Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0003597
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Sheila McKevitt
Support inspector(s):	Shane Walsh
Type of inspection	Announced
Number of residents on the date of inspection:	7
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 2 day(s).

The inspection took place over the following dates and times

From:	To:
27 January 2015 10:00	27 January 2015 17:30
28 January 2015 08:00	28 January 2015 18:00

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 formed part of the assessment of the application for registration by the provider. The inspection took place over two 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 of the centre were also sought.

The nominated person on behalf of the provider and the person in charge were in attendance during the inspection. They had experience and knowledge of working with residents with disabilities. However, as outlined in the body of this report they

were not managing the centre effectively. The person in charge told inspectors she did not feel she could manage the centre effectively, as a number of the residents had developed medical problems which required nursing care input and she did not have a qualification in nursing.

Some evidence of good practice was found across all outcomes; management had addressed one non-compliance and partially addressed two non-compliances from the last inspection in September 2014. On this inspection the centre was in compliance with 3 out of 18 Outcomes inspected against. Seven residents were living in the centre which was originally designed to accommodate six residents'. Adequate resources had not been put in place to meet the needs of residents which had resulted in negative outcomes for the residents.

As part of the application for 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 by the inspector.

Inspectors found evidence that maximum efforts were not being made to protect residents' against all forms of abuse, such as self-harm or potential financial abuse as robust care systems were not in place and policies were not being followed. Some staff had not got up-to-date refresher training in the protection of vulnerable residents'. Families were not communicated with appropriately and their complaints were not addressed as per the centres policy. Residents' assessments and care plans had been developed. However, resident representatives were not involved. Some care plans did not reflect the care needs of residents and were not updated when there was a change in residents care needs. Social care plans in place were not being implemented.

The statement of purpose had been amended but still did not reflect the legislative requirements and a copy had not been provided to residents' or their representatives. The dining, communal and storage space for equipment was not adequate to meet the needs of seven residents. This lack of space was resulting in increased noise levels in communal areas of the centre which in return was leading to a number of residents having increased incidents of behaviour's that challenge and self harm.

Medication management practices were unsafe and medication errors were not being followed up on by the management team. The person in charge did not have an adequate number of administration days on the monthly roster to enable her to carry out her role as person in charge. Staffing levels and skill mix were not adequate to ensure residents' needs were being met particularly their social care needs. Staff training was not adequate to meet the needs of residents'.

Records, specifically policies outlined in schedule 5 were not available in final draft and therefore had not been implemented. In addition, some policies were not being

fully adhered to. Records of emergency fire checks completed by technical services staff were not sufficiently detailed and the directory of residents did not contain all the details outlined in the legislation.

The action plans at the end of this report identifies the fifteen outcomes under which improvements are required.

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:
Residents' were consulted with and participated in decisions about their day to day care as much as they could. They were provided with information about their rights and each resident’s privacy and dignity was respected.

Residents had a weekly meeting where they discussed the week ahead with staff. Here they planned their evening meals, activities, appointments and visits to and from family homes.

Resident’s privacy and dignity was respected. Inspectors saw that residents' could lock their bedroom door if they wished; one resident showed inspectors the key for his bedroom door. The bathroom/shower room and toilet doors had privacy locks in place. All windows had blinds and curtains in place.

The rights of residents’ were respected. Inspectors saw evidence that residents' had choice and retained autonomy of their own life as much as possible. Their representatives spoken with confirmed this. For example, one resident liked to spent time in his bedroom playing his piano and staff did not impede him doing so. Residents' who choose to attend religious services were facilitated to do so. Inspectors were told that none of the seven residents' were registered to vote as none had the capacity to do so.

There was a copy of the charter of rights published by the National Advocacy Committee which was on display in the front hallway. Residents' representatives explained how they had been informed about the service.

Inspectors were informed by residents' families and staff that a seventh resident was admitted to the centre in July 2014. The relatives of six residents' residing in the house were consulted with prior to this new admission. A number told inspectors on inspection that they raised concerns about a seventh resident moving into the house and the negative impact this would have on the existing six residents'. These concerns were not addressed by the management team prior to the seventh resident being admitted, one concern made remained ongoing and relatives raised their concerns with the inspectors on inspection.

There was a complaints policy in place which met the legislative requirements and a pictorial copy was on display and accessible to residents in the centre. A copy was also included in the residents guide. However, the management of complaints was inconsistent. Inspectors were told there were two complaints to date, both were reviewed, one received in June 2014 had not been dealt with to date the second was closed. However, records in relation to the first complaint were not in a clear sequential order and the procedure being followed was not in line with the centres complaints policy. Records of the second complaint did not state whether the complainant was satisfied with the outcome of the complaint or not.

Judgment:
Non Compliant - Moderate

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:
The policy on communication with residents did not reflect practice and residents' communication needs were not being met to a high standard. Each of the seven residents' living in the centre had varying degrees of abilities to communicate verbally. These residents' communicated through use of non-verbal means. Each resident had a basic communication needs assessment completed on admission. However, it was not detailed enough to identify what different actions, gestures or movements corresponded with what mood, need or want.

All residents' had been assessed by a speech and language therapist. However, recommendations made had not been fully implemented. For example, recommendations made in June 2014 for one resident included developing visual and sensory aids to communicate with the resident. The inspector was shown the sensory box which consisted of bottles of various herbs and the visual schedule which was stored beneath the television and was not being used to aid communication with the

resident. These recommendations were not included in a communication care plan for the resident.

Staff were aware of the different communication needs of residents. However, they did not take these into consideration when caring for residents. For example, it was recorded in two residents' files that they were sensitive to noise, loud noise caused them distress which often resulted in self harm. At evening meal time all seven residents were in the kitchen/dining room where the noise levels were extremely high due to residents' food being prepared with a hand blender, staff talking across each other to residents and the television been on, together with seven residents' and four staff in the room. The inspector, observed a resident self harming, biting her hand clearly as stated in her file due to her inability to cope with loud noise. However, staff did not react to her obvious sign of distress.

