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:	OSV-0002388
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	John Birthistle
Lead inspector:	Bronagh Gibson
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, 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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 October 2014 09:30	23 October 2014 17:30
24 October 2014 10:30	24 October 2014 12:30

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 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 Authority. The purpose of this inspection was to monitor on-going regulatory compliance.

The centre was a purpose-built premises located in a large town in north county Dublin. The statement of purpose and function stated that the centre's primary function was to provide a respite service to boys and girls aged between zero and 18 years with an intellectual and or physical disability who may have a wide range of needs including complex medical needs. It also stated that the centre provided a combination of respite (4.5 placements) and residential care (1.5 placements).

As part of the inspection, inspectors met with the service manager for the north east region of the parent organisation who was the line manager of the designated person in charge, the clinical nurse manager two (CNM2) who was the designated person in charge and the clinical nurse manager one (CNM1) who supported the CNM2 in the day to day running of the centre. Inspectors walked around and observed the premises and reviewed policies, procedures, children's and staff files and centre documents and reports.

The centre provided a respite service for 145 children, full time residential care to one young person who had recently turned 18 years of age, and part time residential care to one another. There were five children in the centre at the time of the

inspection. Inspectors found that they were well cared for and the majority attended school. One young person did not have a day service but there was an activity programme in place until s/he moved on to adult services.

Inspectors found that the premises was fit for purpose, but there were two immediate actions for the centre due to unsecured rubber gloves and plastic bags located around the centre and children's case files were found to be stored in an unsecured garden shed. The person in charge was found to be suitably qualified and experienced to manage the centre, but required support to fulfill the role of person in charge. This included continuing professional development, adequate and sustainable management arrangements and sufficient staffing resources.

The statement of purpose and function was in draft form and did not meet the requirements under the regulations. The centre was operating outside of its stated purpose and function.

Policies were generic and applicable to all services provided by the St Michael's Group and required supplementing by local procedures to implement them in a centre specific way.

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):
This was the centre's first inspection by the Authority.

Findings:
The centre staff assessed the basic needs of children it catered for and made efforts to meet these needs, but this was not possible due to the combination of respite and long-term residential placements it provided. In addition, one young person was over 18 years of age and required a long-term placement with adult disability services. Individual plans were in place for young people availing of the residential element of the service. These plans were in the process of being adapted and implemented for children receiving a respite service.

There was a process in place to assess the medical, social and educational needs of children on admission to the centre for respite care. Records showed that this information was recorded on a standardised template. The assessment process considered input and reports from parents/guardians, school and other professionals but did not result in a formal needs or risk assessment on admission. There was also a consultative process in place to identify any changing needs as children transitioned in and out of the centre. Inspectors were provided with a copy of the respite admission checklist that was completed at the time of each child's admission for a respite break. Completed checklists reviewed by inspectors showed that this process indicated potential risks, medication, behavioural and communication needs, but as it was a checklist, it did not contain much detail.

There was an organisational policy and procedure in place for the development of individual plans but these plans were not in place for children availing of the respite service. The requirement for improvement in this area was identified by the centre managers and they told inspectors that individual plans (wellbeing reports) currently in place for children in long-term placements were being adapted to suit children on

respite breaks. The CNM2 said that these would be fully implemented for all children by December 2014. Each child had an individual educational plan developed by their school that identified their educational needs. These were provided to the centre. Case files showed that children had plans to manage their behaviour if required.

One young person living in the centre on a full-time basis had recently turned 18 years of age. This young person was in the care of the state prior to their 18th birthday and records showed that s/he had a statutory care plan that was reviewed in line with legislation. This young person's file also showed that there was a written plan to transition them to an adult disability service, and although the service was identified a placement was not yet available. The service manager told inspectors that although this young person was prioritised for the next available placement, there was no indication of when this would be.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
The health and safety of children, visitors and staff was promoted but required improvement.

