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-0002360
Centre county:	Dublin 5
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	John Birthistle
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, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 4 day(s).

The inspection took place over the following dates and times

From:	To:
18 November 2014 09:30	18 November 2014 19:00
19 November 2014 07:30	19 November 2014 18:00
20 November 2014 10:00	20 November 2014 12:00
16 December 2014 13:30	16 December 2014 15:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was an announced inspection and forms part of the assessment of the application for registration by the provider. The registration inspection took place over three days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents and staff members were also sought.

The nominated person on behalf of the provider and person in charge demonstrated knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults with Disabilities) Regulations 2013 throughout the inspection process.

The fitness of the nominated person on behalf of the provider and the person in charge were assessed through interview and throughout the inspection process to determine fitness for registration purposes and were found to have satisfactory knowledge of their roles and responsibilities under the legislation and sufficient experience and knowledge to provide safe and appropriate care to residents.

The centre was established to provide care for a maximum of six adults with physical and/or intellectual disabilities who have both nursing and social care needs.
Only one relatives' questionnaire was received by the Authority during and after the inspection. The opinions expressed through the questionnaires indicated they were satisfied with the services and facilities provided.

Nine of the 14 non compliances from the last inspection had been addressed. Those outstanding relate to health and social care needs premises and policies. However, although evidence of some good practice was found across all 18 outcomes, on this inspection, 10 outcomes inspected against were found not to be in substantial compliance with the Regulations. As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority).

All documents submitted by the provider for the purposes of application to register were found to be satisfactory. However, two documents one in relation to planning compliance and the other relating to fire compliance remain outstanding and are required to be submitted to the Authority before a recommendation for registration can be made. The documents required are; written confirmation from a properly and suitably qualified person with experience in fire safety design and management that all statutory requirements relating to fire safety and building control have been complied with as required in the registration regulations.

Overall, evidence was found that residents' healthcare needs were not being fully met. Residents had access to general practitioner (GP) services and a full time medical officer as part of the overall services provided by St Michael's House Group and although access to allied health professionals such as physiotherapy speech and language therapists and to community health services were stated to be available, it was found these were limited and on a priority basis only.

The inspector found there were many aspects of the service that needed major improvement including governance and management, resources, premises, care planning, staffing and skill mix. These findings were brought to the attention of the provider nominee at the conclusion of the registration inspection and a commitment was given by the provider nominee that actions required to address the most urgent findings would be commenced immediately. A further visit was made on 16 December to establish what if any actions had been taken by the provider since the registration inspection and is included in this report.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the 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, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Evidence that residents were consulted with and enabled to participate in decisions about their care and about the organisation of the centre was found on this inspection. Regular weekly meetings took place and minutes of these meetings outlined discussions and decisions taken on activities and meal planning. Daily routines respected individual choice and preferences such as times for rising or returning to bed.

It was found that resident's privacy and dignity was respected through personal care practices, maintaining private communications and contacts with relatives and friends and maximising independence.

Staff were observed to try to facilitate residents' capacity to exercise personal autonomy and to help residents exercise choice and control in their daily lives in accordance with their preferences. Independence was promoted and encouraged through development and maintenance of life skills.

Systems to safeguard finances were in place and supports to facilitate residents to safely manage their finances were reviewed.
It was found that resident's belongings and finances were protected on this inspection. A robust system which involved recording, balancing and auditing three separate account records was in place consisting of an expenditure record, receipts and bank account statements. Each aspect of the three records were reconciled for every lodgement, withdrawal or transaction conducted. These were audited by the person in charge monthly. Records indicated full reconciliation and corroboration of purchases/payments with receipts expenditure records and bank statements.

There was a written operational policy and procedure relating to the making, handling and investigation of written complaints. The procedure identified the nominated person to investigate a complaint and the appeals process. There was a nominated person who held a monitoring role to ensure that all complaints were appropriately responded to and records were kept. It was also noted that residents were facilitated to have access to advocacy services. A process to record complaints was available however, the inspector was told no complaints had been made to date.

Judgment:
Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Evidence that staff were aware of the different communication needs of residents and that systems were in place including external professionals input where necessary, to meet the diverse needs of all residents was found. Several of the current residents had a variety of communication needs, some were non verbal and others had sight and hearing difficulties. Residents identified with verbal communication difficulties were supported and helped to communicate using alternative methods such as expressive body language and picture prompts.

Most staff were very familiar with the expressive body language prompts used by some residents to indicate a need, these included shouting or nail biting to indicate pain or discomfort. Current regular staff were also able to recognise changes to mood and behaviour which indicate onset of illness or seizures for some residents.

But although most staff knew these individual communication requirements and put them into practice they were not included in personal plans and there were new staff who had only recently commenced work in the centre and could not be expected to recognise and understand their expressive communication signals.

Specific communication care plans were not in place and where healthcare plans were in place they did not mention how the resident communicated how they were feeling for example ; experiencing pain; fear; hunger or thirst, although it was noted that residents were regularly offered food, drink, rest and relaxation or activities.

Although a picture exchange system was available and used to help understanding and recognition of everyday items and activities, this was mainly used for menu formation. A

large folder of pictures depicting types of foods, activities and places to aid communication was available but was not observed to be frequently used.

The centre is part of the local community and residents were helped to visit local shops, restaurants and leisure facilities on a regular basis. Those who wished too had access to radio, television, social media, magazines and information on local events.

Judgment:
Non Compliant - Minor

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Evidence that residents were supported to develop and maintain positive relationships with family and friends was found.

Arrangements were in place for each resident to receive visitors in private without restrictions unless requested by the resident.

Good communication systems were in place and families were kept informed of residents' well being and were involved in their personal plans. In conversation with some family members the inspector was told that they felt very supported by staff to be involved on a daily basis in the life of their relative.

Residents' involvement in activities in the community were supported but this was limited to group activities with other residents and to date there is no involvement with other social groupings for individual residents. This was found to be primarily due to the healthcare needs of the resident profile but it was also found that the social needs of some are being negatively impacted due to resources and this is further referenced under Outcome 16

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The resident profile of the centre was found to be stable and there were no new or recent admissions.

On a sample of those reviewed it was found that each resident had a written contract agreed within a month of admission. The contract set out the services to be provided and all fees were included in the contract. Where additional charges pertained these were also included.

