

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St. John of God North East Services - Greenmount
<b>Centre ID:</b>	OSV-0003992
<b>Centre county:</b>	Louth
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St John of God Community Services Limited
<b>Provider Nominee:</b>	Clare Dempsey
<b>Lead inspector:</b>	Raymond Lynch
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	22
<b>Number of vacancies on the date of inspection:</b>	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 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
20 July 2016 10:00	20 July 2016 20:00
21 July 2016 10:00	21 July 2016 16:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

**Background to inspection:**

This was an unannounced two day monitoring inspection after the Health Information and Quality Authority (HIQA) received unsolicited information related to residents' finances and inadequate resources being available in the centre. The information sent to HIQA alleged that residents were inappropriately charged for services and equipment which should have been supplied by the provider.

Prior to this inspection the centre was inspected in February 2015 where major non-compliances were found in social care needs, premises, workforce and health, safety and risk management. The centre had another inspection in April 2015 where there continued to be major non-compliances in safeguarding and protection of vulnerable persons.

**How we gathered evidence:**

The inspector met all 22 residents and spent a short time chatting with four of them in the centre. One nursing staff was also spoken with as was one health care assistant.

The clinical nurse manager (CNM) was spoken with at length on day one of the inspection and the person in charge was spoken with on day two. The inspector also

got to speak with a relative of one of the residents who was visiting during the course of the inspection.

Residents appeared very much at ease with all staff members and staff were also observed engaging with residents in a caring and dignified manner. Feedback from one relative about the service was very positive and they reported that they felt their family member was very well cared for. The relative also said that they were kept informed of their family member's health and well-being and were also welcome to visit the centre whenever they wished.

Policies and documents were also viewed as part of the process including a small sample of health and social care plans, risk assessments, staff training records and safety documentation.

#### Description of the service:

The centre comprised of four large terraced houses on a campus based setting in a rural location in Co. Louth. The premises had been deemed unsuitable for accommodating 22 residents in a previous inspection and this remained to be the case on this inspection. The inspector did note however, that even though the premises remained unsuitable for its stated purpose it was clean, bright, warm and kept in a reasonable state of repair. Where possible the premises had been personalised to suit the individual preferences of the residents.

Transport was not always available to the centre and because of this and the current staffing arrangements, residents had limited opportunities to access their local town, shops, pubs, restaurants and community-based amenities on a regular basis.

#### Overall judgment of our findings:

The inspector found that the concerns raised in the unsolicited information sent to HIQA were founded. Residents were inappropriately charged for basic services and equipment from their own personal funds. These practices went on over a prolonged period of time. There was an absence of consent or consultation for the charges.

While senior management of the centre were in the process of addressing issues at the time of this inspection, concerns remained with regard to the safeguarding of residents' finances. The provider had commenced a financial review of this matter in August 2015. However, HIQA was not satisfied that this review was sufficiently robust or independent to ensure that residents' interests were protected. Even though the review was on-going at the time of this inspection and a proportion of residents had been reimbursed there was still evidence of inappropriate practices as recently as May 2016.

This inspection also found that there continued to be significant on-going issues regarding premises, staffing levels and in meeting the social care needs of the residents. However, improvements were found regarding health, safety and risk management. The inspector found evidence of good practice in relation to healthcare needs and medication management and both of these outcomes were found to be compliant. These are further discussed in the main body of this report and in 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 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:**

Previous inspections found there were issues with meeting the assessed health and social care needs of the residents. This inspection found that the assessed healthcare needs of each resident were being met to a very good standard however, significant challenges remained in meeting social care needs.

From a sample of files viewed the inspector found that the assessed healthcare needs of each resident living in the centre were being facilitated and supported in the centre. Documentation informed that residents had regular access to a range of allied health care professionals as and when required.

It was also observed that each resident had a meaningful and social activities assessment carried out in 2016. However, there were issues with meeting the assessed social care needs of each resident living in the centre. Some of the goals were basic and had yet to be achieved for the residents.

For example, one resident as part of their assessment had identified they would like to trial a bus outing and attend a day activity centre. While these goals had been set in early 2016, the deadline for their achievement was the end of September 2016. By the time of this inspection in July 2016 neither goal had been achieved for the resident.

The person in charge informed the inspector that no resident had access to a day activation service. This meant the staff working in the centre were providing both residential and day services to all twenty two residents.

A sample of activities that residents engaged in on a daily basis ranged from watching DVD's/TV, relaxation, listening to the radio and hand massage.

