

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	ORG-0011498
Centre county:	Dublin 5
Email address:	carmel.byrne@smh.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	John Birthistle
Person in charge:	Caroline Flynn
Lead inspector:	Sheila McKevitt
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	5
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 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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 02 April 2014 10:00 To: 02 April 2014 18:00

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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of the centre by the Health Information and Quality Authority (the Authority). Eight outcomes were inspected against. The centre was in compliance with two of the eight outcomes. The inspector found the management team had made some efforts to comply with The Health Act 2007 (Care and support of residents in designated centers for persons (Children and adults) with disabilities) Regulations 2013.

The person in charge and some staff are shared with the centre next door. As part of the inspection, the inspector visited the centre and met with residents and the staff members. The inspector observed practices and reviewed documentation such as personal plans, medical records and accident and incident records.

Overall the inspector found there were no immediate risks to residents. Residents' appeared well cared for and happy within the environment. Staff appeared kind and caring and provided the optimal level of care they could to residents' with the resources available to them.

The inspector found that improvements were required in six of the eight outcomes inspected against. Improvements were required in areas such as the statement of purpose, emergency plan and the risk management policy. The provision of staff training, service of food, medication management practices, use of restraint and management of challenging behaviour required review. The inspector found fire

alarm systems were not serviced in a timely manner and records, such as, pre-admission assessments, personal plans, medical and allied health care professional records were not available for each resident.

The action plans at the end of the report reflect the non compliances with regulations and standards.

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 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

Judgement:

Non Compliant - Major

Findings:

Residents did not have a comprehensive assessment completed prior to admission and did not have personal plans in place.

The inspector reviewed one resident's documentation and found that a comprehensive assessment had been completed post admission to the centre. However, this assessment did not include specific details about the individuals level of participation, needs, preferences and preferred routines. The comprehensive assessment was completed by the residents allocated key worker in the centre with the assistance of the resident and their next of kin. There was evidence of inter disciplinary team members input. For example, the speech and language therapist had assessed the resident and made recommendations about food consistency and utensils best suited to meet the residents needs. The dietician had assessed the resident and recommended a specific diet to meet the residents assessed needs.

Personal care plans had not been developed to date to reflect residents' social needs, interests, capabilities goals and aspirations. Therefore, staff did not have a specific goal to assist the resident to work towards achieving. The inspector was informed that wellbeing assessments had commenced on each resident and the inspector saw evidence that these had been completed for two residents' to date. Also, a new filing system was being introduced to assist in the organization of resident files.

Residents attended day care facilities Monday through to Friday where they had the opportunity to participate in meaningful activities. Staff assisted residents to meet their social needs at the weekends. They had access to private transport facilities to enable them to take residents out of the centre.

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

Judgement:

Non Compliant - Major

Findings:

This outcome was not fully met as some legislative requirements were not in place. However, the inspector found risks were well managed in the centre. There was a risk management policy in place, but it did not include the measures and actions in place to control the following specified risks:(i) the unexpected absence of any resident or (iv) self-harm,

Routine risk assessments were carried out in areas such as the internal and external environment and the transport bus. These were reviewed annually by the person in charge, potential risks and control measures were identified and acted upon. In addition, residents had individual risk assessments completed these highlighted any potential risk to the resident and control measures put in place to address the potential risk. For example, a risk assessment for one resident, identified the need for staff to carry a specific type of medication on the bus when this resident was a passenger. There was a health and safety statement on display in the centre, signed and dated in 2014 by the person in charge and the health and safety representative. Staff spoken with were aware of the content of the policy. A health and safety audit was conducted every three months by the clinical nurse managers who had completed training in risk management. There was a detailed computerised system in place for recording, reporting and learning from all accidents/incidents.

Fire fighting equipment and the emergency lighting had been serviced within the past year however, the fire alarm had not. Records reviewed showed a 50% service of the system was last carried out in February 2013. Staff spoken with knew the procedure to follow in the event of a fire, they had practised fire drills and records reviewed showed they had up-to-date fire training in place. There was a fire evacuation plan in place for each resident.