The centre had a number of organisational policies and procedures in place related to the promotion of the health and safety of children, visitors and staff. Policies were listed in the centre's statement of purpose and function. Inspectors were provided with a folder of policies held in the centre and the CNM2 said that it contained all polices that guided day to day practice. Policies contained in the folder included for example, the management of risks associated with the administration of medication, health and safety, working alone, infection control, children missing from the centre and managing behaviour that challenged. However, there was no risk management policy that contained all of the elements required by regulation 26, even though this was listed as in place and under review in the centre's statement of purpose and function. The CNM2 and service manager could not provide inspectors with a copy of the risk management policy and said they were unaware that one existed.

There were procedures in place to assess, notify and analyse risk in the centre but they required improvement. There was a health and safety statement that was last reviewed in June 2014. There was a process in place to identify health and safety hazards and

risks, and control measures to address these. Inspectors reviewed the centre's risk assessment folder and found that workplace risks assessed included physical, biological and chemical risks related areas such as fire, slips trips and falls, clinical waste, challenging behaviour and food safety. The last assessment of these risks recorded by the centre was May 2014. A review of this document showed that major risks in the centre were dealt with. Children's case files held completed risk assessments related to their behaviour.

The service manager and CNM2 told inspectors that there was no risk register (other than health and safety risks) for the centre and they were unsure if there was one for the organisation that would record and report for example low staffing resources as a risk. Risks were reported throughout the organisation via e-mail.

There were some processes in place to learn from reports and analysis of risks but they needed strengthening. Records showed that the service manager had completed an audit of health and safety action plans in April 2014. This identified the need for staff training in risk assessment and findings were discussed at staff team meetings. The service manager told inspectors that there was a health and safety manager for the organisation who provided annual reports to regional management teams on risks in their services. This included analyses of injury and accidents. However, the most recent analysis contained in centre records of slips trips and falls was 2009. The service manager and CNM2 told inspectors that risks to do with health and safety were discussed at various staff and managers' meetings. There was also a forum where persons in charge of centres in the cluster met monthly with the service manager and discussed common risks and approaches to these. Reported risks were also discussed between regional directors and service managers. This was demonstrated in various meeting minutes reviewed by inspectors.

Inspectors walked around the centre and found that it was built to a good standard with non-slip flooring, but rubber gloves were on a window sill and in an unlocked cupboard in a communal bathroom. This was immediately brought to the attention of the CNM2 and was dealt with by the end of the inspection fieldwork. Relevant phone numbers were displayed in the staff office to assist staff in times of an emergency.

There was safe practice related to protection against infection. There was a suite of organisational policies on infection control that included precautions to be taken for example, in relation to food preparation, laundry and managing MRSA. The CNM2 community service manager confirmed that there was a clinical waste disposal contract in place and inspectors observed this waste being stored appropriately. Inspectors found that the centre was clean and counter surfaces were of a good standard. There was an adequate number of bathrooms and washing facilities and hand drying equipment was within access of residents. There was anti-bacterial alcohol gel distributed throughout the centre to facilitate hand hygiene practices, but there was no signage in relation to hand-washing. Inspectors found that bins placed around the centre were foot-operated pedal bins. There was no fridge available for staff food.

There were centre specific emergency procedures in place and a contingency plan was developed by the centre. This was awaiting approval by the service manager but the CNM2 said it was to be used in the interim, should an emergency arise that required the

centre to be evacuated. Evacuation procedures were in picture form and were accessible to residents. The centre took precautions against fire but they required improvement. Inspectors found that the centre had fire fighting equipment and a check of this equipment showed that it was last serviced in August and September 2014. There was signage in relation to fire procedures displayed prominently. There were procedures in place in the event of an evacuation and there was an identified place of safety outside of the centre. This was indicated in signage inside the premises. Centre records showed that fire drills and evacuations were carried out monthly but these records did not contain information on who took part. Records indicated that the last three fire drills took place in the centre in October, September and August 2014. Daily checks of fire equipment/emergency lighting were carried out and recorded. There were two push bar fire exits from the centre that were to be used in the event of a fire, but chain locks had been put in place to prevent residents from exiting the premises. Although this practice was considered in evacuation plans for individual children, it was not formally assessed in fire assessments reviewed by inspectors. Fire records reviewed by inspectors did not include fire retardant certificates for the centre's bed clothes and furnishings.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There were measures in place to safeguard children and protect them from abuse, but clarity was required in relation to reporting child protection concerns.

