Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	ORG-0008515
Centre county:	Dublin 5
Email address:	eamon.delacey@smh.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	John Birthistle
Person in charge:	Emma Gaskin
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	6
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:	To:
14 April 2014 11:30	14 April 2014 17:00

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first inspection of this six bed centre for persons with disabilities within a community setting. The purpose of the inspection was to assess the level of compliance with the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013 and the standard of care delivered to residents in the facility.

This centre forms part of a number of diverse service to persons with disabilities delivered by the provider St Michaels House Group and are considered to meet the criteria for registration as a designated service under the Health Act 2007.

The inspection was announced and took place over one day. As part of the process the inspector met with the person in charge, the services manager, staff, and residents. The provider nominee was not present during the inspection. The inspector observed practices and reviewed documentation such as clinical care records, policies and procedures and rosters.

Promotion of independence and facilitation of individual choice was encouraged and supported by staff within an atmosphere of cheerful domesticity.Throughout the visit it was noted that care was provided in a low key respectful manner which met

service users' needs.

The findings from this inspection are detailed under each outcome in this report, in general evidence of good standards of practice were found although improvements were noted to be required in some aspects of service delivery such as; suitable premises, risk management, policies and procedures and use of resources. Where non compliances are identified an action plan is included under each outcome and identifies areas where improvements are required to comply with the regulations and Authority's 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 - Moderate

Findings:
Overall there was evidence that resident's wellbeing and welfare was being maintained by a good standard of evidence-based care and support Comprehensive personal plans that identified the supports to be provided to maximise each resident's abilities to achieve their potential for personal development in all spheres of daily life such as personal, social, health and education, although not completed in respect of every person, were found to have commenced.

On a sample of personal plans reviewed it was found that resident's were involved to the extent that they were consulted in relation to their wishes and preferences from the perspective of social needs relating to family and community based contacts visits and outings. Although most of those viewed were still being planned and not completed it was found that they were moving to an outcome rather than activity based focus to promote independence and life skills maintenance or development. One completed plan focused on managing an identified fear of one person which was having a serious negative impact on the person's ability to socialise in the community. The plan identified the goal (to reduce anxiety and manage the fear) and detailed four key stages which were interlinked to form a pattern of familiarisation. Each stage involved certain criteria

for success and these were reviewed to determine the appropriate time to introduce the next stage

However, on review of a small sample of clinical documentation, it was found that arrangements to meet each resident's assessed needs, primarily in relation to healthcare needs, were not set out in a personal plan that reflected needs, interests and capacities. A care planning system which ensures the comprehensive assessment of every identified healthcare need and includes the implementation of evidence based care protocols to manage those needs with ongoing review as required to reflect changes was not established. Examples included the management of epilepsy and dysphagia which were discussed with the person in charge. Other risks associated with absence of a comprehensive assessment and care planning process and found on this inspection related to the lack of a complete record of all medical nursing or allied assessments interventions or recommendations which together would provide an up to date picture of the persons overall medical, nursing, social or psychiatric condition.Where plans to manage needs were in place evidence of reviews to determine their effectiveness was not available.

Some opportunities for education, training and development were provided in that the majority of residents were attending day services to maintain and develop life skills.

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Findings:
All lines of enquiry were not reviewed on this inspection. In general the design and layout of the centre were found to be adequate for its stated purpose and appeared to meet the needs of the current profile of residents. The centre was bright and spacious, visibly clean and clutter free. Equipment was stored appropriately and decor, furnishings and fittings were comfortable and homely.

However, it was noted that the centre required to be refurbished and maintenance to improve the general appearance and to ensure safe and appropriate health and safety processes including infection prevention and control were required. Specifically, the entire kitchen area requires to be refurbished with laminate peeling from doors, cupboards and drawers not closing properly. Also all wooden surrounds in the centre were showing signs of wear and tear with chipped, torn and exposed skirting and door frames.

Although each bedroom was personalised with pictures and personal objects and efforts by staff to promote individualisation in terms of colour schemes were noted, most required to be repainted.

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 - Moderate

Findings:
Although all aspects of the lines of enquiry for this outcome were not reviewed on this visit it was found that in general the health and safety of residents, visitors and staff was promoted and protected in that policies and procedures for risk management and health and safety were available and staff were aware of them.

A health and safety statement was in place however, the statement was not specific to the centre but related to the corporate organisation of St Michael's House Group, an extensive organisation which provides a variety of services to persons with disabilities, this statement had not been revised since 2009. It was found that hazard identifications and assessments were carried out annually as part of health & safety practices to manage risks related to the physical environment, biological, chemical and human errors. Many of the policies and procedures in place were found to be non specific such as the missing persons policy and require to be improved this is also referenced under Outcome 18.