Although the contract was in written format an accompanying finance plan which referenced and included all of the fees contained in the contract was in a pictorial format for improved accessibility for residents understanding.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Actions required from the previous inspection had not been implemented and there was limited evidence that resident's well being and welfare was maintained by a good standard of evidence-based care and support. Although some personal plans were in place they were not adequate or appropriate to support resident's continued personal independence and life skills development. Many plans related to basic rights such as spending time with family or going for a walk . These plans were identified for improvement on the previous inspection and although some additional work had been done for the majority of residents all plans had not been formed. Plans in place were not supported by identified supports to achieve the goals and none had been progressed to

date.
This was due to the decision by the person in charge to concentrate on the review of plans in place on healthcare rather than social needs due to the complexity of needs of residents. This decision was found to be appropriate and in the best interests of residents on this inspection

However, on review of a sample of clinical documentation it was found that significant improvements continued to be required to ensure that arrangements to meet each resident's assessed needs were set out in a personal plan that reflected their needs and capacities. A care plan was not in place for every identified healthcare need, such as, ischaemic heart disease, communications and behaviour and where plans were in place all were not sufficiently specific to manage the care needs identified in full for example management of infection weight loss or diabetes.

The inspector reviewed several resident files and found that assessments were in place and had been updated in recent weeks. However, all of the current residents were identified as having specific clinical care needs but these needs were not clinically assessed in sufficient detail to determine the extent of this need. Examples included; nutrition and weight loss, several residents were identified as at risk of weight loss or gain but comprehensive assessments to determine potential or actual risks for overall health were not in place such as a validated nutritional screening tool or accurate and regular weight monitoring. Where some assessments were in place on an annual or bi-annual basis, they were not reviewed as changes in need or condition occurred Cardiac screening and reviews for residents diagnosed with cardiovascular disease were not in place.

Suitable and sufficient arrangements were not in place to meet the assessed needs of residents. Particular concerns related to the level frequency and type of clinical supports and inputs by medical and allied health professional to the nursing and care team in the centre to promote and maintain health. The current profile of residents had a variety of health, personal and social complex needs and there was limited evidence that these needs were being managed holistically in a timely and responsive manner. The inspector found that although a team of allied health professionals were available within the service, the person in charge and her team had difficulty accessing them due to service constraints. The system in place was one of referral and although residents were reviewed when referred, the system did not allow for continuous or intermittent monitoring. Examples of this were found where residents with history of cardiac infarction had not a cardiovascular review in a 10 year period. These findings are further discussed under Outcome 11 Healthcare, 16 Resources and 17 staffing and raises concerns for the standard of care being delivered to residents.

It was also found that the designated centre was not fully suited to meeting the assessed needs of residents in that there was limited space available. Limitations to communal space, small kitchen area and lack of storage for equipment hampered staff's ability to promote independence and meet residents needs for privacy with their relatives and friends. This is detailed under Outcome 6 premises.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Overall the design and layout of the centre was not found to meet the needs of the current resident profile in line with the Statement of purpose. Efforts to provide furnishings, fixtures and fittings which created a personalised comfortable living space which also promoted residents' safety, dignity, independence and well being were noted, although these were noted to be old and worn.

The centre is a bungalow and consists of;
- 6 single bedrooms with wash hand basins for residents and 1 bedroom for staff to sleepover
- 2 toilets with wash hand basins and shower, only one shower is accessible for residents with limited mobility or non ambulant residents
-1 large bathroom with parker bath, overhead tracking hoist and dished shower area
- a small laundry area with sink washing machine and tumble dryer
- L shaped sitting cum dining room with small open kitchen enclosed by a wooden lattice and lockable gate
- a small enclosed garden is accessed through glass patio doors onto a small paved area with benches
- two storage sheds are located in the garden one at either end of a small rectangular grassed area. Staff have to cross the grass to reach the smaller wooden shed in the far corner of the garden which could pose a risk of slips during inclement weather
- the back of the garden is enclosed with gates on both sides and a wall to the rear, the sides are paved allowing safe access or egress.

The inspector found that there was a lack of adequate private and communal accommodation. In particular limitations to communal space, small kitchen area and a lack of storage for equipment hampered staff's ability to promote independence and meet residents needs for privacy with their relatives and friends. All of the residents spent the majority of their time in one room, which was the L shaped sitting cum dining room which adjoined the kitchen at a 90 degree angle. the room is a standard sized domestic sitting room divided in half by two strategically placed couches, behind which the dining room table and chairs are placed. This room is the focal point for all meals and activities for 6 residents.

Two residents require specialised seating and one resident has poor balance and mobility difficulties. The specialised seating and wheelchairs further reduce the amount of circulation space for both residents and staff. Of necessity when the residents are in the sitting room so too are the staff, a minimum of one or maximum of three at any one time. So between seven to nine people are in a very confined area when all residents are at home. There was a lack of suitable storage for specialised seating, wheelchairs and hoists. These were stored either on the corridor just inside the font door or in residents bedrooms at night. There was a lack of alternative suitable communal area of diversion or interest.

A separate room where residents could enjoy private time with visitors was not available. The kitchen was a small square room with fitted cupboards cooker, fridge with small freezer compartment dishwasher, main sink and whb. The layout and accessibility of the kitchen was not suitable for wheelchair users particularly larger chairs. The kitchen space was not adequate to facilitate basic appliances such as a chest freezer without losing cupboard space. The kitchen space available was not sufficient to allow residents be part of organising or assisting staff to prepare and cook meals particularly for residents who were wheelchair users.

The laundry area contains a sluice sink used for emptying commode or shower chair inserts and urinals, but does not have a wash hand basin. This means staff have to go to the staff change room to wash their hands following washing of soiled equipment and poses a risk of cross infection. Due to the ageing profile of residents and their increasing healthcare needs, provision of a bed pan washer should be considered into the future.

A full maintenance programme is required which was identified but not addressed since last inspection. Overall it was noted that the majority of fixtures and fittings needed to be replaced or repaired including but not limited to; wall and floor tiles in bathrooms, shower areas and toilets; linoleum flooring in the dining and kitchen area and flooring needs review throughout the unit; skirting, doors, door surrounds and lintels. paintwork and review of lighting. A painter arrived on site on first day of inspection and began to paint some of the bedrooms.

There was a good standard of hygiene and the centre was found to be visually clean and hygienic. Appropriate assistive equipment was in place and available for use, service records were found to be up to date and maintenance contracts including domestic and clinical waste were in place. Although improvements to storage was found to be needed, the corridors were uncluttered and safe for residents mobilising.

A review of spatial requirements in each unit to meet the needs of staff to deliver safe care, storage available to each resident for personal possessions such as larger specialised wheelchairs and seating and appropriate storage of equipment is required.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Actions required further to findings of the last inspection under this outcome were addressed on this occasion.
The inspector found that in general good governance processes and safe practices implemented by the person in charge with staff promoted and protected the health and safety of residents. Processes and procedures in relation to; health and safety and moving and handling, in accordance with an up-to-date health and safety statement; safe evacuation of residents and staff in the event of fire; fire procedure was prominently displayed; there were regular fire drills and fire records included details of fire drills, fire alarm tests and fire safety equipment was found to be serviced on an annual basis.