However, it was noticed by the inspector that all these activities were facilitated on campus and there was limited opportunities for residents to access their local shops, restaurants, pubs and other community based amenities. This in turn meant that there were inadequate arrangements in place to meet the assessed social care needs of the residents living in the centre.

**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):**

#### **Findings:**

The inspector found that while the health and safety of residents, visitors and staff was being actively promoted, issues remained regarding the management of some areas of risk in the centre.

There was a Health and Safety Statement available in the centre. Its purpose was to promote a safe working environment for staff in order to protect residents and others affected by the activities of the organisation. It also detailed staff member's role and responsibility to the management of safety in the place of work.

There was a policy on fall prevention which was updated in July 2014. The main purpose of the policy was to implement a strategy with each resident to reduce the impact and likelihood of a fall. The inspector observed that each resident living in the centre had a falls risk assessment on file.

From a small sample viewed, the inspector observed that the assessments clearly identified the supports required to mitigate the risk of falling.

For example, one falls risk assessment which was reviewed in June 2016 informed that the resident required one to one support when mobilising outside of the centre. The inspector observed that this support was in place and no adverse incidents regarding falls has been recorded for the last three months for this resident.

However, not all risks were being identified and documented. For example, every resident required the use of a wheelchair when outside of the centre. The inspector

observed that the footpaths were in a very poor state of repair and at times staff were seen to struggle supporting residents in wheelchairs when outside of the unit.

While staff were aware of this problem and were very careful and vigilant when supporting the residents outside of the centre, this issue was not documented, recorded and/or risk assessed. The person in charge informed the inspector that she, along with the support of a quality advisor were compiling a comprehensive risk register for the centre that would identify, record and present strategies to mitigate risk across the entire centre.

The inspector saw a sample of this work and was assured that once completed the centre would be in a position to adequately manage issues related to risk at both individual and environmental level.

The inspector found that the fire register was up to date having last been checked and signed off by an external fire consultancy company in March 2016.

Fire equipment such as fire blankets and fire extinguishers had also been checked in at this time. An issue with fire doors not closing properly was identified in a previous inspection however, this had been addressed by the time of this inspection and the fire doors had been checked in June 2016 with no issues identified.

The emergency lighting had been checked by an external consultancy company in April 2016 as were the fire detectors and alarm system.

Documentation read by the inspector informed that staff did daily checks on the alarm panel and checked that escape routes were clear. Weekly checks were carried out on emergency lighting, smoke detectors, fire extinguishers and manual call points.

Fire drills were carried out as required and from viewing the relevant documentation the inspector observed that some issues were identified with the last drill carried out in the centre. For example, one resident could become upset and frightened during the fire drill and refuse to leave the centre. While each resident had an individual personal emergency evacuation plan in place this resident's plan was not updated adequately to reflect the issue identified during the fire drill.

There was a missing person's policy in place in the centre. The aim of the policy was to identify a resident who may be at risk of going missing and to support staff in what course of action to take should a resident go missing.

Issues with regard to the management of infection control were identified in previous inspections. However, on this inspection the inspector observed that documented hand hygiene procedures were in place. They were to guide staff in the prevention of cross contamination through the appropriate use of hand hygiene.

The inspector observed that the centre was clean and there was adequate warm water and hand sanitizing gels and soaps available.

**Judgment:**

Substantially Compliant

**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):**

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

**Findings:**

The Health Information & Quality Authority (HIQA) received unsolicited information regarding the management of residents' finances which was a factor that triggered this unannounced inspection. The information alleged that residents were being charged substantial sums of money for furniture, medical aids and medical appointments.

This inspection found evidence that validated these concerns and found that safeguarding arrangements were not adequate to protect residents from financial abuse.

For example, between 2012 and 2016 a number of residents were charged €2300 each for the cost of specialised armchairs while another was charged €2499 for an armchair and a dexta scan. Another resident who was assessed as needing a body brace was charged €552 for this specialist medical appliance. Residents or their representatives were not adequately consulted in relation to these charges.

After receiving initial unsolicited information in June 2016, which indicated poor management of residents' finances, HIQA required the provider to carry out its own provider led investigation. The provider was required to submit results of this investigation and other documentation to HIQA.

The outcome of the provider's investigation showed that poor practice had occurred in the management of residents' finances and that residents had been inappropriately charged for items such as basic medical aids and equipment.