The centre had a policy on child protection. This was reviewed by inspectors and found to be in accordance with Children First (2011). Centre records showed that training on child protection was provided to staff and further training was imminent. There was a process in place for recording and reporting child protection and welfare concerns but this was not clear to all staff interviewed. There was an identified (DLP) as per Children First (2011) for the service, but there was lack of clarity amongst the managers on who this was. There was also a lack of clarity on the procedures in relation to reporting concerns about children accessing the service. The CNM2, CNM1 and service manager

told inspectors that there were no child protection concerns reported in the year prior to inspection. However, incident reports showed that there were several incidents where one young person had entered other children's bedrooms at night. Although these incidents went through the organisation's reporting system for incident and accidents, they were not considered a potential child protection issue and assessed and dealt with as such. Records provided to inspectors showed that there was a system in place to record and report incidents of children going missing from the centre.

The centre had risk assessment templates to be completed in order to manage risks to children. Procedures in the management of access to the centre required improvement. There was an organisational visitor's policy in place but there was no system to record all visits to the centre. The centre did not record the names of drivers who transported children to and from the centre and this was particularly important as drivers may vary depending on need. The centre used agency staff when required but did not ensure the agency sent photo identification of the staff member prior to their arrival in the centre. There was an organisational policy on the provision of intimate care but inspectors were not provided with sufficient evidence to show that this care was provided by core staff team members, particularly when there was significant use of agency staff as had been the case during the summer months. These were some additional safeguarding measures that should be put in place by the centre.

There was an organisational policy on positive behaviour support that was found to be adequate but guidance on day to day practice and training required improvement. Records showed that staff were trained in a model of behaviour management in 2012. The CNM2 and CNM1 were confident in the use of this model. Centre managers told inspectors that a support system was in place for children and staff from a multi-disciplinary behaviour support team, and emerging behaviours were reported to the organisations' principal social worker for guidance and support. Children's files showed that behaviour support plans were in place for children who required them. Children were assessed on admission to determine their levels of behaviour and identify any supports or services required to manage it.

The organisational policy on positive behaviour support provided guidance on prohibited practices, some of which related to restricting children's movement such as the use of seclusion. The CNM2 was not familiar with this. Inspectors did not find evidence that locked external doors had been sufficiently considered as a restrictive measure in an open centre. The centre's external doors were protected by an electronic key pad. This meant that children could not enter or exit the premises without the assistance of a staff member. Other external facing fire doors had chain locks attached that were too high for children to reach. Windows had restrictors fitted. Inspectors were not provided with sufficient evidence to demonstrate the balance between protecting children's safety and their right to free movement had been fully considered. Training records showed that there was no specific training provided to staff on the use of restrictive measures. The CNM2 and CNM1 said that physical restraint was not used in the centre but acknowledged that restrictive practices, such as managing the environment and or physically intervening in guiding children in a hands-on approach did occur. They were not recorded or reported. Although staff were trained in a model of managing behaviour, they had no training on how to hold children safely within this model. This training was due to take place in November 2014. The CNM2 told inspectors that a

specific approach using another model may be required for individual children and if this was the case, staff would be trained. This was not safe practice and may cause confusion amongst staff leading to injury to a child or staff member.

There was a policy and procedure in place to hold children's money safely during their stay and account for how it was spent.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
There were systems and processes in place to manage medication.

There was a suite of comprehensive policies and procedures on medication management but not all were centre-specific. Inspectors reviewed an organisational policy on the management of medication and centre-specific procedures for prescribing, administering, recording and safe storage of medication. These were found to meet the regulations. On a walk around the centre inspectors found that there was a suitable, locked storage facility for controlled drugs and a fridge to store medication. Each child had a medication box that contained the medication they required for the duration of their stay. There was a suite of recording sheets to be used by staff on administering medication and prescribed medication. Inspectors reviewed these and found that they contained key information, such as the name of the prescribing doctor and reason for refusal to take prescribed medication. There was a safe system in place to identify report and address medical errors. Medical errors had occurred but records showed the majority were related to parents not providing the centre with medication at the time of a child's admission. Admission procedures were revised to reduce the risk of this happening and records showed that although these incidents happened from time to time they had reduced.