The emergency plan in place was not detailed enough to guide staff on the procedure to follow in the event of all possible emergencies.

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

Judgement:

Non Compliant - Major

Findings:

There were measures in place to safeguard residents and protect them from abuse. However, restrictive practices in use were not documented and individual plans to manage behaviours that were challenging were not in place. There was a policy on, and procedure in place for, the prevention, detection and response to abuse which staff were trained on. Records reviewed staff had up-to-date training in place and those spoken with had a clear understanding of the policy to be followed. There have been no notifications of abuse in this centre to date.

Residents' had intimate care plans in place. However, these lacked specific details required in order to provide appropriate care in a manner which protected the privacy and dignity of the dependent residents' living in the centre.

Each resident had a risk assessment completed for challenging behaviour which identified the individuals' signs and symptoms of challenging behaviour. The person in charge stated that completed Antecedent Behaviour Consequence (ABC) charts were sent to the senior clinical psychologist for review and care plans were based on the recommendations made. However, the inspector found ABC charts were not completed by staff, there were no records available of recommendations made by the psychologist and no corresponding care plan in place to guide staff on how to de-escalate the residents challenging behaviour. All staff had not attended refresher training on how to manage residents' who displayed challenging behaviours.

Some residents' were restrained using a number of means. For example, the inspector saw seat belts, lap straps and obstructed entry to the kitchen being used to restrain residents'. However, only some were mentioned on residents' risk assessment forms and none of the residents who were restrained had a care plan in place to reflect frequency of use, release, duration of use or review. There were no records reflecting what alternatives were tried prior to restraint being used. Staff explained that restricted entry to the kitchen was in place to prevent one resident from entering. However, the impact of this practice on the other four residents had not been considered.

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Judgement:

Non Compliant - Moderate

Findings:

The inspector was unable to determine whether residents' health care needs were being met as residents medical and inter disciplinary team records were not available for review in the centre. The inspector was informed that these were held in an office off site. The nursing care needs of residents' living in the centre were being met. Residents living in the centre required 24 hour care and a waking member of staff remained in the centre over night and whenever residents were home. One resident remained in the house throughout the inspection and was provided with 1:1 care. This was appropriate to meet the residents' needs.

The food prepared, cooked and served by staff appeared nutritious and varied. However, the manner in which food was served required improvement. The inspector observed a member of staff puree meat, vegetables and potatoes together in a bowl using a hand blender. The food looked similar in appearance to baby food, it was served to an adult resident who could not identify what the food was due to the manner in which it was served. Staff training records reviewed showed staff did not have appropriate food hygiene training in place.

Residents were involved in choosing meals at the beginning of the week. For those that were non-verbal there were some photos of meals available to them to choose from. However, this could be improved upon. Staff spoken with had a good knowledge of residents' dietary needs, likes, dislikes and consistency requirements. Snacks and drinks were available to residents' as and when requested. Staff were available to assist residents at mealtimes, the inspector observed residents' having their tea and saw sufficient quantities were available.

Outcome 12. Medication Management

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

Theme:

Health and Development

Judgement:

Non Compliant - Moderate

Findings:

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines. However, the prescribing and therefore administration practices were not in line with best practice or professional guidance.

The practices observed in relation to ordering, storing and disposal of medication were in line with the centres policies and best practice. There was a safe system in place for the ordering and disposal of medications and the inspector saw records which showed that all medications brought into and out of the centre were checked by two staff. An audit of each residents' medications was completed on a weekly basis by two staff, any discrepancies were identified and reported to the service managers by completion of a error form. This was reviewed and recommendations made were fed back to the clinical nurse managers who were given a set period of time to implement the recommendations made.

The prescribing of medications was not in line with best practice and therefore nurses could not administer medications in line with Guidance to Nurses and Midwives on Medication Management (July 2007). For example, nurses could not ensure the right time, as the frequency was not included in the prescription.

