<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by St Michael's House</th>
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</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0002364</td>
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<tr>
<td><strong>Centre county:</strong></td>
<td>Dublin 5</td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>St Michael's House</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>John Birthistle</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Sheila McKevitt</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
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<tr>
<td><strong>Type of inspection:</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
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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**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>02 September 2015 09:30</td>
<td>02 September 2015 17:30</td>
</tr>
<tr>
<td>03 September 2015 09:30</td>
<td>03 September 2015 14:30</td>
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</tbody>
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The table below sets out the outcomes that were inspected against on this inspection.

|--------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------|----------------------------------|---------------------------------|---------------------------------|---------------------------------|-------------------------------|-----------------------------|-------------------------------|-----------------------------|-------------------------------|---------------------------------|-----------------------------|---------------------|--------------------------------|

**Summary of findings from this inspection**

This was the second inspection of the centre by the Authority. It 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 comprehensive assessments, personal care plans, health files, complaints and policies and procedures. The views of the three residents and staff on duty were also sought.

The person in charge and the service manager were in attendance during the
inspection. They both had experience and knowledge of working with residents with disabilities. As part of the application for registration, the provider had been requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). Most documents submitted by the provider for the purposes of application to register were found to be satisfactory as mentioned in this report the statement of purpose required review.

Evidence of good practice was found across some outcomes, however, the centre found to have a high level of non compliance. It was in compliance with just 3 out of 18 outcomes inspected against. This level of non compliance was not expected as the centre was home for three low dependency residents and as mentioned this was the centres second inspection by the Authority.

The provider had applied for the person in charge to manage this centre and another centre attached to it. However, the inspector found that the person in charge could not effectively manage two designated centres and carry out training throughout the organisation.

The inspector also found that the rights of residents were not being actively promoted at all times and residents were not being facilitated to independently manage their own finances or to maintain their independence, as staff undertook tasks which residents could do independently or with support. The culture among management and staff required change and the support of the provider and a strong management team was required in order to ensure this change was planned and implemented.

The action plans at the end of this report identifies the15 outcomes under which improvements are required.
### 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.*

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Individualised Supports and Care</th>
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| Outstanding requirement(s) from previous inspection(s): | Some action(s) required from the previous inspection were not satisfactorily implemented. |

| Findings: | Residents' rights and dignity were not being fully respected. The complaints process had been reviewed since the last inspection, however, the complaints of each resident were not listened to and acted upon by either the provider or the person in charge in line with the policy. |

Residents were consulted with about the running of their home and their care. They told the inspector they had an evening meeting each week, facilitated by staff where they discussed and planned their menu for the week, organised grocery shopping, cleaning schedule and discussed any general issues. One of the residents spoken with told the inspector she was always given choice in relation to how she lived most aspects of her life.

There was a information about the charter of rights published by the National Advocacy Committee on display in the house together with general information about residents' rights. One resident explained to the inspector that she had sought the assistance of an external advocate from the National Advocacy Committee to assist her in having her voice heard and her rights respected. She explained how she needed this assistance as she felt her voice was not being heard by management. The assistance of the external advocate had proved invaluable as the resident was successful in achieving her request to move into the house next door (after a prolonged period of time).

There was a complaints policy in place, it was accessible to residents and included an appeals procedure. However, it was not been adhered to by the complaints person, the
appeals person or the person responsible for overseeing complaints. At the beginning of the inspection the inspector was informed that there were 2 opened complaints. However, on review of the complaints to date in 2015 the inspector saw that 5 complaints had been made, 3 of which remained opened. Records of the 2 closed complaints reflected details of the actual complaint, investigation which took place, the outcome reached and level of satisfaction of the complainant. However, there were no records to reflect details of 2 complaints made and a review showed that 2 complaints had not been investigated properly. For example, residents and staff in the house and/or on duty at the time of the alleged incident which was the subject of a complaint had not been interviewed, there was no evidence that the facts had been established prior to an outcome been reached by the complaints person. The inspector noted one complaint made was sent directly to the provider on the 01 June 2015 at the complainants request, however, the provider did not meet with the complainant until 24 August 2015 to discuss their complaint. The time lapse was not acceptable and was not in line with the centres complaints policy which stated that all complaints would be addressed within 28 days. Although an annual review of the centre completed in June 2015 stated the management of complaints had been reviewed there was no evidence to support this.

