

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by St Michael's House
<b>Centre ID:</b>	OSV-0002333
<b>Centre county:</b>	Dublin 11
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	St Michael's House
<b>Provider Nominee:</b>	Maureen Hefferon
<b>Lead inspector:</b>	Nuala Rafferty
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	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:
31 March 2015 10:30	31 March 2015 18:30
01 April 2015 07:30	01 April 2015 17:30

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 the first inspection of this 4 bed centre for persons with disabilities. This was also an announced inspection and is 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 members were also sought.

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.

The fitness of the person in charge was assessed through interview and throughout the inspection process to determine fitness for registration purposes and was found to have satisfactory knowledge of their role and responsibilities under the legislation and sufficient experience and knowledge to provide safe and appropriate care to residents. The fitness of the nominated person on behalf of the provider was previously considered as part of this process and she was found to be a fit person to carry out the role of provider nominee.

A number of residents' and relatives questionnaires were received by the Authority during and after the inspection. The opinions expressed through both the questionnaires and in conversations with inspectors on site were all satisfactory with services and facilities provided and complimentary on the manner in which staff deliver a good standard of care.

Overall, evidence was found that residents' healthcare needs were broadly met. Residents had access to general practitioner (GP) services and a full time medical officer as part of the overall services provided by St Michael's House Group. Access to allied health professionals such as physiotherapy speech and language therapists and to community health services were also available.

The inspector found there were aspects of the service that needed improvement such as premises, risk management and care planning.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

**Section 41(1) (c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

It was found that resident's privacy and dignity was respected through personal care practices, maintaining private communications and contacts with relatives and friends and maximising independence. A CCTV or other monitoring devices were not in use in the centre at this time.

Staff were observed to facilitate residents' capacity to exercise personal autonomy and residents were enabled to exercise choice and control in their daily lives in accordance with their preferences. Independence was promoted and encouraged in personal care and other activities of daily living relevant to assessed abilities.

Systems to safeguard finances were in place and supports to facilitate residents to safely manage their finances were reviewed and it was found that resident's belongings and finances were protected on this inspection by robust systems of recording, balancing and auditing each resident's bank account statements which were regularly audited by the person in charge.

There was a written operational policy and procedure relating to the making, handling and investigation of written complaints. The procedure identified the nominated person to investigate a complaint and the appeals process. There was a nominated person who held a monitoring role to ensure that all complaints were appropriately responded to and records were kept. A complaints record was in place and on review it was found that complaints made to date were investigated and measures implemented to address them. A review of the level of complainant's satisfaction was subsequently held.

Practices observed throughout the inspection evidenced that residents rights were upheld and daily routines were found to respect individual choice and preferences such as times for rising or returning to bed, going for walks or listening to music.

In conversation with staff and on review of some documentation including returned relatives questionnaires it was found that families were kept informed of all developments in the centre and included to the fullest extent possible in the lives of their loved ones.

Regular residents meetings to discuss and agree the daily or weekly activities programme, menu choices or other group life decisions were held. However, although the inspector was told that opportunities to formally meet with staff to discuss their loved ones care plan on an annual basis in addition to other social occasions were held, a transparent formal consultation process to seek or action the views of residents or relatives on service delivery or development was not in place.

The inspector was also told that this area was being addressed through the development of the organisations' Annual Report whereby a formal consultation process was being devised for all residents and relatives on the development of services. This is further referenced under Outcome 14

**Judgment:**

Compliant

**Outcome 02: Communication**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Evidence that staff were aware of the different communication needs of residents and that systems were in place including external professionals input where necessary, to meet the diverse needs of all residents was found. All of the current resident profile were able to communicate verbally and had few identified needs in relation to communication aids.

The centre is part of the local community and residents visit local shops, restaurants and leisure facilities on a very regular basis. Trips to the local shops and cafés were a daily event.

Residents had access to radio, television, social media, newspapers, internet and

information on local events. Some technology in the form of laptops and smart phones were used by residents with access to internet and Facebook available as aids to maintaining communication with friends and family.

**Judgment:**

Compliant

**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):**

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

**Findings:**

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

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

Good communication systems were in place and families were kept informed of residents' well being and were involved in their personal plans. Through feedback from questionnaires returned some family members felt very supported by staff to be involved on a daily basis in the life of their relative.

Several residents visited their siblings regularly many of whom live in various parts of the country, some travelled independently by train and bus to visit.