The provider led investigation also informed that the regional director of the organisation had already commissioned a full independent review of residents' finances (which had commenced in August 2015) and that the provider had put in place a process to rectify this matter and reimburse residents.



Following this inspection the Chief Executive of the organisation was required to provide evidence to HIQA demonstrating how their own review was sufficiently independent and robust. They were required to clarify what person and/or agency had carried out the independent review of the residents' finances and demonstrate that the scope and terms of reference were sufficiently broad to protect residents.

The Chief Executive confirmed on the 23rd of August that a retired senior staff member of the organisation conducted the financial review. As the person conducting the financial review of residents' finances was a previous staff member of St. John of Gods Services, HIQA was therefore not assured that the process was sufficiently independent.

However, the review resulted in the Chief Executive and the Regional Director deciding that residents were to be reimbursed for items of furniture, medical aids and equipment which they had purchased from their own funds between 2012 and 2016.

On the day of this inspection the inspector observed that some residents had already been reimbursed and others were in the process of being reimbursed for such purchases.

The provider responded that since March 2016 the importance of compliance with the organisations service user finance policy has been discussed at bi-weekly person in charge forums and the Director of Nursing Care and Support re-issued the policy to all managers and persons in charge in order to reinforce compliance with the policy.

With regard to the scope of the provider's review, the organisation responded that due to the quality of documentation relating to residents' personal finances it was difficult to ascertain if residents' monies were used for medical equipment prior to 2012/2013. Therefore HIQA was not assured that the scope and remit of the provider's review was sufficient to protect residents.

The inspector viewed a sample of residents personal financial accounts and saw that there were now robust procedures in place to ensure that their monies could be adequately accounted for at all times.

All items purchased by residents required a receipt and their personal monies were checked by two staff members daily to ensure accuracy. All residents also had an up-to-date inventory of their personal belongings on their individual files.

As a result of concerns raised during this inspection the provider was formally requested by HIQA to take action and to address this matter in all centres operated by the provider nationally.

There was a policy on, and procedures in place in relation to safeguarding vulnerable adults, which provided clear guidance to staff.

Staff had up-to-date training in safeguarding of vulnerable adults and from speaking with two staff members the inspector found them to be knowledgeable in relation to what constitutes all forms of abuse and on the related reporting procedures. The staff members were also aware that there was a designated person to deal with any

allegations of abuse.

There was a policy in place for the provision of intimate personal care. Personal and intimate care plans were in place and provided comprehensive guidance to staff ensuring, consistency, privacy and dignity in the personal care provided to each resident.

There was also a policy in place for the use of restrictive practices in the centre however, restrictive practices that were in use were for safety reasons only and kept under review. For example, some residents used lap straps when out in their wheelchairs.

All restrictive practices were brought before a specialised committee where they were further discussed, reviewed and agreed. The inspector also observed that p.r.n. (as required) medicines were not in use in the centre to manage behaviours of concern.

The centre had a policy on positive behavioural support in place. The aim of the policy was to ensure collaborative and consistency in the approach to supporting individuals with behaviour of concern. From a small sample of files viewed positive behavioural support assessments were being carried out with support by a team of multi disciplinary professionals.

However, some positive behavioural support plans required review and/or updating. The inspector spoke with the person in charge about this and was satisfied that adequate arrangements were in place for the completion of this work in a reasonable timeframe.

Previous inspections found that there were issues with regard to the training of staff in positive behavioural support and the management of challenging behaviour. While this issue had not been completely addressed the inspector saw a schedule of training (which was happening each Wednesday for staff working in the centre) which would bring all staff up to date with required mandatory training by the end of August 2016.

**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):**  
No actions were required from the previous inspection.

**Findings:**

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

The person in charge informed the inspector that arrangements were in place in relation to residents having access to the local GP and a range of other allied health care services as and when required.

From a sample of files viewed the inspector observed that healthcare plans were informative of how each resident were supported to experience best possible health regarding personal hygiene, dental care, mobility, eye care, foot care and positive mental health.

The inspector found that monitoring documents were available and maintained in the centre. From a sample viewed, these files informed the inspector that regular GP check-ups were facilitated and clinical observations and treatments were provided for as and when required

Consultations with the dentist, optician, dietician, speech and language therapist, physiotherapist, chiropodist and GP were provided for as and when required. Hospital appointments were also facilitated as and when required. For example, a resident prone to chest infections had been supported to attend hospital in March for a chest x-ray.

