Use of Information

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

A record of a risk assessment pertaining to one resident could not be located in the centre on the day of inspection

26. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

1. The risk assessment was subsequently located on the day of inspection.
2. The PIC/PPIM has reorganised the storage of records within the DC to ensure that they are stored appropriately, available at all times and easily retrievable for staff and inspection purposes.

Proposed Timescale:

1. Completed 03/01/2017
2. 28/02/2017

Proposed Timescale: 28/02/2017