Residents' involvement in activities in the community was supported with some residents attending retirement and slimming groups, while others were involved in a church voluntary group.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**

Effective Services

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

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

**Findings:**

It was found that residents' admissions were in line with the Statement of Purpose. The resident profile of the centre was found to be stable and there were no new or recent admissions.

On a sample of those reviewed it was found that each resident had a written contract agreed within a month of admission. The contract set out the services to be provided and all fees were included in the contract, however it was noted that where additional charges pertained these were not all included.

The contract did not include or clarify charges made to residents for staffing supports whilst on holidays away from the centre. Although it was found that where possible these were borne by the centre, either from the operational budget or through fund raising activities, it was found that where unavoidable residents did contribute to the costs associated with staffing supports whilst on holiday

**Judgment:**

Non Compliant - Minor

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

Evidence that resident's well being and welfare were maintained by a good standard of evidence-based care and support was found.

The inspector reviewed of a sample of residents records. Detailed personal plans that identified the supports to be provided to maximise each resident's abilities to reach potential for personal development in all spheres of daily life, i.e. personal, social, health and education were in place. These plans were found to reflect resident's involvement to the extent that the resident was consulted in relation to their wishes and preferences on social needs relating to family and community based contacts visits and outings.



Individual personal plans to support residents' development of life skills were in place and identified staff's understanding of the need to provide a balance of physical and emotional supports. Evidence of good practice was also found in positive behavioural support plans with staff aware of risks associated with fixated tendencies, triggers, early warning signs and the importance of monitoring mood and behaviours to maintain mood equilibrium.

Some individual personal plans included detailed phased processes to support the achievement of outcome based goals in relation to identified goals to improve independence such as; literacy skills; increase level of physical activity or improve independence in personal care.

Evidence that residents, their next of kin or nominated advocates were consulted and involved in the development of personal or healthcare plans was available

However, some improvements were found to be required in that plans were not in place for every identified healthcare need such as, management of high cholesterol, cataracts and lethargy.

In addition it was noted that where healthcare plans were in place they were not detailed enough to manage the specific problem, reference the recommendations of allied health professionals or reviewed as needs changed in order to appropriately determine their effectiveness for example; management of mental health; diabetes or constipation.

**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):**

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

**Findings:**

Overall the design and layout of the centre was found to meet the needs of the current resident profile in line with the Statement of purpose. The centre was a two storey terraced house located in a settled urban community. In general the centre included required health and safety aspects and appropriate security. Appropriate equipment for use by residents or staff was available and maintained in good working order. However some improvements in relation to the fabric of aspects of the fixtures, maintenance,

storage and location of electrical equipment were required.

Efforts to provide furnishings, fixtures and fittings which created a personalised comfortable living space which also promoted residents' safety, dignity, independence and well being were noted. Adequate private and communal accommodation included; four single residents bedrooms, two with full ensuite and one staff office cum bedroom also with full ensuite. The downstairs bedroom includes a small sitting room area for use by the occupant as part of a positive support plan. There was a large fully fitted kitchen cum dining room; 1 sitting room; 1 enclosed shower with non assisted bath, toilet and wash hand basin and upstairs.

There was a small enclosed garden with safe access and egress available with small paved patio area and plants and shrubs which one of the residents looked after. A small building at the bottom of the garden which consisted of one room with small kitchenette and table and chairs was available and used by residents on occasion for private visiting or relaxation and could also be used in the event of an emergency. A garden shed was located next to this structure.

The centre was clean, suitably decorated and bright. The kitchen although fully operational with sufficient cooking facilities and equipment the layout was not very ergonomically efficient and some aspects of the built in cupboards and worktop were in need of repair or replacement.

There were sufficient furnishings, fixtures and fittings to meet the individual needs of residents' and although some bedrooms were compact adequate storage space was available.

Efforts to reflect resident's individuality and preferences in relation to colour and furnishings in bedrooms were noted and photographs pictures and fixtures which reflected interests and hobbies were evident.

The sitting room was bright and contained comfortable couches, nest of tables and coffee table, a TV unit with space for dvd and cd player.

However, although the centre was in general well maintained some aspects needed to be improved such as; door frames, skirting's, and stairway which were marked and scuffed, paint work on walls, rust on some radiators and mould on one bedroom ceiling.