Residents did not have access to assistive technology, aids or appliances to promote their full capabilities.

Judgment:
Non Compliant - Major

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:
Positive relationships between residents and their family members were supported. There was a visitor's policy in place. Residents' representatives who spoke with inspectors explained how they were welcome to visit residents' in the centre at anytime. They also explained how staff facilitated the residents' to visit the family homes by providing transport. However, inspectors observed and residents' families all mentioned the lack of a visitor's room as having a negative impact on privacy. during visiting.

Communication between staff and residents' next of kin was not good. Residents representatives/next of kin said that they were consulted with on issues in relation to their loved ones health but were never asked or involved with the residents personal plan of care. Four residents' representatives spoken with expressed concern about recent communication via telephone from the person in charge who called a residents' next of kin to say that the resident may be moved out of the centre. All four expressed concern that residents' who had lived in the centre for over ten years would be moved out.

Inspectors found that residents' were not being adequately supported to link with the

local community on a day to day basis.

Judgment:
Non Compliant - Moderate

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:
Contracts of care were available for each resident and admission to the centre was in line with the admissions policy. The three contracts reviewed were signed and dated by the respective residents' representative and the person in charge. The contracts included details about the supports, care and welfare the resident would be expected to receive, details of the services to be provided and the fees to be charged. They also referred to additional costs that may be charged.

The admissions policy in place outlined the procedure to be followed prior to a resident being admitted to the centre. It included the involvement of the person in charge, the resident to be transferred and his/her next of kin. It stated that residents would be facilitated to visit the centre prior to their admission. However, inspectors formed the view that the mix of residents' currently living in the centre was not safe.

Inspectors were informed by residents' families and staff that a seventh resident was admitted to the centre in July 2014. The relatives of six residents' residing in the house were consulted with prior to this new admission. A number raised concerns about a seventh resident moving into the house and the negative impact this would have on the existing six residents'. These concerns were not addressed by the management team prior to the seventh resident being admitted, one concern submitted in writing remained ongoing and relatives raised their concerns with the inspector on inspection.

Inspectors saw that the seventh resident's behaviour had a negative impact on the other six residents' living in the house. The new resident communicated by making loud verbal sounds, this resulted in an increase in anxiety levels/distress for a number of residents', which in turn lead to varying degrees of self harm by residents who as mentioned in Outcome 2 had been assessed as self harming when noise levels increased.

The admission of a seventh resident had also resulted in the loss of communal space available as the second communal room/private sitting room had been converted into a bedroom. Also, this resident did not attend day care and required 1:1 supervision from

staff. An appropriate number of additional staff had not been recruited and therefore staff did not have the time to meet the social care needs of the other six residents living in the centre as evidenced under Outcome 5.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
An assessment of each resident’s health, personal and social care and support needs was carried out as required to reflect changes in the residents' need and circumstances, and at a minimum once a year. The assessments reviewed had multi-disciplinary input. However, there was no evidence of families being involved in residents assessment or personal plan. Those spoken with confirmed they were not involved and were not aware of these documents.

The assessment completed did not comprehensively reflect the care needs of all residents. As mentioned under Outcome 2, a number of residents who could not communicate verbally did not have comprehensive communication assessments completed.

Residents who required nursing care did not have comprehensive assessments in place to reflect their nursing care needs. For example, one resident at risk of developing pressure ulcers did not having an appropriate assessment in place to identify the level of risk. Residents with nursing care needs had nursing care plans in place however, these were not being updated when there was a change in the residents' care. For example, an insulin dependent diabetic was prescribed 14 units of insulin each evening but the residents care plan stated to administer 12 units of insulin each evening.

All seven residents' had a personal outcome based social plan in place, all had been written in 2014 and each outlined up to three individual goals set for the year. However, none of the residents' personal plans had been implemented in full. For example, one residents' 1st goal was to go swimming twice per month, there was no recorded evidence that this had been achieved. Staff told inspectors it had not happened due to

the lack of staff. The 2nd goal, to set up a communication programme (the resident was non-verbal), such as a communication passport, objects of referral had not been completed and the 3rd goal to engage in techniques for the resident to interact in the community, inspectors were told this was being implemented in the residents' day care. Each resident had a maximum of one of their three personal goals implemented and inspectors found little evidence of improved social care outcomes for the residents'.

Residents' personal plans were not made available in an accessible format to the residents as mentioned under Outcome 2, residents had complex communication needs and personal plans were available in written format only.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
This semi detached single storey building was initially home for six residents but some internal changes were made and a seventh resident moved in July 2014. However, it was not meeting the individual and collective needs of the seven residents' in a comfortable and homely way.

Inspectors saw that the premises were well-maintained with suitable heating, lighting and ventilation. It was clean, tidy and suitably decorated.

There were seven resident bedrooms. Some residents' showed inspectors' their bedrooms which had been furnished to meet their personal taste.

There were sufficient furnishings, fixtures and fittings to meet the individual needs of residents', including storage space in each resident's bedroom.

The communal areas included a well equipped kitchen/dining room and a sitting room. However, although the dining room table could seat 8 people without assistive equipment, it was not large enough to accommodate the seven residents, as two residents were wheelchair bound and both required some assistance from staff at mealtimes.

The sitting room was not large enough to accommodate seven residents' and to

overcome this problem a two seater sofa had been put in the kitchen but this had reduced the amount of dining space available. The laundry and cleaning storage room contained all required equipment. There were two large assisted shower rooms, one with a large assisted bath and ceiling hoist, both had a assisted toilet with wash hand basin. There was a third separate assisted toilet with wash hand basin situated beside the communal room. As mentioned under Outcome 1, there was no private room for residents' to receive visitors in private and there was no activities/quite room for those residents' identified on assessment as being noise sensitive.