A centre specific emergency plan was not in place. A generic fire evacuation plan was available but was not sufficiently specific to guide staff on the resources or arrangements in place to provide supports and back up in the event of such an emergency.

Regular fire drills practices were conducted by staff with the support and involvement of residents both day and night to ensure familiarity with the procedures for evacuation and the inspector was told that staff received regular fire safety and fire drill training, and some records to evidence this training were provided.

There were two staff on duty each night, one person on 'live' night duty and the other on 'sleepover', this mitigated any potential risks raised by the lack of specific back up resources and specific guidance available to both staff and service users. Directional signage to the front and back entrance of the house was in place and both exits were clear. Fire equipment and alarms were tested and arrangements were in place for the maintenance of the fire alarm system and equipment within this centre.

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 - Moderate

Findings:
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. In conversation with some staff members, the inspector found they were competent in their knowledge regarding reporting mechanisms within the centre and what to do in the event of a disclosure about actual, alleged or suspected abuse. Residents were observed to be comfortable with staff and did not exhibit behaviours associated with distress or anxiety.

Overall a restraint-free environment was found to be promoted within the centre, behavioural supports to manage behaviour that challenges were not observed during this inspection. Restrictive measures such as use of bed rails and lap belts were noted to be in use for some residents, specifically those persons with balance or sitting difficulties who were full time wheelchair users. In conversation with nursing staff and the person in charge it was found that alternative, less restrictive measures were in place for some residents such as crash mats or posey bed alarms were in place. Other methods to promote independence whilst maintaining safety were also found to be in use such as audio and visual monitors. These monitors were in place in service user's bedrooms and were considered to form part of the positive behavioural supports employed in the centre to manage behaviours that challenge in a restraint free manner. However the use of these monitors were not covered by a policy and could constitute an abuse of the residents rights to privacy and dignity. This is referenced again under outcome 18 further in this report.

However some restrictive practices were found to be in place and were found to have negative impacts on other service users and not just the individual for whom they were intended.Examples included the use of physical restraint on one person during the provision of assistance with activities of daily living (ADL's). The restraint involves hand holding by staff. The inspector was informed that the restraint was not employed in all ADL's and that the practice has been reviewed and forwarded to the 'positive approaches committee', for 'sanction'.

It was also found that residents were restricted from gaining access to all rooms in their

home. In order to limit the potential for behaviours which could possibly be self injurious, bedrooms, kitchen and office doors were locked on occasion however, documentation referencing the need for restrictive practices did not always identify whether alternative, less restrictive measures were considered or trialled prior to the use of these methods, or whether the least restrictive procedure used for the shortest duration possible.

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

Theme:
Health and Development

Judgement:
Compliant

Findings:
Residents had access to medical services. Some evidence of access to specialist and allied health care services to meet the diverse care needs of residents such as opticians, dentists and chiropody services was found on a review of some clinical documentation, although it was found that all information in relation to reviews of residents health status by medical officers or palliative care specialists, speech and language, physiotherapy and dietician services was not held in the centre, this is further referenced under outcome 18 of this report.

Residents were provided with food and drink at times and in quantities adequate for their needs. As the inspector was concluding the visit, residents were returning home. Each was offered a cup of tea and light snack whilst waiting on their evening meal and where assistance was required it was offered in a discreet and sensitive manner. All meals were prepared in the centre and residents were encouraged to be involved in the preparation of evening meals in the centre as appropriate to their ability and preference and were observed assisting staff to lay the table with serviettes and condiments.

Menus were displayed in word and pictorial format and were compiled with consideration of the preferences and nutritional needs of each resident. Drinks such as juices, milk, tea and coffee were freely available and there were ample stocks of fresh food and larder stores to facilitate snacks or meal alternatives as required.

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:
Evidence that the processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation were not found and robust systems were not in place for reviewing and monitoring safe medication practices.

There were written operational policies relating to the disposal of medications and self administration but policies for ordering, prescribing, storing and administration of medicines were not available and it was found that prescribing and administration or checking practices were not in line with best practice or professional guidance.

Issues in relation to prescribing practices included;
- each person's General Practitioner (GP) name was not identified on the chart
- the signature of the medication prescriber a Medical Officer (MO) was not original,
- there was no maximum dose prescribed for PRN medications.

Administration practices were not in line with professional guidance as staff were not administering from an original prescription or from a prescription sheet with an original signature.