Judgment:
Compliant

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

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The centre had a draft written statement of purpose and function that did not fully meet the requirements under the regulations. The centre was not operating within its stated purpose and function. The statement of purpose and function was not clearly displayed in the centre.

Inspectors reviewed the centre's statement of purpose and function. It contained the majority of the requirements under the regulations such as a description of the facilities it provided, the aims and objectives of the service, the organisational structure and the floor plan but it did not adequately outline the criteria for admission to the centre. For example, the CNM2 told inspectors that one criteria was that a child attended St Michaels Group school. The service manager said that other criteria included children determined as high priority for the service and were of school age.

The statement outlined that the centre could provide respite care for up to six children with an intellectual and or physical disability at any one time, who were aged between zero - 18 years of age. It also stated that the centre provided a combination of respite and residential care. This was not adequate, as the needs of children requiring a stable home environment cannot be met within a centre that caters for up to 145 children availing of the respite element of the service. Inspectors found that the statement of purpose was too broad in relation to the range of children the centre to catered for. Inspectors were not provided with sufficient evidence to demonstrate the centre could consistently cater for such a wide-ranging group of children in terms of their age, and diverse and complex needs.

The centre was operating outside of its stated purpose and function, as one young person living there on a permanent basis was over the age of 18 years. The service manager and CNM2 told inspectors that the broad nature of the statement of purpose and function required a robust gate-keeping system to ensure children were appropriately placed there both on admission and during respite breaks. The CNM2 and service manager acknowledged that the statement of purpose and function required amendment but the CNM2 told inspectors that inspection findings were awaited to assist in this endeavour. This was not satisfactory, as the determination of the purpose and function of the centre is a clearly defined governance issue.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a system in place to manage the centre but this was not adequate or sustainable and required review. Systems in place to quality assure practice and monitor the overall effectiveness of the centre required improvement.

There was a clearly defined management structure in place that identified lines of authority and accountability at a centre and organisational level. Managers interviewed by inspectors were clear about their roles and responsibilities within this structure. The centre was managed on a half-time basis by a CNM2 who was the designated person in charge since May 2014. The CNM2 was supported by a CNM1 who assisted in the day to day operations and running of the centre. The CNM2 reported to the service manager who reported to a regional director.

The CNM2 was found to be suitably qualified, and had training in management and intellectual disabilities. She was also the half-time person in charge of a centre for adults with a disability, also provided by the St Michael's Group. These dual roles meant that the CNM2 shared her time between two centres (these were on the same campus) as well as working on shift as a member of the staff team. The CNM2 said that at present there was no difficulty managing these roles. The service manager said s/he was confident that the CNM2 was competent in her role as person in charge, but it was unclear to inspectors how this was measured on an on-going basis. The CNM1 was provided with one management day per week to fulfil specific administrative duties such as petty cash, staff rosters and ordering for the centre. However s/he told inspectors that it was not possible to dedicate one day per week to the management of the centre due to working as a staff member on shift. The CNM2 and CNM1 told inspectors that there were days when there was no manager on duty in the centre.

Inspectors found that there were some infrastructures in place to support and facilitate the management of the centre. The CNM2 and service manager told inspectors that there were clear lines of accountability in place and systems to monitor the performance of the centre as a whole and individual staff practice to ensure it was managed in a safe and effective way. Reports were made to the service manager for example on the use of

bed nights to ensure maximisation of the service and health and safety risks/accidents and injuries. The service manager said that a defined set of key performance indicators to be reported on routinely was not in place.

The CNM2 described systems she had developed to monitor practice, such as checking young people's daily reports and the management of medication, but acknowledged that there was no way for her to demonstrate this happened. There was an inadequate system in place to supervise staff. Inspectors were told by the CNM2 and CNM1 that there was a policy on the provision of staff supervision in the centre through support meetings, but this was not evident in the centre's policy folder. The managers had not clearly divided up the task of supervising the team so this meant that staff may receive supervision from either of them depending on their availability. There was no established agenda for these sessions. The CNM1 said that there were delays in providing supervision due to time constraints and other duties. The CNM1 had no training in the provision of supervision.