Positive mental health was also provided for and where required residents had access to psychology and psychiatry supports. The inspector observed that care plans promoting best possible mental health had recently been reviewed in a psychiatrist in February 2016.

Health care plans were informative of how best to manage special conditions such epilepsy. Residents with epilepsy were reviewed by their neurologist and of a sample of care plans viewed the last neurology appointment was June 2016. An epilepsy outreach clinic was also made available to the residents in the centre. The last outreach clinic was facilitated in June 2016.

The inspector found that arrangements were in place to ensure residents nutritional needs were met to an acceptable standard.

Weights were recorded and monitored on a monthly basis. While meals were provided from a centralised kitchen, residents' nutritional needs and food preferences were recorded on their personal files.

**Judgment:**

Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

The inspector found that the medicines management policies were satisfactory and that practices described by the person in charge were suitable and safe.

The medicines management policy in place in the centre had been reviewed and updated in 2013. The aim of the policy was to ensure that medicine management practices were clear and to outline the role and responsibilities of all employees who supported residents with any aspect of their medication.

Each house that comprised the centre had a locked drug press or trolley in place. Medication prescription sheets were available that included sufficient detail to ensure safe prescription, administration and recording standards. There were also appropriate procedures in place for the handling and disposal of unused medicines in the centre.

There was a system in place to record any drug errors however, there had been no recent drug errors recorded in the centre. The inspector observed that only qualified nursing staff administered medication.

The person in charge and/or staff nurse regularly audited all medicines kept in the centre and from viewing a sample of these audits, the inspector observed that all medications in use could be accounted for at all times.

All p.r.n. (as required) medicines had strict protocols in place for their use and were reviewed regularly by the GP and/or psychiatrist. The only p.r.n. medicines in use in the centre were pain relief and rescue medication for the management of seizure activity.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Overall the inspector found that there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility. However, no annual review of the quality and safety of care was carried out by the provider nominee.

The centre was managed by a suitably qualified, skilled and experienced person in charge who was a registered nurse. From speaking with the person in charge in length on day two of the inspection it was evident that she had an in-depth knowledge of the individual needs and support requirements of each resident.

She was also aware of her statutory obligations and responsibilities with regard to the role of person in charge, the management of the centre and to her remit to the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

She was supported in her role by a clinical nurse manager 1 (CNM I). The inspector spoke with the CNM I on the first day of the inspection and found that she was knowledgeable of the regulations and also had an in-depth knowledge of the residents individual needs and support requirements.

The inspector also observed that there was an on-call system in place where staff could contact a senior manager/CNM III at any time if the need arose.

Announced and unannounced visits and audits were carried out in the centre. These audits identified areas of non compliance and required actions. For example a recent audit identified that a stock sheet was required to enhance the auditing system in place for medicines management. The inspector observed that this was in place on the day of inspection.

Another audit identified the need for privacy locks to be applied to bathroom doors. Again the inspector observed that these were in place on the day of inspection.

While the internal auditing systems were bringing about effective change in the centre there was no annual review of the safety and quality of care undertaken by the provider nominee as required by the Regulations. The inspector had serious concerns about this as earlier findings in this report identified concerns regarding the monitoring and safeguarding of residents personal monies.

While evidence was found that the organisation was now addressing these specific concerns, the inspector was not satisfied that there was adequate on-going monitoring of the centre by the provider nominee or someone nominated on their behalf.

The person in charge worked on a full-time basis in the centre and was directly engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

She was committed to her own professional development and engaged in all mandatory training required for the centre.

Throughout the course of the inspection the inspector observed that the person in charge knew the residents and their individual support requirements very well.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

The inspector found that while staff were experienced, skilled and held relevant qualifications, the number of staff in place required review as some of the assessed social care needs of the residents were not being met.

There was a team of registered nurses working in the centre supported by a team of health care assistants. The inspector viewed a sample of staff files and found that staff were recruited, selected and vetted in accordance with best practice and schedule 2 of the Regulations.

Issues were identified with regard to gaps in staff training earlier in this report however, these were discussed and actioned under Outcome 8: Safeguarding and Safety.

While there were informal systems in place to support and supervise individual staff members, the person in charge informed the inspector that this process had yet to be formalised.

Plans were in place however to progress this and the inspector saw a template for the process of formal staff supervision which was to be implemented and used in the centre as a priority.

The inspector observed that residents received assistance in a dignified, timely and respectful manner at all times during the course of the inspection.

From observing staff at work it was evident that they were competent to deliver the care and support required by the residents. Family members also spoke very highly of the entire staff team and care provided.