Personal emergency evacuation plans for all residents were in place and were sufficiently specific to guide staff. However, during recent fire drill practices the person in charge noted an increase in the level of non compliance by some residents. This was particularly noted when residents were settled in bed. In view of this and deteriorating levels of mobility the person in charge had requested the purchase of emergency evacuation sheets to facilitate the assisted evacuation for three identified residents, however it was noted that these had not yet been received.
Arrangements were also in place for responding to emergencies including procedures and policies covering responses in the event of a resident being absent or missing without staff knowledge. Some additional equipment to effectively and safely respond to emergencies was available such as; blankets and search torches.

A risk register was in place which identified some risks and the control measures in place to manage the risks for aspects of the environment, accident and incidents behaviour that challenges restrictive practices and medication management. Not all risks were included and the register required to be updated to include risks identified on the inspection such as; risks associated with staff having to cross the grass to access the wooden storage shed which contains the chest freezer; lack of compartmentation in the centre to give staff time to facilitate safe evacuation in the event of a fire. The person in charge undertook to update the register to reflect these.

Written confirmation from a properly and suitably qualified person with experience in fire safety design and management that all statutory requirements relating to fire safety and building control have been complied with as required in the registration regulations has not been provided.

There was an infection control policy in place and practices throughout the house were safe.

The inspector was informed and saw evidence that the bus being used to transport

residents to and from the centre had failed the National Car Safety check in November 2014, the inspector was informed that repairs to the vehicle had been completed and the bus was re-tested and had passed. However, the disc indicating compliance with the NCT was not displayed or available. This was followed up by staff and the Disc was available along with the certificate showing that the bus was roadworthy prior to the end of inspection.

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

Findings:
Actions required further to the last inspection were found to have been substantially progressed although not yet fully completed and all other lines of enquiry under this outcome were reviewed on the last inspection and found to be compliant.

In conversations with residents some expressed feeling safe and could tell inspectors the names of staff they were familiar with. Although all residents spoken with were unable to express feeling safe, the inspector observed they appeared comfortable with staff and did not exhibit behaviours associated with distress or anxiety. Where some residents exhibited aspects of behaviour that is challenging on occasions, staff were familiar with potential triggers and efforts were made to identify and alleviate the underlying causes for each individual resident to be completed

Restrictive measures such as use of lap belts and chair trays were noted to remain in use for some residents, specifically those persons with balance or sitting difficulties who were full time wheelchair users. But it was also found that alternative, less restrictive measures were in place for some residents such as crash mats or posey bed alarms. Where bed rails were used these were not used in a restrictive manner as the rails were found to be on the 'inside' aspect of the bed beside the wall and used so the resident could easily lever themselves into a sitting position to get out of bed.

Audio and visual monitors were also found to be still in place for some residents. However, while clear reasons for the use of the audio monitor were found, related to enabling staff provide safe care, the use of the visual monitor was not clear.

The person in charge had commenced a process of reviewing the use of the visual monitor and had formed the view that this monitor was neither appropriate in terms of privacy and dignity and was not an effective means of ensuring the safety of the resident as staff could not watch the monitor on an ongoing basis throughout the night. However, an alternative means of providing a safe environment at night were still being discussed with all of the key stakeholders involved in the residents' life and options such as posey or mat alarms had already been rejected.

Evidence of a review of restrictive practices associated with locks on bedroom doors, wardrobes and kitchen area was also found. Where some of these practices remained in place there was a clear rationale for their use, for example; locks on wardrobe doors to prevent risk of injury associated with pulling shelves down on top of the person. The use was time limited and clear guidance on the triggers for initiating the practice were in place, for example, recognition of searching behaviours and inability to distract.

Other more appropriate forms of behaviour management strategies were also being explored to promote a restraint free environment such as sensory stimulation assessments as an appropriate alternative.

The inspector was satisfied that residents' privacy dignity and rights were being safeguarded through a positive supportive environment on this inspection.

Judgment:
Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
An electronic record of all incidents occurring in the designated centre was found to be maintained and where required were notified to the Chief Inspector within the specified time frames.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Staff endeavoured to facilitate resident's opportunities for new experiences, social participation. All residents' attended day care facilities four to five days per week. There was evidence that staff also tried to facilitate residents' to maintain and develop personal interests within and outside the centre.

The capacity of the residents to avail of education or training opportunities was limited due to a combination of cognitive, health and physiological constraints. Currently none of the residents were engaged in education, training or employment programmes.

Participation in interests and activities such as arts and crafts music and exercise was primarily through attendance at the day services.

Judgment:
Compliant

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Access to leisure activities during the week usually included a drive out to Howth or a short spin down to the local shops. At weekends the afternoons were spent shopping or bowling or going to the cinema.

However, it was noted that due to the high level of interventions required by some residents and the restriction of time spent in wheelchairs for others, all residents had a time limitation of 90 minutes for any particular outing when everyone was out together. This severely curtails the freedom of all residents to enjoy a social outing. It was also found that the diverse social needs of the residents were not being met with some who would benefit from increased opportunities to develop new life skills not having the opportunity to do so due to time and staff restrictions on the service.

Residents were provided with food and drink at times and in quantities adequate for

their needs. All meals were prepared in the centre and despite the limitations of the environment; residents were encouraged to be involved in the preparation of evening meals as appropriate to their ability and preference. Food was properly served and was hot and well presented. The evening meal was found to be a relaxed and sociable affair. Residents were facilitated to enjoy their meal independently, privately and at their own pace, where assistance was required it was offered in a discreet and sensitive manner.

Evidence that the health care needs of residents were being met was not available on this inspection. The records of clinical interventions which had taken place relating to ongoing healthcare needs were not up to date and did not give a complete and accurate picture of each resident's health care status.

This resident group had a variety of very diverse and complex health and personal needs. They required a high level of intervention and support with all of the activities of daily living in terms of physical personal emotional and social needs. As was previously mentioned under Outcome 5 comprehensive assessments, and care plans to identify and manage the needs of each individual in a person centred and holistic manner were not in place.

The Inspector was concerned for the current health status of a number of residents who had medical histories related too, for example; type 2 diabetes; cardiovascular disease; cardiac infarction; unstable blood pressure. Despite the aging profile of the residents most of whom have complex needs and co morbidities, ongoing review and monitoring of these underlying health issues were not in place. Evidence that residents had a full review of all of their healthcare needs was not available.

Although the person in charge had only recently taken up the position in the centre it was noted that she had identified a need for comprehensive re assessment and referrals to the multi disciplinary team for all residents. However, the inspector learned that access to the clinical team in place for the broader St Michael’s house organisation was priority based due to limited staff availability and no reviews had yet taken place.