Resident medication prescription charts were reviewed and the findings were as follows:

- the residents General Practitioner (GP) name was not identified on the chart
- the name of the centre was not always identified on the chart
- the signature of the medication prescriber a Medical Officer (MO) was not original, it was a faxed signature
- the first name of medical officers only appeared on a number of the prescription charts.
- the frequency that each medication was to be administered was not written on the charts
- each medication that was required to be crushed in order to be administered was not prescribed as crushed.
- there was no maximum dose prescribed for as needed (PRN) medications.

Social care workers had Safe Administration Medication (SAM) training in place and the policy indicated that they were covered to administer PRN medications only.

In addition, there were no records available to show that all residents' medications were reviewed on a regular consistent basis by their GP. Some residents had a large number of PRN medications written up for a long period of time. For example, one resident had nine PRN medications prescribed, one of which had been prescribed in 2005 for administration pre-dental care.

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

Judgement:

Non Compliant - Moderate

Findings:

There was a written statement of purpose available. However, it did not accurately reflect all the services and facilities provided in the centre and it did not contain some of the information as required in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013.

For example, it did not reflect information regarding the following:

- 2.(a) the specific care and support needs that the designated centre is intended to meet;
 - (b) the facilities which are to be provided by the registered provider to meet those care and support needs;
 - (c) the services which are to be provided by the registered provider to meet those care and support needs; and
 - (d) criteria used for admission to the designated centre, including the designated centre's policy and procedures (if any) for emergency admissions
3. The number, age range and gender of the residents for whom it is intended that accommodation should be provided
 5. Any separate facilities for day care
 7. The organisational structure of the designated centre
 8. The arrangements made for dealing with reviews and development of a resident's personal plan
 9. Details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision
 11. The arrangements for residents to engage in social activities, hobbies and leisure interests
 12. The arrangements for residents to access education, training and employment.

Its content was known by staff and a copy was available to them. However, it was not available in a format that was accessible to residents and a copy had not been made available to residents' representatives.

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

Judgement:

Compliant

Findings:

There was a clearly defined management structure that identified the lines of authority and accountability. The centre was managed by a suitably qualified, skilled and experienced Clinical Nurse Manager 2 (CNM2) with authority, accountability and responsibility for the provision of the service. She was the named Person in Charge (PIC), employed fulltime, spending .5 of her time in the centre and the other .5 in the centre situated directly next door. The inspector observed that she was involved in the governance, operational management and administration of the centre on a regular and consistent basis. Residents knew her well.

During the inspection she demonstrated sufficient knowledge of the legislation and her statutory responsibilities. Records confirmed that she was committed to her own professional development. She was supported in her role within the centre by a Clinical Nurse Manager 1 (CNM1). She reported directly to a Service Manager who reported to a Regional Director (also nominated person on behalf of the provider). The PIC and CNM1 had regular scheduled minutes meetings with the service manager and the nominated person on behalf of the provider attended the centre approximately once per month.

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

Judgement:

Compliant

Findings:

There were appropriate staff numbers and skill mix available to meet the assessed needs of residents and the safe delivery of services at the time of inspection. Residents received continuity of care as permanent staff covered vacant shifts and as much as possible regular agency staff were requested to work in the centre. The planned staff roster was reviewed and reflected this.

Staff confirmed and records showed staff had access to education and training to meet the needs of residents. Staff had up-to-date mandatory training in place. Those spoken with were confident regarding the procedure to follow in the event of a fire and in the event that they witnessed any form of abuse to a resident. The inspector saw evidence that refresher training for staff covering response to behaviour that maybe challenging was planned for the month of April.

The inspector observed that all staff, including agency staff were supervised according to their role and each resident was allocated two staff as key workers. There were no volunteers working in the centre. The provider had ensured that there were robust recruitment processes in place and that staff employed in the centre were suitable to work with vulnerable adults. Two recruitment files reviewed contained all the documents outlined in schedule 2. All staff nurses had an up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (The Nursing and Midwifery Board of Ireland or NMBI).

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Sheila McEvitt
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 Michael's House
Centre ID:	ORG-0011498
Date of Inspection:	02 April 2014
Date of response:	21 May 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

There was no evidence that a comprehensive assessment was completed on each resident prior to their admission to the centre.