Inspectors found that one role of the CNM2 was to ensure organisational and centre policies and procedures were implemented. However, the CNM2 was unclear about some of the organisation's policies and procedures. These included reporting child protection concerns, risk management, the use of physical restraint and prohibited practices-particularly those related to restrictive measures. There was a need for the organisation to continue to support the CNM2 in her professional development as the person in charge and to review the arrangements in place to manage this centre to ensure it is consistent, effective and sustainable. The service had not been formally evaluated and there was limited consultation with children and families on their experience of the service and its effectiveness. This was a gap in practice that was acknowledged by the managers and improvements in this area were planned.

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):
This was the centre's first inspection by the Authority.

Findings:
The centre was not resourced to meet it's statement of purpose and function. There was

no formal supervision of staff..

The statement of purpose and function showed that the staff team consisted of a head of unit (house manager), seven staff nurses, four care assistants and a cook/cleaner. The service manager and CNM2 told inspectors that current staffing levels may not reflect what may be required when specific children are admitted to the centre and that additional staffing would be made available by the organisation through a relief panel it maintained, agency staff or through negotiations with the HSE on a needs basis. The centre managers told inspectors that the majority of care assistants were trained to FETAC level five, but neither they nor nurses working in the centre had training or qualifications in intellectual disabilities. There was one vacant care assistant post at the time of the inspection fieldwork. Inspectors found that the service did not demonstrate fully how the numbers and skill mix of the team would have the capacity to meet all assessed needs of residents, based on the current statement of purpose and function.

The centre had training planned for the rest of 2014 but there was no written training plan for 2015 provided to inspectors. The CNM2 said that core training such as manual handling, fire safety and child protection was identified at an organisational level and provided to the staff team. This was evident in training records reviewed by inspectors. Additional training was identified on a needs basis.

Inspectors were not provided with a policy on staff supervision although a staff support system was in place. The service manager said that a performance management system was being developed by the organisations HR department. There was a staff induction programme and this was demonstrated in centre records.

There was a safe recruitment policy and procedure within the organisation. Inspectors reviewed staff files and found that the required checks were made and vetting was appropriate. Staff files sampled were found to be in accordance with schedule 2 of the regulations. There was a policy on use of volunteers for the organisation.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Bronagh Gibson
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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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:	OSV-0002388
Date of Inspection:	23 October 2014
Date of response:	

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessment process considered input and reports from parents/guardians, school and other professionals but did not result in a formal needs or risk assessment on admission.

Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive

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

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:
• The Person in Charge will co ordinate and ensure the completion of a Personal Assessment in relation to all service
users who attend the unit.
• Regular users of the respite service will be prioritised, with a completion date for these plans of 31st March 2015. Regular service users are defined as those using the respite service at least once per month.
• An experienced staff nurse, familiar with the needs of service users has been removed from the Roster and assigned to this task with immediate effect (December 2014) and until completion.
• When the Social Work department identify non-regular respite service users to receive breaks in the respite house the completion of Personal Assessments will commence immediately.
• Any new referrals will have a Personal Assessment and Support Plan completed prior to their visit.
• A standard template to assess needs will be used and will be available for inspection.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an organisational policy and procedure in place for the development of individual plans but these plans were not in place for children availing of the respite service.

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 Person in Charge will co ordinate and ensure the completion of a Personal Support Plan in relation to all service users who attend the unit.
• Regular users of the respite services will be prioritised, with a completion date for these plans of 31st March 2015. Regular service users are defined as those using the respite service at least once per month.
• An experienced Staff Nurse, familiar with the service users has been removed from the Roster and assigned to complete this task with immediate effect (December 2014) and until completion.
• When the Social Work department identify non-regular respite service users to receive breaks in the respite house the process of completion of Personal Support Plans will commence immediately.

• Any new referrals will have a Personal Assessment and Support Plan completed prior to their visit.
• A standard template for developing support plans will be used and will be available for inspection.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One young person living in the centre had turned 18 years of age and although a future service was identified, a place was not yet available.