Access to clinical governance and leadership for the person in charge and the nursing and care staff team were also lacking. Findings related to the lack of clinical direction and knowledge and which compound the lack of timely responsive and co ordinated reviews of residents health included;
- health monitoring processes by the nursing team to identify and respond to signs of clinical deterioration were not in place. Examples include; blood monitoring further to medical advice, evidence was found where a hospital medical team recommended a blood screen within three days of discharge (at end of August) but no evidence of this was found. Following further discharge at the beginning of November, monitoring of blood haemoglobin was recommended but again no evidence of this being done was found.
- regular and ongoing review processes and assessments to maintain health such as ; regular blood pressure monitoring; weight and body mass index monitoring.

Nutritional screening processes were not adequate or specific enough to determine whether weight loss in the case of one resident was due to malnutrition or fluid loss. Adequate monitoring processes which could analyse patterns of intake and output and

determine levels of hydration and nutrition were not in place. On review of three out of six residents' files the inspector found a lack of timely referral to medical and allied health care personnel where there were clear indicators of clinical deterioration requiring such review.

A follow up visit to the centre on 16 December found that the person in charge had commenced a series of case conferences and multi disciplinary meetings to co ordinate reviews of the health status of all residents. There was evidence that an initial case conference for three of the residents was held on 5 December, a mutli disciplinary meeting was held on 11 December and further meetings are scheduled on 27 January and 5 February 2015.

The inspector was informed that all of the residents have been seen by a speech and language therapist and a dietician since the registration inspection in November and that full medical histories were being sought from the general practitioners of some residents.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Staff were aware that there was a new operational policy which included the ordering, prescribing, storing, administration and prescribing of medicines, although a copy of the new policy was not available in the centre. The inspector found that practices regarding drug administration and prescribing had improved since the last inspection.

The practices in relation to ordering, storing and disposal of medication were in line with the policy. There was a safe system in place for the ordering and disposal of medications and the inspector saw records which showed that all medications brought into and out of the centre were checked and recorded. An audit of each resident's medications was completed on a weekly basis by staff; any discrepancies were identified and reported to the service manager by completion of an error form.

The inspector saw that each of the residents had their prescribed medications recently reviewed by a Medical Officer.

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):
No actions were required from the previous inspection.

Findings:
The statement of purpose was found to contain all of the information required by Schedule 1 of the Regulations and copies were available for residents in the centre.

However, the statement did not reflect the service being provided in the centre in that the facilities and services outlined in the document were not in place in order to meet the diverse needs of the client group the designated centre is intended to meet.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
Evidence that management systems were sufficient to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored was not found. The person in charge engaged with the process to determine fitness as part of the inspection and demonstrated sufficient knowledge of the legislation and statutory responsibilities associated with the role. It was found that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis, provided good and consistent leadership to staff, support to families and was clearly resident focused.

The person in charge was also supported in her role by a senior services manager who was familiar with staff and residents. The service manager and person in charge met regularly to discuss the service provision and evidence was available that the service manger was proactive in seeking additional supports and resources for the centre. Due to financial budgetary constraints these were primarily limited to replacement of staff and two care workers had recently been appointed to the centre.

However, the management structure did not include an identified person with oversight of and responsibility for the professional development and co ordination of the nursing team to ensure the nursing and care personnel are skilled and competent to fully meet the needs of residents.

It was also evident that there were limitations to the supports in place to facilitate the purpose and function of the designated centre. Systems were not established and in place to monitor risk and quality of care. It was noted that this centre forms part of a larger service provider with a complex management structure and supports and it was found that an urgent review of the overarching structures to provide appropriate systems to ensure effective and timely review of residents' health and social care needs such as; communication processes; lines of authority; assigned clinical teams; responsiveness to referrals and prioritisation of the care of residents with complex needs.

An annual review of the quality and safety of care in the designated centre had not yet been conducted although a report on a six month quality review by the service manager was carried out in conjunction with the person in charge. This incorporated aspects of service such as; staff training; equipment maintenance; emergency procedures and planning; transport maintenance; restrictive practice review; nurse manager on call supports; safeguarding and medication management.

An action plan on areas identified for improvement was incorporated. it was noted that this was the first review conducted to comply with the regulations and efforts to improve the quality and safety of care was ongoing however, the management team were reminded that this six monthly review should be prepared further to an unannounced visit and subsequently used to inform the annual review.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Authority. All documents submitted by the provider for the purposes of application to register were found to be satisfactory. However, two documents one in relation to planning compliance and the other relating to fire compliance remain outstanding and are required to be submitted to the Authority before a recommendation for registration can be made.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The Chief Inspector was formerly notified of the absence of the person in charge in an earlier notification and the arrangements for the absence.

On this visit it was noted that as stated under Outcome 14 the recently appointed person in charge demonstrated their suitability for the role to a good level.

A formal interview process was not conducted with the staff person identified to deputise in the absence of the person in charge. Alternatively, suitability was determined throughout the inspection process in terms of their understanding and knowledge of their role under the Health Act 2007. Whilst the nominated person demonstrated familiarity with residents' needs, and had the required experience it was noted that they would benefit from training and development in clinical and leadership skills as they appeared to lack confidence in the role.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Evidence that there were sufficient resources to fully meet residents needs was not found.

As already referenced and detailed in findings under Outcomes 5, 6, 10, 11, 13, 14, and 17, resources were not targeted or prioritised to meet all care needs of the current resident profile in that;
- the centre routines and activities were resource led and not person centred. Activities were dependent on all residents being or feeling 'well', that there were no incidents of behaviour that challenges and all agree to go out. The outing further depended on a qualified driver being rostered on duty. Currently only five of the regular or permanent 12 staff were licensed to drive the centre's bus. Usually at least one trip to the local

shops could be arranged between Monday and Friday. But it's primarily the weekend before any quality social outing could be organised. These outings generally include trips to the cinema; bowling; shops; coffee and to meet up with family. It was also only at weekends and again only if there were two registered nurses on duty could some residents have a choice of remaining at home if they wished without everyone having to stay home

-as outlined in full under premises Outcome 6 the facilities and services do not reflect the statement of purpose

- as outlined under Outcomes 5 and 11 there was limited access to the multi disciplinary team and there has been a lack of timely review of healthcare needs. Due to the deteriorating health and aging profile of the residents a full review and update on their current health needs and health and social care status was required yet the person in charge has little management time to conduct such an in depth process

- as outlined under Outcome 11 the diverse social needs of the residents were not being met with some who would benefit from increased opportunities to develop new life skills not having the opportunity to do so due to time and staff restrictions on the service

- as outlined under Outcome 13 the facilities and services outlined in the statement of purpose were not in place in order to meet the diverse needs of the client group the designated centre is intended to meet

- as outlined under Outcome 14 systems were not established and in place to monitor risk and quality of care

- staff had access to the nurse manager on call system however, this system was an on call rota and did not provide staff with a level of consistent clinical nursing leadership. – there was a significant gap in the nursing structure and a lack of clinical leadership and governance. The management structure did not include expertise with oversight or responsibility for the professional development and co ordination of the nursing team to ensure the needs of residents were fully met

- clear plans were not in place, which took account of funding and resources available to in order to ensure the provision of safe effective residential services and demonstrate an understanding of the level of need which require to be met now and into the future.