The inspector viewed the rear garden accessible to residents' via two patio door exits. The garden contained a paved area where residents could enjoy dining outside. The garden was secured by closing the side gate entrance leading from it. Car parking spaces were available to the front of the house.

There was a staff office and bedroom. The staff bedroom had ensuite facilities which included a shower, toilet and wash hand basin.

Assistive equipment required by residents' was available and inspectors saw all equipment had been recently serviced. However, large pieces of equipment were being stored in two residents' bedrooms; staff explained that this was due to a lack of storage space for large pieces of equipment.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The health and safety of residents, visitors and staff was promoted and protected. The risk management policy in place met the legislative requirements as it included measures in place to identify and manage risk and outlined procedures to follow in the event that specific risks did occur. The person in charge completed risk assessments on a monthly basis. There was an up-to-date local health and safety statement in place. The emergency plan in place was detailed and included the procedures to be followed in the event of an emergency. Staff had an emergency pack in place.

Records were available to confirm that fire equipment including fire extinguishers, the fire blanket, emergency lighting and the fire alarm had all been tested by professionals within the required time frame. However, the records of emergency lighting checks in the centre were not detailed enough, this is discussed in more detail under Outcome 18.

All staff had completed fire training within the past year and those spoken with had a clear understanding of the procedure to be followed in the event of a fire. The inspector saw that each resident had an individual fire evacuation plan in place and records reviewed showed that fire drills were practiced on a regular basis during the day and night by both staff and residents.

Judgment:
Compliant

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

Theme:
Safe Services

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

Findings:
Some measures were in place to protect and safeguard residents which included a policy on, and procedure in place for, the prevention, detection and response to abuse. However, measures in place required improvement as inspectors found that systems in place to manage residents' petty cash were not as per the centres policy and two staff had not attended safe guarding vulnerable adults training since 2008.

Residents' representatives spoken with told inspectors that they felt residents' were safe and secure in the centre. They had an enclosed rear garden, all the exit/entry doors could be secured by locking and the house was alarmed. Residents could lock their bedroom door if they wished; they had access to bedroom door keys. Inspectors saw bathroom and toilet doors had secure locks.

All residents' required staff support with their personal needs and all had intimate care plans on file. There was a minimum use of restraint in the house and those with restraint in use had appropriate risk assessments completed to reflect its use.

Communication between residents and staff required improvement. Staff were observed communicating appropriately with residents' when they were providing one to one care. However, when all residents were gathered in the open plan kitchen/dining room, staff communicated with resident and each other by raising the volume of their voice in order to be heard over the increased noise levels in the room. Inspectors observed the increased noise levels in this area at two different mealtimes. It was not possible to hear anybody speak at normal volume.

Inspectors observed one of the resident's communicated by making sounds at above normal sound volume. The resident communicated this way in reaction to feelings of joy, distress and happiness. This in turn led to two residents who were sensitive to high volumes of noise to react by self harming. For example, on one occasion inspectors saw one resident slapping her face continuously in response to the raised noise levels made by this resident.

Inspectors observed that staff did not respond swiftly to residents' who displayed self harm despite detailed guidelines being in place. For example, during breakfast time inspectors observed one wheelchair dependent resident biting her hand continuously and becoming red in the face when positioned opposite another resident in the dining room. Staff present explained that this behaviour was due to the fact that the distressed resident did not react well to the presence of the other resident. However, staff had placed the wheelchair dependent resident in the position and did react to her display of self harm by determining the underlying cause of her distress, until inspectors brought it to staffs attention.

There was a policy and procedure for the management of residents' monies and a procedure on personal possessions however, it was not being adhered to. Residents' not capable of managing their finances independently were facilitated by staff to do so. There was an individualised system in place and residents could access their money when they wished however, the records did not reflect monies held and receipts were not available to reflect all monies spent. Money was being shared between residents' and this was not accepted practice according to the recently update policy. This is discussed further under Outcome 18.

Judgment:
Non Compliant - Moderate

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:
A record of all incidents occurring in the designated centre was maintained. Quarterly reports had been submitted to the chief inspector in a timely manner. No incidents' notifiable within three working days had occurred in the centre to date.

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:
There was no policy on access to education, training and development. There assessment process to establish each resident's educational/employment/training goals was not detailed in their personal file.

Six of the seven residents' attended day care facilities for 3-5 days per week. The seventh resident to be admitted to the house did not have access to any day care facility or training centre. Therefore, this resident spent most of every day in the house with staff with occasional trips out to nearby shops in his wheelchair. Staff explained that as it took two staff to take the resident out in transport and only one staff member was on duty it was not possible to take the resident out Monday to Friday.

The remaining six residents were not facilitated to engage in activities outside of the centre. They were engaged in a limited amount of social activities accessed from the centre. Residents' representatives spoken with said staff had no time to engage in one to one activities with residents' which most of the residents' required due to their high dependency needs

Judgment:
Non Compliant - Moderate

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:
There was evidence that overall the health care needs of residents were being met. All residents had assessments completed. Multi-disciplinary team members had been involved in these assessments'.

Inspectors reviewed three residents’ files and saw evidence that they were facilitated to access their General Practitioner (GP) and to seek appropriate treatment and therapies from health care professionals when required. Inspectors were satisfied that the allied health services were availed of promptly to meet residents' needs. Completed referral forms were available for review in residents' files and written evidence of relevant reviews were also available. However, there was no evidence in one of the three files reviewed to determine if the resident had a full medical review within the past year.