Action Required:
Under Regulation 25 (4) (c) you are required to: Discharge residents from the designated centre in accordance with the resident's assessed needs and the resident's personal plans.

Please state the actions you have taken or are planning to take:
An assessment of need for a resident that is now 18 has been completed and an appropriate designated centre has been identified. The PIC of current centre, the PIC of proposed centre and the MDT will meet to confirm the suitability of the new centre. Once confirmed the two PIC's will agree a suitable transition plan.
Minutes of the meetings will be available for review

Proposed Timescale: 14/02/2015

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 risk management policy that contained all the elements required.

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 Registered Provider has developed a risk management policy which includes hazard identification and assessment of risk throughout the designated centre.

The risk management policy is available for review by inspectors.

Proposed Timescale: 15/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy that contained all the elements required.

Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
The Registered Provider has developed a risk management policy that includes the measures and actions in place to control the risks identified.

The risk management policy is available for review by inspectors.

Proposed Timescale: 15/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy in place that contained all the required elements.

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 Registered Providers have developed a risk management policy that includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving Service Users.

The risk management policy is available for review by inspectors.

Proposed Timescale: 15/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy in place that contained all the required elements.

Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:
The Registered Provider has developed a risk management policy that includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the Service User's quality of life have been considered.

The risk management policy is available for review by inspectors.

Proposed Timescale: 15/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no risk management policy in place that contained all the required elements. There was no risk register for the centre (other than health and safety risk) and managers were unclear if one was in place for the organisation. There were some processes in place to learn from reports and analyse risk but they needed strengthening.

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:
The Registered Provider has developed a risk management policy that will include a risk register for the centre, the region and the organisation.

The Service Manager and the PIC will discuss the risk register every 4-6 weeks. The agenda will include a review of accidents/incidents, challenging behaviour and near misses. The purpose of the meeting is to manage risk and reduce the incidence of recurrence.

The minutes of these meetings will be available for review by inspector.

Proposed Timescale: 15/12/2014

Theme: Effective Services

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

the following respect:
Fire drills and evacuations were carried out on a monthly basis but records did not contain information about who took part.

Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
All future fire drills will now include the names of staff and service users that are in the building at the time. Monthly fire drills records will be amended to reflect this. Fire safety will be discussed with individual Service Users on admission.

All staff will be instructed by the PIC at staff meeting on 22/01/15.

Minutes of the staff meeting will be available for review.

Proposed Timescale: 22/01/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were two push bar fire exits from the centre that had chain locks fitted. This was not formally assessed as a potential fire risk.

Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
The PIC reviewed the chain locks on the push bar doors. They provided reassurance that a Service User could not open the doors and access an open car park and main road. Secured side gates are now in place ensuring that if the push bar doors opened Service Users would be safe in the back garden. The PIC and Service Manager have assessed the risk and the chain locks are now removed. - COMPLETED

Proposed Timescale: 06/01/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire records did not contain fire retardant certificates for centre's furnishings and bed clothes.

Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
The PIC has contacted the supplier to get confirmation that all furniture supplied is fire retardant.

The PIC will ensure that when bed clothes are being replaced, fire retardent bedding will be purchased.

The fire register will contain the appropriate fire register certificates.

Proposed Timescale: 12/12/2014

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:
There was a need for improved guidance and training on the use of positive behaviour support and in particular restrictive practices.

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:
7 staff had previously completed day 1 & 2 training in a model of positive behaviour support. They will complete the programme on 7th and 8th January.

The PIC has listed all staff to complete Positive Behaviour Support training in 2015. This is a Fetec level 5 course and is of 4 day duration. Training will commence in January 2015 and will be complete for all staff by October 2015.

A psychologist will attend a staff meeting on 11/02/15 to brief all staff on the Positive Behaviour Support policy.

Proposed Timescale: 01/10/2014

Theme: Safe Services

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

There was insufficient evidence to demonstrate that the balance between protecting children's safety and their right to free movement was fully considered.

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 key code pad and window restrictors are currently in place to ensure the safety of the Service Users using the centre.

The Registered Provider has a system for approving and monitoring the use of all restrictive practices. The review of restrictive practices is carried out by the Positive Approaches Management Committee. The PIC will make a referral to review the use of the key code pad and the window restrictors to the Positive Approaches Management Committee.