It was also noticed that wall brackets for TV's were not available in residents bedrooms, on enquiry the inspector was told that they were taken down when the house was last painted and not replaced as there appeared to be concerns regarding the risk to residents neck position when watching wall mounted TV's, but this had not to date been risk assessed and some residents were trying to watch their TV's which were surrounded by personal items and clutter on their tall boys.

Although the current profile of residents did not require a high level of assistive equipment where it was required same was available.

Service records were found to be up to date and maintenance contracts including

domestic and clinical waste were in place.

Storage space was very limited with a small storage cupboard under the stairs for linen and small household items such as iron, hoover and stepladder, but cleaning items such as mops and mop buckets were stored outside on the patio. In addition it was found that there were risks associated with the inappropriate location storage of electrical equipment in the main hallway and these are fully referenced with accompanying actions under Outcome 7

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

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

**Findings:**

Overall, the health and safety of residents, visitors and staff was promoted and protected in that policies and procedures for risk management and health and safety were available and staff were aware of them.

Records relating to fire safety were readily available regarding the regular servicing of fire equipment and fire officer's visits. Fire escape routes were unobstructed. Fire equipment and alarms were tested and arrangements were in place for the maintenance of the system and equipment. Individual personal emergency evacuation plans for all residents were in place and were sufficiently specific to guide staff.

Staff had received annual training in fire safety as required under the legislation and all staff spoken with demonstrated a good knowledge of the procedures to be followed in the event of a fire, and the contents of the emergency plan. Each resident had a detailed evacuation plan which had been risk assessed.

However, fire risks associated with the location of electrical equipment were found. During a review of the premises the inspector was shown the 'laundry' area, which was, in essence, a partitioned area of the main hallway, to the right of the front door and immediately in front of the stairs. It was also adjacent to a residents bedroom to the left. This laundry consisted of a washing machine, tumble dryer and a locked cupboard which stored detergents and cleaning chemicals.

The location of this electrical equipment raised concerns for the safe evacuation of residents in the event of a fire as they were in very close proximity (within one step) to

the stairs where three out of four people were sleeping, adjacent to another residents' bedroom and within two to three feet of the staff's sleeping area. On review of health and safety records and in discussions with the person in charge the inspector learned that this had been raised with the fire safety officer on a number of previous occasions.

The person in charge had been advised that the location would not have been chosen had it posed any risks and the following measures were to be employed at all times; regular cleaning of filters and both appliances to be turned off at night. However, evidence that the location had been fully risk assessed in line with relevant legislation or current guidance was not available.

It was further noted that automatic door closures or intumescent strip seals were not in place on any doors within the unit, although gaps between the door and door frames were noticed on some doors which raised concerns for the containment of smoke, fumes or flames in the event of a fire.

All of this was raised with the person in charge and the person in charge agreed to turn off both appliances and ensure they would not be used until re located to a more appropriate and safe location.

The storage of other less frequently used electrical and gas fuelled equipment in the garden shed also raised some concern in that gas cylinders, petrol powered lawnmowers, tins of paint, cleaning chemicals, Christmas decorations and a gas bar-b-que were all stored within very close proximity to each other in the small garden shed next to the identified room where residents would be evacuated in the event of a fire or other emergency. A risk register identifying these risks and the measures in place to minimise or eliminate them was not in place.

Although a newly revised draft risk management policy was available in the centre this had only been received the previous week and the person in charge had not had an opportunity to read fully or commence implementation of the policy including the establishment of a risk register as required.

Arrangements were in place for responding to emergencies including procedures and policies covering responses in the event of a resident being absent or missing without staff knowledge. In conversation with them it was found that staff were fully aware of these procedures.

Evidence of effective review of the systems in place to assess and manage all risks associated with response to emergencies was found. A centre specific emergency plan to direct and guide staff in response to any major emergency such as power failure, flooding or other form of emergency was available and had recently been reviewed. The plan identified all resources available to ensure residents safety such as alternative accommodation. Some additional equipment to effectively and safely respond to emergencies was available such as search torches, blankets and lists of emergency numbers.

Written confirmation from a properly and suitably qualified person with experience in fire safety design and management that all statutory requirements relating to fire safety and building control have been complied with as required in the Registration Regulations had

not been provided. An action in relation to this is included under Outcome 14

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

The inspectors observed that the centre was a safe environment for the residents and that there were measures in place to protect residents from abuse. In conversation with staff it was found that they were knowledgeable on the different types of abuse, and were aware of the reporting mechanisms in place if abuse was reported or observed.