Residents' spoken with told inspectors they had a choice of food. Staff did the cooking. Inspectors observed mealtimes and saw they did have a choice and were actively involved in choosing the weekly menu. They had access to an adequate quantities and a good variety of nutritious food to meet their individual dietary needs. The inspector saw that residents preferred foods reflected in their individual assessment records was provided to them at meal times. Healthy snacks were also available.

Staff were available to assist residents' at mealtime however, inspectors observed that the manner in which assistance was provided was not in line with best practice. For example, staff were seen standing beside residents' while assisting them with their meal.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
There was a new operational policy available which included the ordering, storing, administration and prescribing of medicines. However, inspectors found that practices regarding drug administration were not in line with the policy. There was a separate policy on self administration of medicines.

The practices in relation to ordering, storing, disposal and prescribing 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 by staff.

Administration practices followed by staff were not in line with best practice. A new system of dispensing medication called "blister packs" had been introduced to the centre in November 2014. However, the medication management policy had not been updated

to reflect this change and staff had not received training on how to safely administer medication using this system. Inspectors observed three staff administering medications and none of the three administered medications in line with best practice. Two staff signed to say they had administered the medications to residents prior to doing so and the third did not check the dosage of the medication prescribed prior to administration.

An audit of each resident's medications was completed on a weekly basis by staff; any discrepancies were identified and reported to the nurse manager on call by completion of an error form. However, they were not being risk rated and inspectors observed that there had been a number of serious medication errors since the new system had been introduced. For example, one resident had been given another resident's medication. The follow-up measures taken post these incidents were not comprehensive enough to prevent there repeat occurrence and the inspectors had serious concerns due to the high risk to residents' posed by errors in practice to date. At the feedback meeting the provider gave an undertaking that qualified nurses would be brought into the centre to administer medications until all staff had completed further training regarding drug administration practices.

The inspector saw that each of the residents had their prescribed medications reviewed by the Medical Officer within the past week.

Judgment:
Non Compliant - Major

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

Findings:
A copy of the statement of purpose had been submitted to the Authority and was reviewed post the last inspection. However, it did not reflect the purpose and function of the service. For example, it stated that the centre was a social house, caring for residents' with high support needs. However, inspectors found that a number of residents' living in the centre had both social and nursing care needs.

Also, it did not contain all of the information that is required in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013. For example, it did not state how frequently residents' personal plans would be reviewed.

Relatives representatives told inspectors they had not received a copy of the statement of purpose and there was no copy accessible to them or residents' to their knowledge.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
There was a clearly defined management structure that identified the lines of authority and accountability. The centre was managed by a suitably qualified, skilled and experienced social care worker with authority, accountability and responsibility for the provision of the service. She was the named person in charge, employed full time to manage the centre. The inspector observed that the person in charge was involved in the governance, operational management and administration of the centre on a consistent basis. She had a good knowledge and understanding of the residents' and they appeared to know her well.

During the inspection the person in charge demonstrated sufficient knowledge of the legislation and of her statutory responsibilities. She was supported in her role by a team of social care workers. One of whom had been nominated to manage the centre in her absence. The person in charge was not allocated an adequate number of protected management days on the monthly schedule to enable her to fullfill her roles and responsibilities as person in charge of a residential centre caring for seven residents'.

The person in charge reported directly to a Service Manager who reported to a Regional Director (also nominated person on behalf of the provider). The inspector was informed by the person in charge and saw evidence that regular scheduled minuted meetings took place with the service manager. The nominated person on behalf of the provider attended the centre occasionally.

The service manager had visited the centre unannounced and conducted a review of the health and safety and quality of care and support provided to residents'. Here areas and issues were identified for improvement. The inspector noted that all 38 issues had been addressed by the person in charge. The inspector was informed that this information would be used to inform the annual review of the service, a format for which was being

developed by management.

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 by the inspector.

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 had not been notified of the proposed absence of the person in charge of the centre to date and the inspector was satisfied that arrangements were in place for the management of the centre during her absence.

As mentioned under Outcome 14, a social care worker met on inspection demonstrated a good clinical knowledge of residents' and had the required experience and qualifications to manage the centre in the absence of the person in charge.

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:

The centre was not resourced to ensure the effective delivery of care and support in accordance with the centre's Statement of Purpose.

As mentioned under Outcome 2, residents who were non verbal did not have access to appropriate communication aids to meet their assessed needs and as mentioned under Outcome 6, the dining room, sitting room and communal private space did not meet the needs of the seven residents' living in the centre.

The general welfare and development needs of residents' were not being met as referred to under Outcome 10 and the staffing numbers and skill mix were not meeting the needs of residents as evidenced from the content of this report.

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

Findings:
The staffing levels and skill mix were not adequate to meet the assessed needs of residents. This was evidenced by a number of negative outcomes for residents. For example, staff shortages had resulted in residents' not having their social care needs met. Residents had minimal access to social activities outside of day care and had not achieved their personal goals set for the past year due to a lack of staff on duty.

A number of residents had nursing care needs which were overall being met with the assistance of external personal been brought in to assist social care staff. However, records to reflect the assessment of residents' with nursing care needs were not always in place. In addition, care plans reflecting residents' nursing care needs were not being updated as their nursing care needs changed as referenced under in Outcome 11.

Inspectors reviewed the staff roster and noted that 236 hours were covered by relief staff over a four week period. This was a regular occurrence due to inadequate number of staff employed to work in the centre. The person in charge had brought this to the provider's attention in December 2014 however, no improvements had been made and the lack of appropriate staff was leading to negative outcomes for residents'. For example, a staff member stated that when she was in the house alone with two

residents and had to assist one the toilet she had to bring the other resident out into the corridor and leave the bathroom door open in order to observe both residents at once.