However, the staffing allocation to the centre required review as some of the assessed needs of the residents were not being met (in particular social care needs).

From speaking with management and staff, observations during the inspection and reading residents files the inspector noticed that the health and mobility care supports required for all twenty two residents living in the centre were individual and complex.

All twenty two residents required the support of a wheelchair when on social outings. A number of residents also had epilepsy, some had dementia/onset of dementia and some required a two to one staff ratio for intimate care support.

There was a requirement that a nurse was to be available at all times in the centre and at all times if supporting a resident with epilepsy on a social outing.

Because of these complex health related issues the inspector noted that the allocation of staff to the centre required review as some of the assessed social care needs of residents were not being met.

This issue was further compounded by the fact that the centre was in a rural location and there was limited access to adequate transport for residents to avail of.

**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:***

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 report<sup>1</sup>

<b>Centre name:</b>	St. John of God North East Services - Greenmount
<b>Centre ID:</b>	OSV-0003992
<b>Date of Inspection:</b>	20 July 2016
<b>Date of response:</b>	06 October 2016

### Requirements

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

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

### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

Adequate arrangements were not in place to meet the assessed social care needs of the residents.

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

**1. 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 Person in Charge is reviewing and enhancing the meaningful and social assessments for each of the residents. 30/10/2016
- When the assessments are complete the Person in Charge, will liaise with each keyworker in the planning of the social events. The Person in Charge and Clinical Nurse Manager will monitor each resident's progress to ensure that goals and being achieved within the agreed timeframe. 30/10/2016
- The Person in Charge is completing Self-Supported Directed Living training. As part of this training project, the Person in Charge is initially focussing the discovery process on one resident in the Designated Centre. When the training is completed the Person in Charge will support each resident with self-supported directed living. Self-Supported Directed Living information sharing is on-going at daily handover and team meetings. 10/12/2016
- The Person in Charge has arranged staff training in social goals setting. This training will be linked with the social role valorisation theory and self -support directed living module, to ensure appropriate social goals setting are in place. Social goals setting will be discussed at each resident's annual circle of support meeting, at weekly residents meetings and designated centre meetings. 21/11/2016
- Each resident's wheelchair was assessed and fitted for headrests, this allows for transportation in public taxi services.
- Each resident will be supported to apply for their travel pass
- The Person in Charge will ensure that each key worker will continue to support residents develop their weekly meaningful schedule and to identify additional opportunities for local community participation and also additional opportunities across the campus.

**Proposed Timescale:** 30/12/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The current system in place was not adequate for the assessment and management of risks throughout the designated centre.

**2. Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- The Person in Charge has undertaken a review of the Risk Management Policy to ensure all identified risks are documented.
- The Person in Charge has liaised with the Quality and Safety Advisor and they are completing the compiling of the risk register.
- The process for inducting staff in risk management policy and the risk register is being addressed at daily handovers, team meetings and resident meetings.

**Proposed Timescale:** 14/10/2016

**Theme:** Effective Services

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

One personal evacuation plan was not adequately updated to reflect issues with regard to a resident's evacuation from the centre.

**3. Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

- A full fire evacuation was carried out on 6th September 2016. The Person in Charge ensured that each resident's personal emergency evacuation plan was updated.  
Completed 06/09/2016
- It is now the responsibility of the Shift Leader conducting the fire drill to ensure that the personal emergency evacuation plan for each resident is updated after each evacuation. The Person in Charge will audit the effectiveness of this process.
- The Fire officer was consulted with in relation to residents who do not wish to leave their home during a fire drill. Their recommendations on safe management during a fire evacuation are included in the resident's personal emergency evacuation plans.  
Completed 30/06/2016

**Proposed Timescale:** 30/11/2016

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

There were still gaps in staff training for the management of behaviours of concern.

### **4. 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:**

- 31 out of 48 staff members are training in positive behavioural approaches in managing behaviours of concern, within the Designated Centre.
- A revised training calendar has been developed for the Designated Centre. The Clinical Nurse Manager has identified the staff to attend training in management of behaviours that challenge in line with this schedule. Training dates commence on 14th October 2016, 21st October 2016 & 28th October 2016.
- The Person in Charge and Clinical Nurse Manager ensure that there is a cohort of staff on duty each day that are trained in the management of behaviours of concern when planning and scheduling the rosters

**Proposed Timescale:** 30/11/2016

**Theme:** Safe Services

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

Some residents positive behavioural support plans required review and/or updating

### **5. 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:**

- There are three residents who have completed Multi Element Positive Behaviour Support plans that were developed with the Positive Behavioural Support Sub Committee.
- One resident is currently being supported by the Positive Behavioural Support Sub Committee to develop their Multi Element Positive Behaviour Plan.
- A new easy assessable behavioural support plan format has been developed for other residents, particularly to support residents who have dementia. These plans will be

reviewed with the Positive Behavioural Support committee.