On the follow up visit on 16 December the inspector was told that a change to the management team had been made to endeavour to provide staff with better access to clinical back up and that a service manager from a clinical nursing background was overseeing the centre.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff

have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Evidence that the numbers and skill mix of staff were appropriate to meet the assessed needs of residents was not found.

Although respectful and attentive interactions were observed between staff and residents and it was noted that staff provided ongoing reassurance to residents, sufficient staff with the diversity of skills, and qualifications required to meet the needs of the current profile were not available. All of the residents in the centre have an intellectual disability. The extent of disabilities range from high and severe to profound. Several residents were also diagnosed with mental health issues such as bi polar disorder.

However, other than the recently appointed person in charge, no other nursing staff with an intellectual disability qualification were on the team. Nor were there nursing staff with a psychiatric qualification. Overall, it was found a high standard of evidence based nursing care was not found, and this is detailed under Outcomes 5 and 11 in the report.

The skill mix of non nursing staff also requires review and consideration of household or catering staff added to the profile should be considered. All of the current profile of residents were on therapeutic and/or modified diets. It was noted that where there were adequate numbers of care staff available to assist in delivering personal care to residents there were none with a recognised qualification in catering or nutrition. Although staff had been given some training on modifying diets none had any identified training on managing food and its nutritional content.

The education, training and development opportunities available to staff did not enable them to meet the full needs of residents.

On review of staff training it was noted that all staff had received required training in areas such as moving and handling, safeguarding and fire safety. Other training was also provided in; safe administration of medication; positive behavioural supports; nutrition and management of dysphagia and catheter care. But in discussion with the person in charge and on review of the content of some training, specifically training on the latter two, it was found that additional training was required. For example, the inspector observed and spoke to staff who had prepared and cooked the evening meal for residents. Potatoes was one element of the meal provided. These had been mashed and butter was added to them. The inspector noted that all residents had been given

these same potatoes however, two residents were on low fat diets which stated clearly they should not have butter added to their food.

It was also noted that training and subsequent guidance provided to staff on the care and management of supra pubic catheter was not sufficient to manage all of the complications being encountered by staff such as maintaining patency of site in the event of dislodging. Also the inspector found that frequent complications such as blockage and recurrent infections were resulting in frequent re admissions for the resident concerned.

Additional training on clinical practice specific to the resident profile was also required in areas such as; assessment and care planning; non verbal communication methods and food safety.

An assessment of competency of staff following training delivered should also be considered.

The numbers of staff were not sufficient to meet the social needs of residents as detailed under Outcome 16 and there was insufficient access to allied health professionals. It was also noted that both nursing and care staff share the responsibility for all household tasks such as preparing and cooking food, cleaning and laundry duties. The freeing of qualified nursing staff from household tasks to enable appropriate clinical monitoring reviews and assessments is required.

The role of the person in charge involves being part of the roster delivering care as part of the team. Although a level of management time was available, this was not sufficient at this time to facilitate the full review and update of the current health needs and social care status of residents required by the person in charge.

Whilst the current staff were very familiar with residents needs and staff endeavoured to deliver good care it was found that there was a lack of clinical knowledge and experience available to provide guidance and direction to staff and the person in charge on the management of complex care needs. Currently the nursing structure within the service does not include a level of management to provide clinical governance and ensure all nursing staff were up-skilled and develop professional competencies within an evidence based framework over the twenty four hour period seven days a week and not only when the person in charge was on duty.

In conversation with the staff and person in charge on 16 December the inspector learned that a meeting had been held that morning to discuss the resources required in the centre. The person in charge was hopeful that additional staff such as household staff would be provided to free up existing staff to provide a greater level of direct care to residents.
A full performance and development review for all staff in the centre was also discussed with the focus of identifying the skills and training needs required by staff to meet residents needs to be commenced early in the new year by the person in charge.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:
Use of Information

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

Findings:
In a sample of those reviewed it was found that general records as required under Schedule 4 of the Regulations were maintained including key records such as the statement of purpose and function, resident's guide, complaints and notifications as required under Regulation 31.

Records were maintained in respect of accident and incidents, nursing and medical records and improvements further to the last inspection were found to have been made with documentation of reviews and recommendations by clinicians now retained in the centre. However, the records of medical nursing and allied assessments interventions or recommendations which together gives an up to date picture of the persons overall condition although available required further improvement in respect of maintaining clinical records in accordance with professional standards and linking clinical assessments and risks with care plans to aid evaluation.

In addition it was found that a directory of residents to be established under regulation 19 (1) and containing all of the information specified under Schedule 3 point 3 (a) - (e) and schedule 4 Points 7,8 and 9 was not in place.

All of the policies required to be maintained under Regulation 4 and listed in Schedule 5 were not available, including policies to guide staff on;
- communication with residents'
- monitoring and documentation of nutritional intake.
- the creation of, access to, retention of, maintenance of and destruction of records.
- policies to guide staff on aspects of clinical care specific to the resident profile are also required.

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:

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:	OSV-0002360
Date of Inspection:	18 November 2014
Date of response:	20 February 2015

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 02: Communication

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The means of communication for each resident were not documented to ensure that all staff were aware of them

Action Required:
Under Regulation 10 (2) you are required to: Make staff aware of any particular or

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

individual communication supports required by each resident as outlined in his or her personal plan.

Please state the actions you have taken or are planning to take:
With the assistance of a speech and language therapist the person in charge will co-ordinate the development of personal communication plans for each resident. The plans will include the specific communication supports required by each resident and the communication aids used to support the residents communication. The PIC will develop with the support of the staff team specialist plans as necessary. The person in charge will discuss development of the individual communication plans with all members of staff at a staff meeting on (23-01-2015). The communication plans and minutes of the staff meeting will be available for review.

Proposed Timescale: 28/03/2015

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:
Comprehensive assessments of health personal or social care needs were not always in place and where they were in place were not reviewed as changes in need or condition occurred.

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:
The person in charge with the support of a nominated Senior Clinician will review the current assessments of need. In order to do this the PIC will be facilitated to be off the frontline. The PIC and Senior Clinician will review and update the assessment of health, personal and social care needs of each resident. Where clinically indicated nominated clinical staff will complete additional clinical assessments. Each assessment will indicate the next review date which will be no less frequently than on an annual basis or more frequently as needs change.

The updated assessments of need will be available for review.

Proposed Timescale: 20/02/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Suitable and sufficient arrangements to meet residents needs were not in place.