Most of the staff had all the required mandatory training in place. All staff had completed refresher fire training since the last inspection. However, as mentioned under Outcome 8, two staff did not have up-to-date protection of vulnerable residents' training in place. Staff were not adequately trained to meet the needs of residents. One resident was having grand-mal seizures which had resulted in the resident requiring oxygen therapy on two occasions and being transferred to hospital on one occasion. Only 5 of 10 staff had up to date first aid or cardio-pulmonary resuscitation training in place therefore there was not always a staff member in the house capable of providing first aid to this resident if required.

Staff did not have food safety refresher training in place. However, inspectors were informed that this was booked for all staff for 10 February 2015.

Staff had not had supervisory meetings every 4-6 weeks as stated in the organisations policy.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Residents and Adults) with Disabilities) Regulations 2013 were maintained in a manner so as to ensure ease of retrieval. However, a number of schedule 5 policies were not finalised and therefore not implemented. Also, some records were not completed accurately.

An insurance certificate was submitted as part of the registration pack and it showed that the centre was adequately insured against accidents or injury to residents, staff and visitors. It also confirmed that the bus used to transport residents was adequately

insured.

There were two paper based directory of residents' both of which contained some elements of what is required within the directory of residents however, not all information as required by regulations was contained in either directory.

The centre had some of the written operational policies as outlined in schedule five available for review. However, the following were not available
• access to education, training and development
• communication with residents'
• monitoring and documentation of nutritional intake.
• provision of information to residents'.
• the creation of, access to, retention of, maintenance of and destruction of records'.

Some policies outlined in schedule 5 which were available had not been reviewed within the past 3 years. For example, the intimate care policy was last reviewed in September 2004.

The inspector noted that the medication management and the communication policy were not reflecting practices.

The records of emergency lighting checked completed by technical services staff were not detailed enough.

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:

Sheila McKevitt
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-0003597
Date of Inspection:	27 January 2015
Date of response:	08 April 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The voice of residents' representatives who were advocating on the residents' behalf were not listened to prior to the seventh resident been admitted to the centre.

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
A comprehensive review of the service will be carried out by the multidisciplinary team focusing on assessment of need, personal plans, staff skill mix, families and the environment. Following the review the provider nominee will convene a meeting in order to determine the direction and model of service required to meet the needs of the residents.

The PIC, Social Worker and Service Manager will meet with all the families to hear their concerns.

(A) The development and introduction of a local policy on communication with families. A copy of the Organisational Complaints policy will be provided to all family members.

(B) Training will be provided to all staff in dealing with complaints and concerns raised by family
(C) monthly contact between family members and key workers will be established records maintained

Proposed Timescale: 30/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complaints were not been dealt with promptly.

Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
-The Organisational policy on the management of complaints will be presented at the next staff meeting.
-Minutes of the staff meeting will be available for review.
-The Provider Nominee has requested that the Social Worker and PIC review the two complaints referred to in the report to ensure both are now dealt with in line with complaints policy to include details of any investigation into the complaint, the outcome, any action taken and whether or not the resident or family member is now satisfied with the outcome
-1:1 training / coaching for PIC on the management of complaints.
-All complaints will be dealt with under the organisational complaints policy

Proposed Timescale: 14/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of complaints did not reflect whether the resident was satisfied with the outcome of the complaint or not.

Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
- Provider Nominee has requested Social Worker and PIC to review two complaints to ensure both are now dealt with in line with complaints policy to include details of any investigation into the complaint, the outcome, any action taken and whether or not the resident or family member is now satisfied with the outcome

Proposed Timescale: 14/04/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not assisted to communicate effectively as they did not have comprehensive communication assessments completed and recommendations made by allied health care team members were not implemented to aid their communication.

Residents were not been supported to communicate in accordance with their needs due to the high level of noise they were subjected too.

Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
(a)Full speech and language assessments were completed. These will be reviewed and communication systems developed for individuals.

(b)Service Manager will spot check the implementation of the plans and prepare a report for the Provider nominee. Minutes / reports will be available for review.

Proposed Timescale: 14/04/2015

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents required/recommended communication needs were not outlined in a personal care plan.

Action Required:
Under Regulation 10 (2) you are required to: Make staff aware of any particular or 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:
Speech & Language assessments for individuals to be reviewed and ensure they are still relevant. Communication systems to be developed from the assessments for individuals.

-Speech and language therapist to review previous recommendations and ensure they are up to date and still relevant.
-Speech and language therapist to deliver training on implementation of individualised communication plans. Plans to include environmental conditions required to support residents.
-PIC to ensure plans are fully implemented.
-Additional supports from SLT will be provided to support the PIC. (B) A review of the implementation of plans will be carried out by the SLT and PIC three months after implementation.

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not being facilitated to use assisted aids such as visual schedules and assistive technologies were not available for their use.

Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
-The review of the communication plans outlined above will include a review of the need for assistive technology and aids/appliances including visual schedules and assistive technologies.
-The PIC will ensure any assistive technology, aids, appliances and plans are implemented.
-Service Manager will spot check the implementation of the plans, technology, aids and appliances.
-Service Manager will provide regular updates to the Provider nominee
-SLT reports available for review.

Proposed Timescale: 14/04/2015

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no facility available for residents to receive visitors in private.

Action Required:
Under Regulation 11 (3) (b) you are required to: Provide a suitable private area, which is not the resident's room, to a resident in which to receive visitors, if required.

Please state the actions you have taken or are planning to take:
-A full review of the premises is being undertaken by Technical Services.
-A temporary second sitting room will be made accessible to Service Users and visitors until this work has been completed.
-Following scheduled family meetings with Service Manager, PIC, PPIM and Head of the Social work DEPT., one family indicated to the team that they were open to considering an alternative residential placement.
-Consultation has begun with the family, MDT meeting scheduled 28/4/15,
-There will a reduction in the number of residents and a second sitting will be made available permanently

Proposed Timescale: 30/07/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Communication between the centre, residents' and their families was not adequate to maintain good relationships.

Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
-PIC to develop an agreed local policy on communication strategy with families, records to be maintained and available for review.
-Regular communication with family members to be recorded. Families to have access to personal plans and be involved with the review process.
-PIC to invite families to review personal plans and contribute to the development of new plans.
-Staff member will be identified to conduct a feasibility study of the local / wider

community.
-Events to be scheduled to invite families to unit i.e. coffee mornings / consultations / information sharing.
-PIC will review outings and links with the wider community, and report monthly to the Service manager.
-Service Manager will update Provider nominee

Proposed Timescale: 30/05/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The mix of residents in the centre is unsafe.

Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
-A full review of the service will be carried out by the multidisciplinary team which will include the PIC. A consultation process with staff and families will be developed. The review will focus on assessment of need, personal plans, family involvement and the environment. Following the review the Provider nominee will convene a meeting in order to determine the direction and model of service required to meet the needs of the residents.
-As per admission policy a review will be completed of the last admission.
-A clinic nurse manager will be assigned to support the service and review current practices / guidelines with the staff. The focus will be on implementation of guidelines to ensure residents are safe.
-The Psychologist will review ABC charts monthly to measure the effects of the guidelines. The data will be made available for review.
-Clinic Nurse Manager has been temporarily assigned as supernumerary for enhanced supervision of staff , the monitoring of the delivery of best practices and the implementation of all positive behavioural support plans ensuring best practices are adhered to.
-Family meetings have commenced, one family has indicated they would be open to considering an alternative residential placement .
-The numbers of residents will decrease to six.
-The PIC will be fully involved in the discharge process.
-The allocation of staff is sufficient to meet the residents assessed needs.
-The CNM2 will ensure all staff will strictly adhere to therapeutic interventions.

Proposed Timescale: 30/07/2015

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:
There are deficiencies in documentation i.e. assessments and care plans relating to those residents' identified as having nursing care needs.

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

Please state the actions you have taken or are planning to take:
(A) PIC will support a full review of assessment of need carried out by a multi disciplinary team (including a nurse).
(B) Care plans and assessments will be updated to reflect the changing needs of each Service User.
- Personal Plans will be made available to residents in an accessible format.
- Plans are available for review.
- A social worker will meet with families who made complaints and review their satisfaction levels.

Proposed Timescale: (A) 30/04/2015 (B) 30/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The needs of all residents' were not comprehensively assessed.

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

Please state the actions you have taken or are planning to take:
A full review of the service will be carried out by the multidisciplinary team focusing on assessment of need, personal plans, families and the environment. Following the review the provider nominee will convene a meeting in order to determine the direction and model of service required to meet the needs of the residents.

- Care Plans will be made available to residents in an accessible format.
- Assessment of need and care plans will be available for review

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' next of kin were not involved in their personal plans.

Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
- PIC will discuss and agree personal plans with residents and family members.
- PIC will ensure personal plans are accessible to all residents.
- Development of local policy to include families in process.
- Provider nominee will review personal plans
- Staff meeting to advise of agreed goals/actions..
- SLT supports will be made available to residents to enable participation in the development of their personal plan
Schedule of family meetings to facilitate input will be developed

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' personal plans were not made available in an accessible format to the residents and, their representatives were not aware of them.

Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
- PIC will discuss and agree personal plans with residents and family members, these plans will be made accessible to residents as outlined above.

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no written evidence why residents personal goals outlined in their personal plans were not being implemented by the residents' named key workers.

Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
- Key workers will update the personal plan before monthly staff meetings.
- The updated plans will be discussed at the staff meeting.
- Actions and Minutes from the meetings will be available for inspection.
- Staff will receive mentoring in relation to developing and implementing personal
- Plans by the Person in Charge
- PIC will implement a system for reviewing personal plans on a monthly basis.
- Protected time will be allocated for key workers to work with residents in the implementation of their personal plans .
- Staff to be advised of new systems working with Personal planning at a staff meeting on 11/03/2015
- PIC will review implementation of personal plans and evidence that they are carried out at support meetings.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not effective in improving outcomes for residents' as they were not being implemented.

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

Please state the actions you have taken or are planning to take:
- (A) PIC will implement a system for reviewing personal plans on a monthly basis. Key workers will update the persons plan for discussion at monthly staff meetings. Service Manager will review progress at monthly meetings
- (B) A report will be developed outlining the progress being made in the Personal plans.

Proposed Timescale: (A) 30/04/2015 (B) 30/06/2015

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 designated centre did not meet the needs of residents in relation to dining ,

communal and storage space.

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 service will be carried out by the multidisciplinary team focusing on assessment of need, personal plans, families and the environment. Following the review the provider nominee will convene a meeting in order to determine the direction and model of service required to meet the needs of the residents.

- A full review of the premises is being undertaken by Technical Services.
- A temporary second sitting room will be made accessible to Service Users and visitors.

Proposed Timescale: 30/04/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Therapeutic interventions were not being implemented by staff at all times as soon as the resident displayed signs of self harm or in accordance with guidelines set out in the residents' file

Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
Clinic Nurse Manager has been temporarily assigned as supernumerary for enhanced supervision of staff , the monitoring of the delivery of best practices and the implementation of all positive behavioural support plans ensuring best practices are adhered to .
- A Psychologist will attend the next staff meeting to brief all staff on the implementation of individual personal plans and therapeutic interventions. The psychologist will be available to the designated centre
- Clinic Nurse Manager will review the implementation of all guidelines and positive behaviour support plans and discuss monthly with service manager.
informed consent of each resident or his/her representative will take place as part of the personal planning process.
- PIC will review guidelines, ensuring their effectiveness or will organise the psychologist to review and amend.
- Safeguarding and best practices are fixed items on the staff meeting agenda
- The requirement of Safeguarding and best practices will a standard item at all

individual supervision meetings.
- Where required staff will receive couching and mentoring in relation to best practices and Positive Behavioural Support Guidelines.