Where some residents exhibited aspects of behaviour that is challenging on occasions, staff were familiar with potential triggers and efforts were made to identify and alleviate the underlying causes for each individual resident.

In conversation with residents the inspector was told they felt safe in the centre. A warm, respectful and friendly relationship between the staff and residents was evident and residents' privacy dignity and rights were being safeguarded through a positive supportive environment

The centre promoted a restraint free environment. Restraint was not observed to be in practice in the centre at the time of this inspection.

However, on review of a record relating to a report of bruising sustained by a resident it was noted that staff did not fully follow the policy on safeguarding to establish all possible causes of the injury. Although the inspector was satisfied that there was no evidence of or risk of abuse related to the bruise, through conversations with staff, the resident concerned and reviewing the medical officer's notes on the injury, the policy on safeguarding had not been fully implemented in that a preliminary screening into the possible causes of the bruising was not conducted. An action in relation to this is included under Outcome 18

**Judgment:**

Compliant

### **Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

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

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

**Findings:**

A record of all incidents that had occurred in the centre was maintained and where appropriate all notifiable incidents had been submitted to the Chief Inspector. All quarterly notifications had been submitted to the Authority within the appropriate time frame.

**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):**

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

**Findings:**

Evidence that an assessment process to establish each residents educational, employment or training goals in accordance with their wishes and capacities was found.

All residents were engaged in social activities internal and external to the centre to the extent that they had capacity or wished to be. All attended day centres where they were supported to avail of a variety of classes which developed or maintained independent life skills such as; using mobile phone; building confidence and self esteem; food preparation; independent travelling on public transport.

Community involvements were actively supported by staff with some residents attending arts and crafts; slimming groups, retirement groups and voluntary groups. Supported employment opportunities were also in place for some in cafés and large retail outlets.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Evidence that residents' health care needs were met through timely access to GP services and other allied health care services and were provided with appropriate treatment and therapies was found.

Records of clinical interventions relevant to ongoing healthcare needs were found to be up to date and reflected the residents' health care status. Residents were supported on an individual basis to enjoy the best possible health, and in general it was noted that their particular healthcare needs were well managed by staff who were vigilant in attending to health promotion checks and follow ups including; flu vaccinations; blood monitoring; mammograms; audio and oral checkups.

Inputs from allied health professionals such as; psychology, physiotherapy; speech and language and occupational therapy services with written evidence of relevant reviews were available.

However, improvements to care planning were identified in order to fully meet healthcare needs and an action relating to this finding is included under Outcome 5

Residents were provided with food and drink at times and in quantities adequate for their needs. A good variety of nutritious food was also available to meet their dietary needs.

The kitchen was well equipped and staff had received training in basic food hygiene. All meals were prepared in the centre and residents were involved in the preparation of evening meals as appropriate to their ability and preference. Food was properly served and was hot and well presented. Meals were relaxed and sociable; Residents were facilitated to enjoy their meal independently, privately and at their own pace.

**Judgment:**

Compliant

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**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Staff were aware that there was a new operational policy which included the ordering, prescribing, storing and administration of medicines, although a copy of the new policy was not available in the centre.

The administration of medication to residents was observed, and it was noted that staff were familiar with each resident's medication and facilitated residents to take their medication at the prescribed time as part of their daily routine. Details of all medicines administered were correctly recorded

It was found that each of the residents had their prescribed medications recently reviewed by a Medical Officer. Observation of medication administration practice was satisfactory and a record of nursing staff signatures and initials were maintained in line with best practice

A closed single dose, individualised medication administration system was recently established and systems were in place for safe disposal and return of unused or out of date medications. Whilst an overarching policy on this system was not yet available the person in charge had devised a local process with advice from the pharmacist to guide staff on the implementation of the system.

There was a safe system in place for the ordering and disposal of medications and the inspector saw records which showed that all medications brought into and out of the centre were checked and recorded. There were two secure disposal containers for medications.

An audit of each resident's medications was completed on a weekly basis by staff; any discrepancies were identified and reported to the service manager by completion of an error form

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the*



*manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

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

These included clarifications to staffing whole time equivalents and room sizes. A revised document was submitted immediately following the inspection which clarified all of the information.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Evidence that management systems within the centre were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored was found

The person in charge and the service manager both engaged with the process to determine fitness as part of the inspection and demonstrated sufficient knowledge of the legislation and statutory responsibilities associated with their roles. It was found that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis, provided good and

consistent leadership to staff, support to families and was clearly resident focused.