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

Please state the actions you have taken or are planning to take:
The person in charge with support from a nominated Senior Clinician will review the current assessments of need. They will then review and where necessary develop individual personal plans to meet the assessed needs of the residents. The provider nominee will meet with the person in charge and Senior Clinician to review the assessment of needs and personal plans, in order to ensure arrangements are put in place to meet the assessed needs of each resident. The individual plans and the arrangements to meet the assessed need will be discussed at the staff meeting on (23-01-2015). The plans and the minutes of the staff meeting will be available for review. It has been identified that the needs of all the residents are not being fully met in the designated centre, see attached confidential report.

Proposed Timescale: 20/02/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal and social plans which were in place did not fully reflect the residents assessed needs

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 with the support of a nominated Senior Clinician will review the current assessments of needs including personal and social need. They will review and where necessary update or develop individual personal plans including personal and social plans to meet the assessed needs of the residents. The developed individual plans will be discussed at the staff meeting on (23-01-2015). The plans and the minutes of the staff meeting will be available for review.

Proposed Timescale: 20/02/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Plans in place had not been reviewed as needs changed and were not adequate or appropriate to support resident's continued personal independence and life skills development.

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:
The person in charge with support from a nominated Senior Clinician will review the current assessments of need and individual plans. Each personal plan will indicate the next review date which will include a review of the residents circumstances change and be no less frequently than on an annual basis.
The plans and the minutes of the staff meeting will be available for review.

Proposed Timescale: 20/02/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Plans in place did not reflect assessed needs and did not adequately or appropriately support promotion or maintenance of life skills.

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 with support from a nominated Senior Clinician will review the current assessments of need. They will review and when necessary develop or update individual personal plans to meet the assessed needs of the residents. These plans will include specific measures to promote and maintain life skills. The developed individual plans will be discussed at the staff meeting on (23-01-2015). The plans and the minutes of the staff meeting will be available for review.

Proposed Timescale: 20/02/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
plans in place had not been reviewed to take account of changes in needs or circumstances

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:
As part of the review of assessment of need and individual plans outlined above the person in charge will ensure that review dates are included. The review dates will

include specific instructions to review as "changes in need/ changes in circumstances" occur or at least annually.

Proposed Timescale: 20/02/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre was not suited to fully meet the assessed needs of residents

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

Please state the actions you have taken or are planning to take:
During the process of reviewing the assessment of need and individual plans the person in charge with support from a Senior Clinician will consider the suitability of the premises to meet the assessed need of residents. Where the needs of the residents are not being met the information will be included in the review of the premises as outlined under outcome 6.

A full review of the premises was carried out on 19-01-2015. This review was taken in conjunction with the assessed needs of the residents. The review identified certain area's of the designated centre which may be having an impact on the well-being of residents.

One area identified was the kitchen area, "the kitchen is small and compact and is fully accessible for a person in a wheelchair. However it is not operationally accessible for someone in a wheelchair." This fact when looked at in accordance with the assessed needs of some residents who are wheelchair users, identifies the fact that they cannot be given the opportunity to operationally access the kitchen area. Therefore the suitability of the premises for some residents is being considered (see separate report in relation to this action plan)(completion date 04-05-2015).

A second area identified was the lack of a suitable area to be a second sitting room for residents. As per the plans in the report, "area 9 on the schedule of accommodation was originally designed as a quiet room or visitors room it is now used as the staff sleepover room".
As per the separate report attached to this action plan, a plan is in place for a room in the house to be converted to a second sitting room (completion date 06-04-2015).

Proposed Timescale: 13/07/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

the following respect:
The design and layout of the centre was not found to meet the needs of the current resident profile in line with the Statement of purpose

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
A full review of the premises was carried out on 19-01-2015. This review was taken in conjunction with the assessed needs of the residents. The review identified certain area's of the designated centre which may be having an impact on the well-being of residents.

One area identified was the kitchen area, "the kitchen is small and compact and is fully accessible for a person in a wheelchair. However it is not operationally accessible for someone in a wheelchair." This fact when looked at in accordance with the assessed needs of some residents who are wheelchair users, identifies the fact that they cannot be given the opportunity to operationally access the kitchen area. Therefore the suitability of the premises for some residents is being considered (see separate report in relation to this action plan)(completion date 04-05-2015).

A second area identified was the lack of a suitable area to be a second sitting room for residents. As per the plans in the report, "area 9 on the schedule of accommodation was originally designed as a quiet room or visitors room it is now used as the staff sleepover room". As per the separate report attached to this action plan, a plan is in place for a room in the house to be converted to a second sitting room (completion date 06-04-2015).

A third area which was identified as requiring attention was a lack of storage in the designated centre. "…there was no significant issue with storage for equipment other than a mobile hoist which is currently only intermittently used. (this could be stored in a new external storage facility)." A chest freezer could also be stored in this facility as there is currently no space for this item in the kitchen area. See costings for works attached. (Completion date 13-07-2015).

The current statement of purpose will be amended accordingly to reflect all changes to the designated centre. (Completion date 31-07-2015)

A full review of the staff skill mix within the designated centre has also been undertaken. This review highlighted some deficits.
• The PIC will now permanently be in addition to the full staffing requirement.
•The HR dept are currently in the process of recruiting two RNID Staff Nurses to replace two RGN's currently on the staff team. These posts will enhance the skill mix of nurses currently in the centre. (start date 01-04-2015)
• There is currently a half time post for a Staff Nurse within the designated Centre. This post will be converted to a Social Care Worker post and filled accordingly. This will also enhance the current skill mix and provide input on residents assessed social needs.

(start date 01-04-2015)
• The review identified the need for all staff to be suitably performance managed. This will include the CNM 1/ 2 X Senior Staff Nurses and all Care assistants. The PIC and Service manager have to date met with all Nursing staff individually in relation to performance management and on-going Clinical Professional Development. Minutes of these meetings are available for review in the designated centre. These meetings will continue going forward on a monthly basis. The PIC will meet with all Care Assistants in relation to performance management and their on-going development.
• The staffing review also identified the requirement for household staff in addition to the current staff ratio. The HR dept are currently in the process of identifying a fulltime housekeeper and cook for the designated centre. (start date 09-03-2015).

A separate confidential report has been submitted to the authority to be taken in conjunction with this Action Plan. This report directly supports some actions highlighted in this plan.

Proposed Timescale: 31/07/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A full maintenance programme is required- this was identified but not addressed since last inspection.Overall it was noted that the majority of fixtures and fittings needed replaced or repaired including but not limited to; wall and floor tiles in bathrooms, shower areas and toilets; linoleum flooring in the dining and kitchen area and flooring needs review throughout the unit; skirting, doors, door surrounds and lintels. paintwork and review of lighting.

Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
A full review of the premises was carried out by the Technical Services Dept on 19-01-2015. This review was taken in conjunction with the assessed needs of the residents. The review identified certain area's of the designated centre which may have been having an impact on the well-being of residents. The review also focused on the general state of repair of the building externally and internally. This report is available for review in the designated centre and a copy was forwarded to the Authority.

Proposed Timescale: 19/01/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre does not currently meet all of the requirements of schedule 6 including but not limited to;

Adequate private and communal accommodation was not available for residents including adequate social, recreational dining and private accommodation.
Suitable or sufficient storage was not available for large items of equipment to meet residents mobility or seating needs or to house basic kitchen appliances such as a chest freezer.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
A full review of the premises was carried out on 19-01-2015. This review was taken in conjunction with the assessed needs of the residents. The review identified certain area's of the designated centre which may be having an impact on the well-being of residents.

One area identified was the kitchen area, "the kitchen is small and compact and is fully accessible for a person in a wheelchair. However it is not operationally accessible for someone in a wheelchair." This fact when looked at in accordance with the assessed needs of some residents who are wheelchair users, identifies the fact that they cannot be given the opportunity to operationally access the kitchen area. Therefore the suitability of the premises for some residents is being considered (see separate report in relation to this action plan)(completion date 04-05-2015).

A second area identified was the lack of a suitable area to be a second sitting room for residents. As per the plans in the report, "area 9 on the schedule of accommodation was originally designed as a quiet room or visitors room it is now used as the staff sleepover room". As per the separate report attached to this action plan, a plan is in place for a room in the house to be converted to a second sitting room (completion date 06-04-2015).

A third area which was identified as requiring attention was a lack of storage in the designated centre. "…there was no significant issue with storage for equipment other than a mobile hoist which is currently only intermittently used. (this could be stored in a new external storage facility)." A chest freezer could also be stored in this facility as there is currently no space for this item in the kitchen area. Costing for works have been submitted to the Authority. (Completion date 13-07-2015).

The current statement of purpose will be amended accordingly to reflect all changes to the designated centre. (Completion date 31-07-2015)

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of accessibility within the designated centre with reference to the statement of purpose to ensure the centre achieves and promotes accessibility specifically in relation to access to the kitchen area is required and any necessary alterations are carried out.

Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
A full review of the premises was carried out on 19-01-2015. This review was taken in conjunction with the assessed needs of the residents. The review identified certain areas of the designated centre which may be having an impact on the well-being of residents.

One area identified was the kitchen area, "the kitchen is small and compact and is fully accessible for a person in a wheelchair. However it is not operationally accessible for someone in a wheelchair." This fact when looked at in accordance with the assessed needs of some residents who are wheelchair users, identifies the fact that they cannot be given the opportunity to operationally access the kitchen area. Therefore the suitability of the premises for some residents is being considered (see separate report in relation to this action plan)(completion date 04-05-2015).
The current statement of purpose will be amended accordingly to reflect all changes to the designated centre. (Completion date 31-07-2015)

Proposed Timescale: 31/07/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records of clinical interventions which had taken place relating to ongoing healthcare needs were not up to date and did not give a complete and accurate picture of each residents' health care status.

Ongoing review and monitoring of underlying health issues were not in place. Evidence that residents had a full review of all of their healthcare needs was not available.

Regular and ongoing review processes and assessments to maintain health were not in place.

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

Please state the actions you have taken or are planning to take:
The PIC will organise for all residents to have a full review of their health care status. St Michaels House Medical Doctors will attend the review of assessments of need.
Health status going forward will have a full review as required or on an annual basis.

Records will be maintained relating to clinical interventions and on-going changing healthcare needs. Copies of reports of all medicals will be available for review in the designated centre.

Proposed Timescale: 20/02/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Access to the clinical team in place for the broader St Michael's house organisation was priority based due to limited staff availability and reviews of the current resident profile had yet taken place.

There was a lack of timely referral to medical and allied health care personnel where there were clear indicators of clinical deterioration requiring such review.

Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
All residents have had multi-disciplinary team meetings since mid November to December 2014. The minutes and subsequent actions from these meetings are available for review.
The Organisation has moved to a clinical cluster model of service provision. This will include a Senior Clinician and Service Manager who can ensure the input of clinical supports in a timely manner. This will also ensure that access to clinical input will be on a needs basis and will involve specific designated time where all clinicians/ stakeholders involved in a person's care will come together to co-ordinate that care.

Proposed Timescale: 20/02/2015

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 did not reflect the service being provided in the centre in that the facilities and services outlined in the document were not in place in order to meet the diverse needs of the client group the designated centre is intended to meet.

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 person in charge will review the statement of purpose and will revise it to ensure it reflects the current facilities and services available in the centre. The statement of purpose will be further reviewed and revised to reflect any future changes to facilities and services.

Proposed Timescale: 31/07/2015

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:
Two documents one in relation to planning compliance and the other relating to fire compliance remain outstanding.

Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Fire Safety Compliance; An Inspection was carried out on the premises and a report issued on 04-09-2014. The area's identified on this report will be rectified and the Independent Fire Safety Consultant will issue a letter stating his opinion that the residence is fully compliant in fire safety.

Planning and Building control; A report by an independent Architect will be available by 16-01-2015, stating his opinion that the designated centre is compliant in the Planning and Building regulations.

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 were limitations to the supports in place to facilitate the purpose and function of the designated centre. Systems were not established and in place to monitor risk and quality of care.

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:

An experienced RNID has been appointed as service manager to the unit. She will provide support on clinical issue's for PIC and staff.
A further six monthly quality of care review will take place on 14-01-2015 and going forward will be completed every three months. A Health and Safety audit will also be conducted to support the PIC to identify risks and complete relevant risk assessments.

Proposed Timescale: 30/01/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure does not include an identified person with oversight of and responsibility for the professional development and co ordination of the nursing team to ensure the nursing and care personnel are skilled and competent to fully meet the needs of residents

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 who was in post when this Inspection took place has since left the organisation. A suitably qualified RGN with 13yrs experience in the field of Intellectual disabilities has taken up the post as of 09-02-2015. This person also has 8yrs experience in a managerial role working in both day and residential services. As requested by the authority she is currently in the process of submitting an NF30 pack, this will be submitted to the authority by 02-03-2015

An experienced RNID has been appointed as service manager to the unit to provide specific professional support and development to the PIC and staff. The PIC and service manager will initially meet with all staff together to identify specific supports required for professional development. The PIC will meet with the service manager every four to six weeks for support, supervision and professional development. The PIC will meet every four to six weeks with each staff member to support them in their role, review and supervise their performance and identify area's for professional development. The service manager will assist the PIC in this undertaking. Minutes of these meetings will be kept and will be available for review.