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:

All residents had an assessment carried out prior to there admission irrespective of

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

when they were admitted and all documentation relevant to these admissions irrespective of when they were admitted will available on site.

Proposed Timescale: 04/07/2014

Theme: Effective Services

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

Residents did not have personal plans in place.

Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

Care plans are in place for all of the residents in the centre and personal plans will be further developed in conjunction with outcomes highlighted from the well being outcome review.

Person Responsible: Person in charge

Proposed Timescale: 30/07/2014

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:

There was no procedure outlined to guide staff on how to respond to emergencies.

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:

A procedure for responding to emergencies was further developed and implemented on 25th April 2014.

The procedure for responding to emergencies has been discussed individually with all staff and will be circulated and discussed with all staff at the staff meeting on 5th June 2014.

The procedure responding to emergencies will be circulated to all personnel involved in responding to any emergency by 16th May 2014.

The procedure for responding to emergencies was discussed with residents at the house meeting on 12th May 2014.

Families have been informed by letter from the person in charge of the procedure responding to emergencies on 12th May 2014.

The procedure will be updated as necessary and reviewed annually.

Person responsible for communicating the plan for responding to emergencies: Person in Charge

Proposed Timescale: 06/06/2014

Theme: Effective Services

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

The risk management policy did not include the measures and actions in place to control the specified risk of the unexpected absence of any resident.

Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

A procedure for responding to the unexpected absence of a resident from the centre was developed and implemented on 25th April 2014.

The procedure for responding to the unexpected absence of a resident has been discussed individually with all staff and will be circulated and discussed with all staff at the staff meeting on 5th June 2014.

The procedure responding to the unexpected absence of a resident was circulated to all personnel involved in responding to the unexpected absence of a resident including Nurse Manager on Call, Staff at The Laurels on 16th May 2014.

The procedure for responding to the unexpected absence of a resident was discussed with residents at the house meeting on 12th May 2014.

Families have been informed of the procedure responding to the unexpected absence of a resident by person in charge on 12th May 2014.

The procedure will be updated as necessary and reviewed annually.

Person responsible for communicating the plan for responding to the unexpected absence of a resident: Person in Charge

Proposed Timescale: 06/06/2014

Theme: Effective Services

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

The risk management policy did not include the measures and actions in place to control self harm.

Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

A resident who presents with self harm tendencies will have a comprehensive assessment done with the psychologist and staff team. Their positive behaviour support plan will reflect a management strategy to deal with this behaviour should it arise.

Person responsible for this: Person in Charge

Proposed Timescale: 04/07/2014

Theme: Effective Services

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

Records showed the fire alarm had not been tested by professionals in over one year.

Action Required:

Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

Records of fire alarm testing and servicing in September 2013 and February 2014 were sourced on 9/5/2014 and are kept on site . St Michael's House contracts the monitoring, servicing and maintenance of the fire equipment to reputable external contractor. Staff in the centre have been informed by the person in charge that if they are on duty when the fire alarm testing and servicing takes place that they also co-sign the records with the technician. The person in charge will contact the external contractor to schedule a full servicing of fire equipment in September 2014

Person responsible: Person in charge.

Proposed Timescale: 30/09/2014

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:

Staff did not have up-to-date training to enable them to manage behaviour that is challenging including de-escalation and intervention techniques.

Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

All staff had attended the mandatory challenging behaviour training and therapeutic management of aggressive and violent behaviour.

The person in charge will schedule all staff to attend the Positive Behaviour Support Training programme run in conjunction with the Open Training College. The training programme will allow for 5 staff to attend throughout 2014, this commenced on 16th April 2014 and will be completed on 20th December 2014 , remaining 5 staff will complete this training by 30th December 2015.

Person responsible: Person in charge

Proposed Timescale: 30/01/2015

Theme: Safe Services

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

Records did not reflect what if any alternative measures were considered before a restrictive device was used.