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

An action plan on areas identified for improvement was incorporated. It was noted that this was the first review conducted to comply with the regulations and efforts to improve the quality and safety of care were ongoing. 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.

Although a formal consultation process to seek or action the views of residents or relatives on service delivery or development was not in place, as previously mentioned in Outcome 1 the inspector was told that this area would be addressed through the development of the organisations' Annual Report whereby a formal consultation process was being devised for all residents and relatives on the development of services

The service manager and person in charge also met regularly to discuss the service provision budgets and resources for the centre.

However, it was noted that the person in charge did not have access to peer supports which were available to other persons in charge within the broader St. Michael's House Organisation. This was due to the makeup of the 'cluster' of units for which the service manager was responsible as this centre was the only residential service within the cluster. This lack of peer support was negatively impacting on the ability of the person in charge to make appropriate and informed decisions on service development in that communications on changes to policies, procedures and service planning were not being communicated in a timely and complete manner at all times. Although this was not found to have had a negative impact on the service currently being delivered within the centre it is of concern going forward if steps to address it are not taken.

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. This was also referenced under Outcome 7.

**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:**

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

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

**Findings:**

There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge.

A senior experienced and qualified social care worker was identified to replace the person in charge and was noted to be familiar with residents' social and healthcare needs and aware of the responsibilities of the role in relation to notifications and protection of residents.

A second person was identified to replace the person in charge. This person was qualified and experienced in the role of social care worker and this was their first managerial role. It was clarified by the person in charge that the process in place forms part of staff development/future proofing for the centre. In conversation with both the identified second person participating in the management of the centre and the person in charge it was noted that this person would be working closely with both the person in charge and the person who replaces the person in charge in her absence, for mentoring and familiarity with the role prior to undertaking duties alone of the centre

**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):**

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

**Findings:**

Evidence that resources were available and directed towards supporting residents to achieve the goals set within their individual personal plans was available. Examples include the flexibility of staff rosters to support residents on a regular basis to enjoy special events such as concerts and also to go on holidays abroad with staff resources made flexible and available.

There was evidence of good access to clinical supports such as medical officers; physiotherapy; speech and language and occupational therapy, although it was noted that access to Dietetic services were not always timely.

On review of current and historic rosters it was found that additional staffing hours had been recently allocated to the centre to improve the level of service available to residents' midweek.

It was found that up to February 2015 there were no staff on duty for a three hour period on four days per week; this was now addressed to meet the changing needs of residents some of whom no longer attend their day services every day.

Overall, the facilities and services in the centre reflect those outlined in the statement of purpose.

**Judgment:**

Compliant

**Outcome 17: Workforce**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**

Responsive Workforce

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

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

**Findings:**

An actual and planned rota was in place and absences were covered by a panel of relief staff which although this included agency staff; these were usually the same people to provide consistency.

The inspector found supervision of staff practice by the person in charge in conjunction with supports to provide learning and development were reviewed and monitored on an ongoing basis. The person in charge worked alongside staff on a regular basis and regular team meetings to discuss improvements and ongoing developments were held.

The levels and skill mix of staff were sufficient to meet the direct care needs of the current resident profile on this inspection and staff were supervised appropriate to their role.

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

Evidence that all staff received up-to-date mandatory fire training, moving and handling and vulnerable adult protection was viewed and also additional training provided such as; basic food hygiene, management of dysphagia, bereavement and loss, and first aid. The person in charge was aware of the importance of staff training and development to continue to meet residents' needs going forward and had identified further training in positive behaviour supports, lámh sign language care planning and risk assessment and management.

Recruitment processes were reviewed on this inspection and on review of a sample of staff files these were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013.

**Judgment:**

**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):**

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

**Findings:**

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

Records were maintained in respect of accident and incidents, clinical records and documentation of reviews and recommendations by clinicians were retained in the centre.

An insurance certificate was submitted as part of the registration pack, but this had expired at the time of inspection however the service manager contacted the insurance company who provided written confirmation that the renewal of insurance cover was being processed to ensure that the centre was adequately insured against accidents or injury to residents, staff and visitors.