A copy of the referral and review will be available for inspectors.

Proposed Timescale: 15/01/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a process in place for recording and reporting child protection and welfare concerns but this was not clear to all interviewed. Some incidents were not considered or assessed as potential child protection/welfare concerns.

Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
The PIC has organised with the social work department for all staff to have refresher Safeguarding training. This is scheduled for 22nd Jan 2015.

An attendance sheet will be completed and available for inspection

Proposed Timescale: 22/01/2015

Theme: Safe Services

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

There was insufficient evidence to show that intimate care was provided in as sensitive a way as possible when there was significant use of agency staff in the centre.

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:
The process for developing Personal Assessment and Support Plans as outlined previously will support the provision of intimate care in a sensitive manner. The support plans as outlined will include an intimate care support plan for each person who requires support. The plan will include details of the services users needs and preferences in relation to intimate care. All staff involved in the provision of intimate care will follow the support plan to ensure the dignity and bodily integrity of the service user is respected.

When shifts are being planned permanent staff will be allocated to provide intimate care. If this is not possible permanent staff will discuss in advance, the individual service users intimate care support plan with relief staff.

Personal Intimate Care Support Plans will be available for review each month. The PIC will co ordinate and ensure completion.

Proposed Timescale: 31/03/2015

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 and function did not adequately outline the criteria for admission to the centre.

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 PIC and the Service Manager will review the statement of purpose and function to ensure the criteria for admission to the centre are outlined.

New statement of purpose will be available for review.

Proposed Timescale: 18/12/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose and function was too broad in relation to the range of children it catered for.
The statement of purpose was too broad in relation to the type of service the centre provided.
The centre was operating outside of it's purpose and function.

Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
The PIC and Service Manager will review the statement of purpose to ensure the range of Service Users and type of service provided is clearly defined.

Proposed Timescale: 18/12/2014

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:
Management arrangements were not adequate or sustainable.
The person in charge required continuing professional development and support to fulfil the role.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has begun a review of the role of the PIC as person in charge of more than one designated centre. This will include a full review of CPD needs and supports required to ensure the effective governance, operational management and administration of the designated centres concerned.

Proposed Timescale: 28/02/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no centre policy on the provision of staff supervision.
There was an inadequate system in place to provide staff supervision.
Systems in place to quality assure day to day practice required improvement.

Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
The PIC and Service Manager will develop a staff supervision template that will include a opportunities to develop and performance manage all members of the workforce to exercise their personal and professional responsibility. The template will include a review of the quality and safety of the services delivered by individual staff members to ensure Service Users needs, preferences, guidelines and plans are being followed.

Proposed Timescale: 28/02/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Monitoring of the service required improvement.

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

Please state the actions you have taken or are planning to take:
The Registered Provider will put a management system in place to ensure regular supervision and support for all staff. This will include supervision for frontline staff with the PIC, support and supervision for the PPIM's from the PIC, support and supervision for the Pic from the Service Manager.

In addition the Service Manager will carry out unannounced visits and reviews of the risk register every 4-6 weeks.

Proposed Timescale: 28/02/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to demonstrate fully how the numbers and skill mix of the staff team would have the capacity to meet all the assessed needs of residents based on the current statement of purpose and function.

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:
Based on the assessed needs of Service Users and qualifications and skill mix of the staff team, a training needs analysis will be carried out by the PIC (with support from the Training Department.) Staff will be supported to access external training opportunities where required. The training needs analysis will take the updated statement of purpose and the size and layout of the house into account.

The Personal Assessment and Support Plans for Service Users will be complete by 31st March 2015. The training needs analysis will be conducted once all the assessments of need have been completed.

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no policy on the provision of staff supervision.
Supervision arrangements in place were not adequate.

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

Please state the actions you have taken or are planning to take:
The Registered Provider will put a management system in place to ensure regular supervision and support for all staff. This will include supervision for frontline staff with the PIC, support and supervision for the PPIM's from the PIC, support and supervision for the PIC from the Service Manager.

Proposed Timescale: 28/02/2015