Action Required:

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

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

Risk assessments will be carried out and alternative options explored. Positive Approaches Monitoring Group will be informed of findings, information regarding the other resident's capabilities and needs will be included and issues addressed immediately.

Person responsible: Person in charge

Proposed Timescale: 04/07/2014

Theme: Safe Services

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

The use of therapeutic measures used to address behaviours that are challenging were not identified in residents' personal plan.

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:

Currently all therapeutic interventions are agreed and reviewed with relevant clinicians. The person in charge will ensure that the use of therapeutic measures used to address behaviours that are challenging will be included in resident's personal plans. As previously outlined under (Outcome 5: Social Care Needs) each resident will have a well being review completed by July 30th 2014 and a plan to support the person will be developed. This plan will include all necessary details of therapeutic interventions if they are in place.

Person responsible: Person in charge

Proposed Timescale: 30/07/2014

Theme: Safe Services

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

The personal intimate care plans in place for residents' were not detailed enough to ensure residents who require such assistance do so in a manner that respects the resident's dignity and bodily integrity.

Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

Individual Intimate Care Plans are in place. The person in charge will ensure these intimate care plans are updated to include specific information required to be compliant with the regulations. The language used will be reviewed to ensure it is appropriate. The person in charge will review all aspects of these care plans bi-monthly.

Person responsible: Person in charge

Proposed Timescale: 15/06/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

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

This could not be determined as resident medical and allied health care records were not kept in the centre.

Action Required:

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

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

The centre recently implemented a new recording system for service users information. The new system includes recording of all relevant information on individual clinical recording sheets, these include records from medical and allied health care professionals.

Person responsible: Person in Charge

Proposed Timescale: 01/05/2014

Theme: Health and Development

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

Staff did not have up-to-date food hygiene training in place.

Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

All staff have completed Food Hygiene training and records are available for review. Refresher training has been requested to the Training Dept.

Training records show that staff received 'food safety for food handlers' training in early 2011. Refresher training has been requested to the Training Department. Refresher training requirements are under review as part of updating of the Foods Safety Manual. The Food Safety Manual provides guidelines on safe food handling which has been developed by St Michaels House Health and Safety Manager in consultation with Environmental Health Officers.

Proposed Timescale: 30/08/2014

Theme: Health and Development

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

Modified diets were not served in an appropriate appetising manner.

Action Required:

Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

New equipment has been procured for appropriate blending and storage of individual foods. All staff have been made aware of the guidelines and good practice in food preparation and presentation by the person in charge at a staff meeting on 12/5/2014

Person responsible: Person in charge

Proposed Timescale: 12/05/2014

Outcome 12. Medication Management

Theme: Health and Development

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

Medication prescriptions were not completed in accordance with best practice.

Action Required:

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

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

The person in charge has been advised by the Director of Psychiatry and the Head of the Medical Department that they are developing an organisational prescribing policy and the organisation's Medication Administration Group are also developing a policy for service users being referred to hospital/external providers and their medication reconciliation.

Proposed Timescale: 30/08/2014

Theme: Health and Development

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

Medication administration was not in line with professional guidance as medication prescriptions were not completed accurately.

Action Required:

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

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

The policies referred to above will support the accurate administration of medication. The person in charge will implement these policies and provide the relevant training to the staff to ensure that medication is administered as prescribed.

Proposed Timescale: 30/09/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not reflect the services, facilities and all the requirements outlined in Schedule 1.

Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Statement of purpose will be reviewed to ensure it meets regulatory requirements.
Person responsible: Person in charge

Proposed Timescale: 30/06/2014

Theme: Leadership, Governance and Management

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

A copy of the statement of purpose was not available to residents and their representatives.

Action Required:

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

Statement of purpose to be made available to residents and their representatives.

The statement of purpose will be updated and then discussed with residents at a house meeting on 7th August 2014

Photographs and symbols will be used to help residents understand the statement of purpose.

A copy of the statement of purpose will be circulated to family members.

The statement of purpose will be available in the centre for residents to view by the above date.

Person responsible: Person in Charge.

Proposed Timescale: 07/08/2014