- The Person in Charge will ensure that each key worker reviewed and updates each residents behavioural support plan.

**Proposed Timescale: 30/11/2016**

**Theme: Safe Services**

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

Safeguarding procedures to protect residents from financial abuse were not adequate.

The financial review carried out by the provider was not sufficiently independent or of sufficient scope to protect residents' interests.

While a plan of reimbursement had commenced, not all residents had been fully reimbursed by the time of this inspection.

The service could not demonstrate to HIQA that residents' personal monies were not used inappropriately prior to 2012/2013.

**6. 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:**

- Each resident within this Designated Centre has been reimbursed for items of expenditure made by them which was not in line with the Service Users Policy 2013 since 2012/2013 onwards.
- The Person in Charge will ensure that each staff member is inducted to the Order's policy for service user's finances. 30/10/2016
- There is a new financial review system set up and a financial review is being conducted for each resident annually.
- The Person in Charge will ensure that each resident's financial passport is updated and accurate. 30/10/2016
- Each resident's will continue to have a detailed inventory maintained of their personal belongings. Personal items are marked with discreet labels for each resident.
- The Service will complete a further comprehensive review of all residents' finances within this Designated Centre backdated to 2010 to ensure that they are in line with the Corporate Service Users Finance Policy 2013 and all recommendations and actions from this review will be actioned and fully implemented. The Service is engaging the Reviewer who has completed the Residents Finances Review which commenced in August 2015 within this Designated Centre. This review and implementation of

recommendations will be completed by 30/12/2017.

- The rationale for the decision to review resident's finances back to 2010 was based on the completion and publication of the revised HSE, Patients' Private Property Guidelines 2010.
- Should the Provider identify any irregularities regarding the use of residents personal finances during the review dating back to 2010, then the Provider will ensure that the investigation process is re-evaluated and the time frame of the review adjusted accordingly and appropriately.
- The Provider has confirmed with the Authority on 4/10/2016 that they will engage an Independent Consultant to conduct an audit of a random sample of resident's finances, for residents residing within this Designated Centre and all other Designated Centres, within St Mary's Residential Services to independently ascertain if there are incidents of residents being inappropriately charged for goods and services. This Independent Review is expected to commence in January 2017.
- This Independent Consultant will complete a random sample of residents finances within this Designated Centre backdated to 2010. 30/03/2017
- Any findings or recommendations arising from this Independent Review relating to residents living within this Designated Centre and within all Designated Centres within St Mary's Residential Services will be actioned and prioritised for full implementation. 31/07/2017

**Proposed Timescale:** 31/07/2017

#### **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:**

The provider nominee did not carry out the annual review of the quality and safety of care for the centre.

#### **7. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

- The Register Provider has nominated the Person in Charge to compile the annual review of the quality and safety of the care for the centre.

**Proposed Timescale:** 30/10/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

The numbers of staff employed in the centre were not adequate in meeting some of the assessed needs of the residents.

### **8. 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:**

- This designated centre has been prioritised as part of the De-congregation plan under the Self Supported Directed Living module. As part of this plan there will be a full review of the staffing levels, skill mix, rosters to meet the assessed needs of the residents and particularly to meet their social goals.
- 9 residents from the Designated Centre are to transition in Phase 1 of the overall De-congregation project. The two residential properties identified for these residents are in the advanced stages of purchase. The residents transitional workbooks have commenced and will be further developed as the properties are secured.
- Three additional registered nurses will be allocated to this Designated Centre to ensure continuity of care. 30/10/2016
- The roster for this Designated Centre is developed monthly by the Clinical Nurse Manager and Person in Charge
- The roster for this Designated Centre is reviewed on a weekly basis by the Person in Charge and the Manager to ensure consistency of skill mix.
- On call staff will be ring fenced for this Designated Centre to ensure greater consistency of service delivery.
- Additional measures have been put in place to address the management of absenteeism and to ensure greater stability to the workforce within this Designated Centre.

**Proposed Timescale:** 28/02/2017