The inspector was informed that checking processes were in place for the receipt disposal and storage of drugs and in particular for those classified as MDA drugs requiring stricter controls. Some medications were classified as MDA 2 or 3 drugs and therefore stock controls required to be monitored closely and frequently on either a weekly or monthly basis.

On review of the records the inspector noted that there were discrepancies in the recording of some medications which related to a lack of consistency in the checking process, for example, the centre policy (confirmed verbally by a senior nurse manager with the person in charge) stated the checks were to be conducted weekly, yet this was not always implemented in practice; loose sheaf pre printed forms were used to document the checks, which were then filed in a document folder. However, in relation to checks on a specific medication for one resident records between January and July 2013 could not be located; the pre printed checking template was not always fully completed. Furthermore, on checking the actual medication to ensure the actual number matched the recorded number, it was noted that the expiry date on the foil container had been cut off and the medication was not in a container which identified the expiry date.

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:
A written statement of purpose was available which broadly reflected the service provided in the centre. On review it was found that some improvements were required to ensure the document contained all of the information required by Schedule 1 of the Regulations.

The following Information requires to be included in the statement of purpose;
- the specific care and support needs the centre intends to meet
- range of needs and the facilities and services available to meet those needs
- criteria used for admission including policy and procedures for emergency admissions
- the arrangements for residents to access education, training and employment.

It was also noted that aspects of resident's and staff personal information was included in the document and represents a potential breach of their privacy, dignity and rights to protection of confidentiality under the Data Protection Act 1988 & 2003

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:
All lines of enquiry in relation to this outcome were not reviewed on this inspection and concentrated primarily on governance and management of the centre and not on the

broader governance of the service by St Michael's Group.

The inspector formed the view that within the centre there was evidence of good management systems to support and promote the delivery of safe care services however, this centre formed part of a larger service provider with a complex management structure and associated levels and lines of authority and accountability. These lines of accountability were not clear to inspectors. Additionally, the person in charge and service manager referred to other people with responsibility for clinical governance that they report to or relied upon for support.

The centre was managed by a full time experienced person in charge who along with other staff displayed knowledge and interest in all of the residents. They were familiar with each of the long stay resident's personal social medical and clinical interests, background, history and current status. All resident's were familiar with all staff on duty on the day of the visit on sight, those who could communicate verbally called them by name and observation of communication between staff and service users both verbally and through body language displayed warm and mutually respectful and caring interpersonal relationships.

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:
Non Compliant - Moderate

Findings:
It was found that at the time of this inspection, the levels and skill mix of staff were sufficient to meet the needs of residents and staff were supervised appropriate to their role. Two staff were rostered at all times, one of whom was a registered nurse which provided opportunities for staff supervision and guidance of practice however, it was noted that the person in charge has limited management time available each week outside of the clinical 'rostered' duty role to plan for the safe effective delivery of care to service users.

The inspector observed staff and residents interactions and found that staff were respectful, patient and attentive to residents needs. It was noted that staff provided reassurance to residents by delivering care to them in a quiet confident manner.

A sample of training records indicated that staff had received training in all required mandatory areas, fire safety, moving and handling and prevention of abuse.

A sample of staff files were reviewed and the majority were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013. However, some improvements were found to be required, evidence of identity including a recent photograph appropriate vetting and two written references were not available for all staff

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Judgement:
Non Compliant - Moderate

Findings:
Although not all records were reviewed on this inspection, it was found that general records as required under Schedule 4 of the Regulations were maintained including key records such as, accident and incidents, nursing and medical records. All records required under Schedule 3 of the Regulations were maintained in the centre however, further improvements were required in respect of maintaining clinical records in accordance with professional standards and establishing a comprehensive care planning system to ensure care needs were appropriately and regularly assessed managed and reviewed. This is referenced in detail under Outcome 5 of this report.

All of the written operational policies as required by Schedule 5 of the Regulations were not available such as emergency admissions policy. Policies including health and safety and risk management policies and missing persons' policy were available and were reviewed. However, these policies required to be revised to ensure they gave sufficient guidance to staff, reflected evidence-based practice and meet the requirements of the regulations in particular the medication management policies, risk management and health and safety as previously detailed under Outcome 7 and 12 in this report.

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:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	ORG-0008515
Date of Inspection:	14 April 2014
Date of response:	16 July 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:
The arrangements to meet each resident's assessed needs, primarily in relation to healthcare needs were not set out in a personal plan that reflected needs, interests and capacities

Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The CNM 2 (PIC) and her staff team are in the process of completing an Assessment of Needs and a Care Plan for each resident. Following on from this the Allied Health

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

Professionals will assess each resident as appropriate in line with each resident's individual needs.