Proposed Timescale: 30/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not always supporting residents' to prevent incidences of self harm as they were putting residents into spaces/situations which increased their tendency to self harm.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
The Psychologist assigned to the designated centre will attend the next staff meeting to brief all staff on the implementation of individual personal plans and therapeutic interventions.
- Clinic Nurse Manager will review and update Service Manager at monthly meetings.
- Service Manager will update provider nominee.

Proposed Timescale: 14/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two staff had not completed refresher training in relation to safeguarding residents and the prevention, detection and response to abuse since 2008.

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

Please state the actions you have taken or are planning to take:
-One staff has completed training. The safeguarding of service users on 4/2/2015.
-Second staff will receive Safeguarding Service Users training scheduled for 22/04/2015

Proposed Timescale: 22/04/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not protected from potential financial abuse as staff were not following the centres policy.

Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
- Financial audit carried out by the Service Manager on 16/10/14 identified a number of issues.

--The Service Manager requested that the finance manager complete a financial audit on 7/11/14. Minutes available for review. Significant areas of improvement were highlighted during this audit. The Service manager noted that these areas had improved on her next audit on 24/11/'14.
-Financial Manager audit available for review - actions were completed.
-PIC is responsible of ensuring Service Users monies policy is strictly adhered to.
-Service Manager will check audits are completed. Service Manager will discuss with Nominated Provider at regular meetings - Minutes available for review.
-Financial / Management matters to be discussed at staff meeting on 11/03/15.

Proposed Timescale: 14/04/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident was not being actively supported to access opportunities for suitable daycare, education and/or training.

Residents living in the centre were not been provided with the support to access activities of their choice in the wider community (outside of daycare).

Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
A full comprehensive review of the service will be carried out by the multidisciplinary team focusing on assessment of need, personal plans, staff skill mix, families and the environment.
-One resident was assessed as requiring an individualised day service. A range of options have been explored.
-Individualised day service has been developed since inspection. Timetable available for review
-This Service User's individualised day service has a staff member assigned to support

the resident to access the community. 11/03/15
-An allocation of hours has been provided to support access to the community in the evening time / weekends to support individuals preferences.
-
-A feasibility study will be conducted to determine community facilities / mapping

Proposed Timescale: 30/04/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no record on file to reflect when one resident had last had a full medical assessment completed.

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:
PIC will ensure a full medical assessment for each Service User annually.
- A full review of latest medical completed are being collated and reviewed.

Proposed Timescale: 14/04/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assistance by staff at mealtimes was not always being provided in an appropriate or sensitive manner.

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

Please state the actions you have taken or are planning to take:
Clinic Nurse Manager will review practices at meal times and identify where practices need to be improved. This will be discussed at staff meetings. All staff will be informed of best practice.
- Clinic Nurse Manager will ensure the continuation of supervision meetings scheduled for each staff member monthly.

Proposed Timescale: 30/04/2015

Outcome 12. Medication Management
Theme: Health and Development **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Practices in place for medication administration were not outlined in the centres policy and were not safe. **Action Required:** Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely. **Please state the actions you have taken or are planning to take:** CNM1 will ensure implementation of safe administration of medication and other local arrangements i.e. sharp management, disposal of medications etc. -Clinic Nurse Manager will ensure safe administration of medications policy is adhered to and all drug errors are forwarded to by Nurse Manager On-Call as per policy. -The use of blister packs are no longer in use in the designated Centre -All staff received refresher training on the safe administration of medications on 10/02/15. -PPIM has developed and implemented a system to track all drug errors and reasons for drug errors. This will be a fixed item on monthly staff meetings. all staff will adhere to the safe administering of medication policy
 Proposed Timescale: 14/04/2015
Theme: Health and Development **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Medication errors were not being risk rated and were not being appropriately followed-up on. **Action Required:** Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely. **Please state the actions you have taken or are planning to take:** - All staff received refresher training on the safe administration of medications on 10/02/15 - PPIM has developed and implemented a system to track all drug errors and reasons for drug errors. This will be a fixed item on monthly staff meetings. where errors / processes will be reviewed.

- PIC and staff nurse have developed a local policy in relation to ordering, receipt, prescribing, storing, disposal and administration of medications.
- PIC will ensure safe administration of medications policy is adhered to and all drug errors are forwarded to Nurse Manager On-Call as per policy
- Service Manager will discuss drug errors with Clinic Nurse Manager at monthly meetings and Provider Nominee at regular meetings

Proposed Timescale: 14/04/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain all the information outlined in schedule 1 and did not reflect the purpose and function of the service.

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

Please state the actions you have taken or are planning to take:
- PIC will review the statement of purpose and ensure it reflects the needs of the residents of the Designated Centre
- Statement of Purpose will be amended following the full review. The Statement of Purpose will then reflect the model of service which will be provided i.e. community house / nursing supports
- Statement of Purpose will be circulated to all families
- The revised and update Statement of Purpose and a copy will be sent to the Authority.

Proposed Timescale: 07/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the statement of the statement of purpose had not been made available to residents or their representatives.

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

Please state the actions you have taken or are planning to take:
- PIC will ensure the statement of purpose will be made available to all residents and representatives.