It was also found that the bus used to transport residents was adequately insured, however the bus was due for testing by the department of the environment and the inspector was told it would not be used until the test was completed; currently there

was a long waiting list in all test centres.

A directory of residents was established which included all the required information and was being maintained.

The centre had some of the written operational policies as outlined in schedule five available for review, some were in draft format such as; provision of intimate care; communication with residents and risk management policies.

Others required review including; infection prevention and control and aspects of the financial management policies, particularly those relating to additional charges for residents.

Policies not developed to date included the following:

- monitoring and documentation of nutritional intake
- access to education training and development
- staff training and development

As previously referenced under Outcome 8 on review of a record relating to a report of bruising sustained by a resident it was noted that staff did not fully follow the policy on safeguarding to establish all possible causes of the injury.

It was also noted that the recently revised risk management policy which was still in draft form had just been received by the person in charge who had not had sufficient time to review and implement particularly in relation to the establishment of a risk register.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by St Michael's House
<b>Centre ID:</b>	OSV-0002333
<b>Date of Inspection:</b>	31 March 2015
<b>Date of response:</b>	30 June 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 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 contract of care did not include all additional charges where these pertained.

**Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details

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

of the services to be provided for that resident and where appropriate, the fees to be charged.

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

- All residents' contracts of care in relation to staff costs have been discussed with residents and their families.
- Contracts of care have been revised to include additional costs in relation to staff support.

**Proposed Timescale:** 12/05/2015

**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:**

All plans in place were not reviewed to assess level of effectiveness or take account of changes in needs or circumstances.

**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:**

- Staff received training from the PIC on the 23/04/15 on Care Plan development
- Well-Being Reviews for all residents commenced on the 23/04/15 and will be completed by the 30/06/15 by key-worker in consultation with the residents, family, day services, service manager, relevant clinicians and P.I.C.
- Each residents' personal plan will be reviewed and the PIC will ensure that changes in circumstances are taken into account
- Care plans will be amended accordingly and appropriate monitoring mechanisms will be included in all care plans inclusive of a monthly review.

**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:**

All plans did not include the recommendations arising from a review by allied health professionals.

**Action Required:**

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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



•All residents' care plans are currently being reviewed and amended to incorporate input from Allied Health Care Professionals.

•An individual co-ordination meeting for each resident will be completed by the 30/06/15

**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:**

A plan was not in place for every identified healthcare need.

**Action Required:**

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

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

•Additional care plans for healthcare needs identified have been put in place.

**Proposed Timescale:** 13/05/2015

### **Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

A programme of maintenance to ensure that all aspects of the environment, fixtures and fittings were not in place.

**Action Required:**

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

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

•It is proposed that the TSD manager will meet with the PIC to review the structure & fabric with a view to agreeing a programme of maintenance.

•A schedule of works will be developed between the TSD manager and PIC on a phased basis.

•Funding has been approved

•The next stage is to get a method statement and project programme from the contractors. It is planned that all works will be completed by the 31/08/15

**Proposed Timescale:** 31/08/2015

**Theme:** Effective Services

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

Suitable and sufficient storage for all necessary equipment was not available including electrical equipment inappropriately located in the main hallway.

**Action Required:**

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

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

- An external storage unit for mops & buckets will be provided by 31/05/2015.
- See Outcome 7

**Proposed Timescale:** 31/05/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The risk management policy did not include the identification or assessment of all risks throughout the centre including but not limited to; storage of combustible materials in small confined spaces and location of electrical equipment along the main evacuation route within the centre.

**Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

- The timber garden shed will be cleared. A separate lockable storage unit will be provided for lawnmower, petrol and barbeque gas cylinder.
- The P.I.C will develop a register of risk by the 31/05/15. The registered provider will review the risk register.
- A detailed risk assessment is being developed with the Fire Safety Officer in relation to risks identified

**Proposed Timescale:** 31/05/2015

**Theme:** Effective Services

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

Containment measures such as automatic door closures or intumescent strip seals were

not in place.

**Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

- All internal doors will be upgraded to FD30s rated. To include intumescent strips and cold smoke seals. Works to be completed by 31/08/2015
- Free door closers to be installed on four internal doors downstairs – Kitchen, Sitting Room, Office and Residents bedroom

**Proposed Timescale:** 31/08/2015

**Theme:** Effective Services

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

Adequate means of escape were not provided due to risks associated with the location of electrical equipment and chemicals in main escape route for all residents and staff

**Action Required:**

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

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

It is proposed that the following works are completed to make the area safe:

- Confirmation of automatic smoke detection in the immediate area directly over appliances linked to units L1 Fire alarm system, which ensures that a fire is detected at an early stage. The presence of staff will ensure that any fire signal is quickly investigated, doors closed and evacuation initiated. It is reasonable to assume that the supervisory nature of staff, coupled with training, regular practiced fire evacuation drills, scale of the property, travel distances, will ensure human verification of a fire or a false alarm within one to two minutes during daytime. At night time the response time for staff is likely to be longer but all fire doors would be expected to be closed (see below)
- Confirmation of a properly fitted half hour fire door set to the front of the enclosure, and that the enclosure itself is of minimum half hour fire rated.
- Confirmation of appliance isolation switches located on the wall outside the enclosure and to be turned off between 8pm and 8 am. Coupled with confirmation from a qualified electrician that the appliances are properly wired.
- Confirmation that use of these appliances will be restricted to between 8am to 8pm.
- Confirmation that the half hour fire doors are kept closed between the hours of 8 pm and 8 am and isolation switches are in the off position.
- Confirmation that there is a no smoking Policy in the house and no naked flame appliances.
- Confirmation of emergency lighting positions.
- The proposal has been risk assessed by the PIC in conjunction with the Technical

Service Manager and Fire Advisor

•As an interim measure the dryer has been re-located to the relaxing room in the back garden. The washing machine has not been used since the 31/03/15. 25/06/15 The washing machine has been risk assessed to be used when the residents are not in the centre.

**Proposed Timescale:** 31/08/2015

#### **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:**

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

**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 13/01/15 states the application that has been submitted without the above documentation will be processed up to a point of processed decision and then after the 01/03/15 assuming all else is in order a notice of proposal will be issued.

**Proposed Timescale:** 31/05/2015

#### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

All of the written 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 were not available including;

- monitoring and documentation of nutritional intake.
- access to education training and development
- staff training and development.

All policies in place had not been adopted for implementation within the centre and some remained in draft form.

The policies on safeguarding and risk management were not fully implemented to ensure the protection of all residents.

**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:**

Organisational Policies

- All Policies that were identified as been in draft on the day of the inspection were replaced on the 21/04/15 with finalised versions of the policies.

- Monitoring and documentation of nutritional intake policy is in place since 31/03/15

- Access to Education Training and Employment:

The registered provider is developing this policy in line with New Directions. The policy will be completed by December 2015. As an interim measure a local policy will be devised by the PIC outlining how service users access education, training and employment.

- The Staff Training and Development Department are currently engaged in a review process. The aim is to review the strategic and operational role of the training function and make recommendations in relation to its focus, objectives and structure, in the context of meeting the organisation's objectives and its regulatory, legal and governance requirements. The Primary Research element of the review commenced in March 2015 and the final report is expected by the end of June 2015. On completion of the Review a Training and Development Policy will be drafted and the deadline for this is end of September 2015.

There are a number of documents currently in place that guide Training for all staff in the residential service:

- Minimum Required Training Standards for Staff 2015 (Covers all In-House mandatory Training for Frontline staff)

- Guidelines for Applicants Seeking Approval for Courses 2015 (Outlines the process by which staff avail of external courses for professional development.

Both documents are reviewed every year.

Centre Implementation of Policies:

- The PIC received training on implementing the Risk Management Policy on the 21st April 2015

- Risk Register will be developed by the 31/05/15

- The PIC and the two P.P.I.M's will complete risk assessment training- The P.I.C and one P.P.I.M will completed by the 27/05/15. One P.P.I.M will complete risk assessment

training on the 15/10/15

•Additional safeguarding is being implemented A system for identifying and recording the cause of any bruising, monitoring required, any treatment given and actions completed has been developed by the P.I.C.

**Proposed Timescale:** 31/05/2015

**Theme:** Use of Information

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

All policies and procedures were not kept under review at three yearly intervals as required by the regulations.

**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 registered provider will review the policies identified to ensure they are up to date and implemented in the designated centre.

Service Users Money Policy: The registered provider will update the Service Users Money Policy and related documents. This will be completed by June 2015.

Holiday Camp Guidelines: The registered provider will review and update the Holiday Camp Guidelines and associated documents. These will be available for review by June 30th 2015

**Proposed Timescale:** 30/06/2015