A full review of the staff skill mix within the designated centre has also been undertaken. This review highlighted some deficits.
• The PIC will now permanently be in addition to the full staffing requirement.
• The HR dept are currently in the process of recruiting two RNID Staff Nurses to replace two RGN's currently on the staff team. These posts will enhance the skill mix of nurses currently in the centre. (start date 01-04-2015)
• There is currently a half time post for a Staff Nurse within the designated Centre. This post will be converted to a Social Care Worker post and filled accordingly. This will also

enhance the current skill mix and provide input on residents assessed social needs. (start date 01-04-2015)
• The review identified the need for all staff to be suitably performance managed. This will include the CNM 1/ 2 X Senior Staff Nurses and all Care assistants. The PIC and Service manager have to date met with all Nursing staff individually in relation to performance management and on-going Clinical Professional Development. Minutes of these meetings are available for review in the designated centre. These meetings will continue going forward on a monthly basis. The PIC will meet with all Care Assistants in relation to performance management and their on-going development.
• The staffing review also identified the requirement for household staff in addition to the current staff ratio. The HR dept are currently in the process of identifying a fulltime housekeeper and cook for the designated centre. (start date 09-03-2015).
• The statement of purpose will be updated and re-submitted to reflect all changes to the staffing structure.

Proposed Timescale: 01/04/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Facilities and services outlined in the statement of purpose were not in place in order to meet the diverse needs of the client group the designated centre is intended to meet. Clear plans were not in place, which take account of funding and resources available to in order to ensure the provision of safe effective residential services and demonstrate an understanding of the level of need which require to be met now and into the future.

Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The PIC will ensure that the majority of staff will be licensed to drive the house minibus.
All non nursing staff will be trained in the safe administration of medication in order to facilitate social activities for residents. This will allow greater access to community facilities.
The statement of purpose will be updated to reflect the current facilities and services.

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 evidence that the number qualifications and skill mix of staff did not meet the assessed needs of all residents in that;
- there were not sufficient staff with a driving license to facilitate the social needs of residents to access leisure activities at times of their choice.
- there were no staff with specific responsibility for household tasks and these are shared between the nursing personnel and care staff which was found to negatively impact on ability of these staff to meet the the personal, health and social care of residents.
- staff with catering qualifications to ensure that residents dietary needs were fully met through the provision of food with accurate nutritional content.
- there were insufficient numbers of nursing personnel with qualifications in intellectual disability and psychiatry to meet the needs of residents.

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:
The PIC will ensure that the majority of staff will be licensed to drive the house minibus.

A full review of the staff skill mix within the designated centre has also been undertaken. This review highlighted some deficits.
• The PIC will now permanently be in addition to the full staffing requirement.
• The HR dept are currently in the process of recruiting two RNID Staff Nurses to replace two RGN's currently on the staff team. These posts will enhance the skill mix of nurses currently in the centre. (start date 01-04-2015)
• There is currently a half time post for a Staff Nurse within the designated Centre. This post will be converted to a Social Care Worker post and filled accordingly. This will also enhance the current skill mix and provide input on residents assessed social needs. (start date 01-04-2015)
• The review identified the need for all staff to be suitably performance managed. This will include the CNM 1/ 2 X Senior Staff Nurses and all Care assistants. The PIC and Service manager have to date met with all Nursing staff individually in relation to performance management and on-going Clinical Professional Development. Minutes of these meetings are available for review in the designated centre. These meetings will continue going forward on a monthly basis. The PIC will meet with all Care Assistants in relation to performance management and their on-going development.
• The staffing review also identified the requirement for household staff in addition to the current staff ratio. The HR dept are currently in the process of identifying a fulltime housekeeper and cook for the designated centre. (start date 09-03-2015).
• The statement of purpose will be updated and re-submitted to reflect all changes to the staffing structure.

Proposed Timescale: 01/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The education, training and development opportunities available to staff did not enable them to meet the full needs of residents.

Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
A full training needs analysis by the training department was completed in October 2014 on all staff to review compliance to the Minimum training requirements as set down by the Organisation. The following area's were highlighted in the training needs analysis as requiring attention;
1. Hand Hygiene; required to be refreshed every 2yrs. Refresher took place on 12-12-2014
2. Clamping Training; scheduled to take place on 7th and 9th January 2015
3. Training in the administration of Sub-Cutaneous fluids took place for all nursing staff on 19th December 2014

For continuous professional development the organisation is committed to supporting nurses in the area. All registered nurses are expected to source relevant professional development via outside agencies. The organisation will then support them in applying for funding, and undertaking to complete the appropriate training/ education. All qualifications achieved will then be uploaded to the relevant training records once the training department have received them. Through individual support meetings the PIC and Service Manager can support all nurses in their continuing professional development.

Proposed Timescale: 28/02/2015

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 policies required to be maintained under Regulation 4 and listed in Schedule 5 were not available, including policies to guide staff on
-communication with residents'
-monitoring and documentation of nutritional intake.
-the creation of, access to, retention of, maintenance of and destruction of records.
- policies to guide staff on aspects of clinical care specific to the residnt profile are also required.

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:
Nutrition Policy: The registered provider is developing a nutrition policy. The policy has been completed as of December 15th 2014 and is available for review.

Records Management:
The registered provider has established a working group to develop the ''Creation of, access to, retention of, maintenance and destruction of records policy' as required in the legislation. The Policy will be in line with the Data Protection Act. This will be a significant organisation policy with many stakeholders including service users, staff, administrative functions and clinical supports. A first draft of the policy has been developed as of 15th December 2014. The final draft will be completed by March 31st 2015. A copy of the initial draft policy is available for review.
Completed By: Phase 1: 15th December 2014 Final Draft : March 31st 2015

Communications and Provision of Information to Residents: The registered provider is in the process of developing a Communications Policy and a Provision of information to residents policy as required in the legislation. The Policies will be discussed at a staff meeting to ensure all staff have up to date knowledge on the policy. The Policies and minutes of the staff meeting will be available for review when completed. The draft policies from Phase 1 are available for review.
Completed by: Phase 1: 15th December 2014 Final Draft : March 31st 2015

The registered provider will update the policy on Urinary Catheter Care to include specific guidelines for staff on how to respond in the event a catheter becomes dislodged.

Proposed Timescale: 31/01/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A directory of residents was not established.

Action Required:
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

Please state the actions you have taken or are planning to take:
A directory of residents is available for review in the designated centre. This directory has been updated to include dates of when residents are not physically present in the house.

Proposed Timescale: 20/11/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure the directory contains all of the information required under schedule 3 point 3 (a) - (e) and points 7,8 and 9 of schedule 4 of the regulations.

Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:
A directory of residents is available for review in the designated centre. This directory has been updated to include dates of when residents were not physically in residence in the house. The Registered Provider will update systems within the organisation to ensure that nights spent out of the designated Centre for all residents will be recorded.

Proposed Timescale: 20/11/2014