A new system has been put in place to store and manage clinical records. All available appropriate clinical reports have been copied into these files and are now available in the unit. These files will be updated and reviewed regularly by the CNM 2 & her staff team when a resident has a clinical appointment.

An individual personal plan for each resident was commenced in February 2014. There are five stages in the individual planning process in SMH.
These are: information gathering using 23 personal outcome measures.
Identify priority outcomes and set goals.
Individual planning meeting.
Work towards the goals.
Review.
The individual plans for all residents are currently at the individual planning meeting (stage 3) or work toward the goals (stage 4).
The goals will be worked on over the remaining course of the year (2014)
A review will take place in the last quarter of the year to determine the effectiveness of the plan.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment of the identified healthcare needs of all residents with ongoing review as required to reflect changes was not in place

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
A comprehensive assessment of need will be used to assess each resident, and will be implemented, with an annual review or more frequently when required.

An assessment of needs will be developed and carried out on each resident. A care plan will be developed to identify how the assessed needs will be met.

Proposed Timescale: 31/08/2014

Theme: Effective Services

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

Ongoing review of personal plans as required to reflect changes was not in place

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
Current plans will be reviewed and updated with each resident, to reflect the residents needs and changes in circumstances.

An individual plan will be in place by 30th June for each resident.
Residents will have their plan reviewed 6 months after its development or sooner if their needs/ circumstances change.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Where plans to manage needs were in place evidence of reviews to determine their effectiveness was not available.

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

Please state the actions you have taken or are planning to take:
The plans will be reviewed annually or more often as required to assess how effective each plan is and alter the plan to reflect the residents changing needs.

An individual plan will be in place by 30th June for each resident.
Residents will have their plan reviewed 6 months after its development or sooner if their needs/ circumstances change.

Proposed Timescale: 30/06/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A maintenance programme for the centre is required to improve the general appearance and to ensure safe and appropriate health and safety processes including infection prevention and control were required.

Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
The main kitchen area was due to be refurbished at the time of inspection. Counters and panelling have been replaced. A request to the technical services department in SMH was sent on 14/5/14 to have the kitchen and rest of the house repainted and the doors and skirting boards that require repair to be done.
Kitchen refurbishment completed.

Proposed Timescale: 16/07/2014

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:
The Risk Policies and processes in place were not sufficiently specific to guide staff in the event of an emergency. The fire evacuation plan in place was generic and health and safety statements and processes were not specific to the centre and were last reviewed in 2009.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The CNM 2 (Person in charge)has completed a unit specific Health and Safety Statement. All staff will familiarise themselves with this policy and sign off on having read this by the 30th June 2014.

The CNM 2 has developed a centre specific fire evacuation plan . All staff will be fully appraised of the plan and will have fully signed off on having familiarised themselves with the content of this plan by 30th June 2014.

The CNM 2 has developed an Emergency Plan . All staff will be fully appriased of the plan and will have fully signed off on having familiarised themselves with the content of this plan by 30th June 2014. The plan includes procedures for the emergency evacuation of the house and provides for an emergency alternative location.

A policy to guide staff in the event of a resident missing has been written by the CNM 2 & is in place. All staff will be appraised of the policy and signed off by all staff by June 30th 2014. The policy will be related to individual risk assessments.

Hazard identification will be carried out monthly by the CNM2/CNM1 to identify and

manage risks associated with the physical environment, biological, chemical and human errors.

A centre specific emergency plan will be drawn up and implemented.
Individual fire evacuation plans for each resident are in place, a unit specific evacuation plan will be drawn up and implemented.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A centre specific emergency plan was not in place.

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 centre specific emergency plan with regards to a missing person, evacuation in case of fire/flood/power shortage, will be drawn up and implemented.

Proposed Timescale: 30/06/2014

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:
Documentation referencing the need for restrictive practices did not always identify whether alternative, less restrictive measures were considered or trialled prior to the use of these methods, or whether the least restrictive procedure was used for the shortest duration possible.

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:
In conjunction with the CNM 2 (PIC) appropriate Clinicians from the Positive Approaches Monitoring Group have been assigned by the Clinic Manager to carry out a review of all restrictive practices. When these reviews are complete all guidelines pertaining to each restrictive practice will be forwarded for approval to the full Positive Approaches Monitoring Group Committee to be reviewed and updated as defined by

this group, i.e. quarterly, every six Months or yearly. These Clinicians from PAMG will also advice and educate the (PIC) on less restrictive alternatives to be implemented.

The person in charge will contact the positive approaches committee to get support to assess and review the current restrictive practices and to assist in identifying alternative less restrictive measures.