Proposed Timescale: 31/03/2015

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:
Correspondence received from HIQA on the 13th January 2015 states "applications that have been submitted without the above documentation will be processed up to a point of "proposed decision" and then after 1st March 2015, assuming all else is in order, a notice of proposal will be issued"
The document in relation to planning Compliance will be forwarded to the Authority

Proposed Timescale: 30/04/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of management days allocated to the person in charge did not allow her time to ensure the service and staff were effectively monitored.

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:
-Service Manager / Provider Nominee carried out a review of protected management hours for PIC
-Any proposed change in management hours will be sanctioned by the Service Manager and replacement hours will be allocated. to ensure that management time is protected.
-Clinic Nurse Manager has been temporarily assigned as supernumerary 156 hours per Rota to manage the designated centre.
-This will be reviewed 30/6/15 to ensure adequate management days are allocated to

the PIC

Proposed Timescale: 30/06/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre is not adequately resourced to meet the needs of the seven residents as outlined in the statement of purpose.

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:
-A full comprehensive and full speech and language assessments will be reviewed and communication systems developed for individuals (31/03/2015).
A full review of premises is being undertaken by technical services (30/04/2015).
A temporary second sitting room will be made accessible 30/03/2015
-A feasibility study will be conducted to determine community facilities / mapping
-Roster will support one service user to avail of an individualised day service 30/04/2015
-Recruitment process has commenced for 2 permanent Social Care Workers
-1 Staff Nurse allocated to the centre from 09/03/'15

Proposed Timescale: 30/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The numbers and skill mix of staff was not adequate 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:
- A full comprehensive review of the service will be carried out by the multidisciplinary team focusing on assessment of need, personal plans, staff skill mix, families and the environment.
- The provider nominee has requested a review of staff levels / skill mix

- As an interim measure a Clinic Nurse Manager and Staff Nurse has been assigned to the service.

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not receiving continuity of care due to the number of care hours being covered by relief/agency staff each month.

Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
A Clinic Nurse Manager and Staff Nurse has been assigned to the service.
- Additional SCW x 2 assigned to unit
- Review of staff working less than full-time hours/contracts

Proposed Timescale: 14/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have up -to-date food safety training in place.

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:
- All staff received food safety training on 10/02/15

Proposed Timescale: 14/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have cardiopulmonary resuscitation training in place to ensure the needs of one resident could be met at all times.

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:
-PPIM organised all staff to be trained in CPR.
-Refresher training for those who have completed CPR training.
-Dates for training as follows:
8th / 9th / 10th & 15th April 2015

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not being appropriately supervised. No supervisory meetings had taken place with staff since mid 2014.

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

Please state the actions you have taken or are planning to take:
-factual inaccuracy
-PIC confirmed at meeting with Service Manager on
13/11/4 that support meetings had been held with 7 named staff

Service Manager to ensure PIC has sufficient time allocation required to implement staff support meetings with all staff.

Proposed Timescale: 14/04/2015

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 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 were not available and not implemented. They included:
• access to education, training and development
• communication with residents'
• monitoring and documentation of nutritional intake.
• provision of information to residents'.
• creation of, access to, retention of, maintenance of and destruction of records'.

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 will be completed by March 31st. The PIC will be will be briefed on the contents and implementation of the policy by April 30th 2015. The PIC will then brief the staff team on the contents and implementation of the policy. The policy will be available for review in the designated centre.

- Records Management:
- The registered provider has developed a policy on 'Creation of, access to, retention of, maintenance and destruction of records policy' as required in the legislation. The Policy is in line with the Data Protection Act. The PIC will be will be briefed on the contents and implementation of the policy by April 30th 2015. The PIC will then brief the staff team on the contents and implementation of the policy. The policy will be available for review in the designated centre.

- Communication: The registered provider has developed a communication policy in consultation with key stakeholders and service users. The PIC will be will be briefed on the contents and implementation of the policy by April 30th 2015. The PIC will then brief the staff team on the contents and implementation of the policy. The policy will be available for review in the designated centre.

- Provision of Information to Residents: The registered provider has developed Guidelines on the Provision of Information to Residents. The PIC will be will be briefed on the contents and implementation of the guidelines by April 30th 2015. The PIC will then brief the staff team on the contents and implementation of the policy. The guidelines will be available for review in the designated centre.

-The legislation requires a policy on the Provision of Information to Residents which is being developed in consultation with a group of service users. This policy will take some time as the consultation process is extensive. The registered provider is using the guidelines as an interim measure until the policy is developed. The policy will be completed by December 2015.

- PIC to write a local policy in relation to access to education, training and development.

- PIC to ensure staff read and understands all policies.

Proposed Timescale: 30/05/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medication management policy has not been updated although there has been a change in administration practices. It did not therefore reflect administration practices.

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

Please state the actions you have taken or are planning to take:
The Clinical Nurse Manager assigned will ensure continued compliance with the policy
- The system of Blister packs are no longer in use in the unit.
- Medication management practices have changed to bring us in line with the current policy

Proposed Timescale: 14/04/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All policies outlined in schedule five had not been reviewed within the past three years.

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

Please state the actions you have taken or are planning to take:
Personal and Intimate Care: The registered provider has updated the Personal and Intimate Care Policy. The policy is accompanied by Guidelines for staff on developing intimate care plans for service users. The PIC will be will be briefed on the contents and implementation of the policy by April 30th 2015. The PIC will then brief the staff team on the contents and implementation of the policy. The policy will be available for review in the designated centre

Proposed Timescale: 30/05/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not contain all the required information.

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:
PIC to establish a Directory of Residents and to ensure it has all the required

documentation.
- Directory of Residents will be available for review

Proposed Timescale: 14/04/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records of emergency lighting checked completed by technical services staff were not detailed enough.

Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Technical services will be contacted and records will be updated.
Technical Services have updated the emergency lighting recording forms.
Emergency lighting will be checked on 31/3/15

Proposed Timescale: 14/04/2015