Proposed Timescale: 30/09/2014

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
However the use of monitors in place were not covered by a policy and could consitute an abuse of the residents rights to privacy and dignity.

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

Please state the actions you have taken or are planning to take:
The CNM 2 (PIC) will be assisted by members of the Positive Approaches Monitoring Group to review the Monitor that is in place and provide advice and education on less restrictive alternatives.

Proposed Timescale: 30/09/2014

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:
Processes in place to ensure appropriate practices were in place for the prescribing and administration or checking of medication were not in line with best practice or professional guidance.

Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
The Director of Psychiatry and the Head of the Medical Department have advised the CNM 2 (PIC) that they are developing an organizational prescribing policy. The Organization's Medication Administration Group will develop a policy for service users

being referred to hospital/external providers. This will assist with their medication reconciliation. The policy referred to above will support the accurate administration of medication. The CNM 2 (PIc) will implement these policies and request the relevant Safe Administration of medication training for all staff to ensure that medication is administered as prescribed. This policy will address all of the issues that have been identified in the HIQA report. The CNM 2 (PIC) will discuss with the Head of the Medical Department the appropriate protocol for the recording of controlled drugs and this will be in line with best practice as per the An Bord Altranas guidelines.

1). The nurse on duty orders Prescriptions every three months from the residents G.P. A copy of the GMS prescription is taken and filed into a logbook for prescriptions received.
The GMS prescription is given to the pharmacy and held on file for three months.
The medications are requested for one month on the last week of each month to be delivered to the house.
On delivery of the medications they are audited for each individual resident on a single individual audit form. These are then filed once they are completely filled.
The mda drugs are audited weekly by two staff members and signed by two staff on a Sunday evening.
Disposal of medication will be carried out and signed for by two staff, as per Organisational Policy. Medication is disposed into the clinical waste bin and collected by a waste management company every quarter.
The staff and pharmacy have been advised to ensure that expiry dates are not cut off the original blister packs that the medication came in.
Medication without a visible expiry date has been disposed off.
There will be an updated organisational policy for the safe administration of medication, and for storing, auditing and disposal of medications.

2) I requested the service users prescriptions to reflect the maximum dose for each prn medication, and to identify the service users G.P.

3) The prescribing of medication is an Organisational issue that will be addressed soon.

No. 1 was addressed and implemented on 15/4/14.

No. 2 has been highlighted with the medical department on 21/5/14 & it is envisaged that it will be addressed by the 30/06/14.

No 3. It is envisaged that it will be addressed by the 30/06/14.

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 following Information requires to be included in the statement of purpose;
- the specific care and support needs the centre intends to meet
-range of needs and the facilities and services available to meet those needs
- criteria used for admission including policy and procedures for emergency admissions
- the arrangements for residents to access education, training and employment.

It was also noted that aspects of resident's and staff personal information was included in the document and represents a potential breach of their privacy, dignity and rights to protection of confidentiality under the Data Protection Act 1988 & 2003

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:
The statement of purpose will be amended accordingly and will be updated to reflect the feedback in the inspection report.

Proposed Timescale: 30/06/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All of the requirements of Schedule 2 were not available such as evidence of identity including a recent photograph appropriate vetting and two written references were not available for all staff

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

Please state the actions you have taken or are planning to take:
The person in charge has requested that all staff submit the required documentation to the HR department. The HR department will review individual staff members HR files to ensure they are in compliance with the regulations.

Proposed Timescale: 30/06/2014

Outcome 18: Records and documentation

Theme: Use of Information

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

All of the written operational policies as required by Schedule 5 of the Regulations were not available.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
The CNM 2 is in the process of completing a statement of needs and a care plan for each resident. The CNM 2 from the date of completion will review this annually.

The CNM 2 will ensure that a report of all clinical appointments will be written up by the relevant clinical disciplines and a copy will be placed in the residents file.
St. Michael's House is reviewing all organisational policies to ensure the required policies are written, adopted and implemented in the organisation.

Proposed Timescale: 30/09/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some policies required to be revised to ensure they gave sufficient guidance to staff, reflected evidence-based practice and meet the requirements of the regulations in particular the missing persons policy, medication management policies, risk management and health and safety polices.

Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The CNM 2 will write up a specific emergency admissions policy where a vacancy should arise and if there is a need for clients to avail of emergency respite. The CNM 2 will review this policy if and when a client leave or avails of respite.

Please see responses to actions under outcome 7 and outcome 12 of this report in relation to operational policies as required by Schedule 5 of the regulations.

Proposed Timescale: 30/09/2014