The poor management of complaints had lead to residents losing autonomy over their own lives. For example, the three residents living in the house were independently managing their own petty cash box during the last inspection in May 2014. In 2015 there had been three separate reported incidences of cash going missing from the residents home, these incidences of alleged theft had not been investigated appropriately. However, as a result the inspector was informed that resident cash boxes were now being stored for them in the adjoining house which was staffed 24hrs per day. This resulted in residents having to go into the house next door, ask staff for the access to the key of their cash box and the cash box which was being stored in the staff office. Hence, all three residents could no longer independently manage their petty cash box.

Residents right to privacy was not respected at all times. As per complaints made some house mates did not respect others right to privacy. There had been a reported incident where one resident had entered another resident bedroom in the middle of the night without first seeking permission. Post this incident staff had addressed the importance of maintaining ones privacy and respect with residents at a recent house meeting. However, the inspector observed staff and residents from the house next door coming in and out (via the patio door at the rear of the house) without knocking or communicating with residents living in the house prior to entering.

All three residents had their own front door key. One resident showed the inspector their bedroom and two residents told the inspector they had keys to their own bedroom. The bathroom/shower room and toilet door had privacy locks in place. All windows had curtains in place.

Residents had access to an adequate amount of storage facilities in their bedroom. Laundry facilities were available within the kitchen all three were independent with doing their own laundry.

Residents attended religious services usually with family. The two residents spoken with confirmed they were registered to vote and did so. Residents told the inspector they
were facilitated to pursue their personal interests at weekends, one resident stating how he watched soccer on T.V. and had been facilitated to purchase sky sports.

**Judgment:**
Non Compliant - Moderate

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**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 was reflected in practice and residents communication needs were being met. All three residents could communicate verbally.

Residents’ had access to some information in written format such as information about rights, the residents guide, standards of care and the complaints policy. Residents had access to a television in the living room and in their bedroom. Two residents had got access to sky sports and all three had access to internet services. There was a house telephone which residents could and did answer independently, all three residents had their own mobile phones.

The three residents attended a daycare facility 3-5 days per week, Monday through to Friday. Two residents were employed 1-2 days per week. All three linked in with the local community independently using the local General Practitioners, community centre for classes, shopping centre and all general services in the locality.

Communication between staff and residents was verbal, however, the inspector overheard one staff member on a number of occasions using an inappropriate affectionate term to address a female resident.

**Judgment:**
Substantially Compliant

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**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 which was displayed at the front door. However, it did not reflect practice in the house as mentioned under outcome 1. Residents told the inspector that their family members and friends were welcome to visit at anytime. They also explained how they visited their family home independently. There were two communal rooms the three residents confirmed they could receive visitors in private in either of these two rooms.

Communication between staff and the residents next of kin was good. There was evidence that they were consulted with on issues in relation to their loved one where necessary or when the resident requested and were involved with the residents personal plan of care.

As mentioned under outcome 2, residents were supported to link with the local community on a day to day basis.

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

Findings:
The admissions policy in place outlined the procedure to be followed prior to a resident being admitted to the centre. It now 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 and one resident who was in the process of moving into the house next door told the inspector she had been facilitated to visit the house on several occasions and was involved in the refurbishment of her bedroom prior to her admission.

Contracts of care were available for each resident. The contracts were signed and dated by the respective resident and the person in charge. The contracts included details
about the supports, care and welfare the resident would be expected to receive and details of the services to be provided. Two of the three included the fee to be charged. However, the inspector noted that the amount stated on the contract of care did not reflect the amount each of the three residents were actually paying. Two residents were paying a sum less than the sum stated on their contract of care and one was paying above the sum stated on their contract of care. Additional charges being paid by residents were not clearly outlined in their contract of care. For example, the sky sport charges been paid by two residents was not mentioned on their contract of care.

**Judgment:**
Non Compliant - Moderate

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**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

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that each residents wellbeing and welfare was maintained. However, this was not been done in line with legislative requirements.

Two residents had a comprehensive assessment completed which reflected their health, personal and social care and support needs they required. However, one had no comprehensive assessment available for review by the inspector, although staff stated it had been completed it was not retrievable. The two assessments that were completed reflected the residents whom the inspector met on inspection.

The inspector reviewed two individual personal plans and found the resident, their key worker/s and their next of kin were involved in the completion these goals. They reflected the residents interests and preferences and identified goals the residents had chosen to achieve. However, they did not provide details of how staff were going to assist the resident to achieve their goals or by when. One had not been updated within the past year and there was no recorded evidence to show if the resident had achieved the goals which had been set in May 2014. The personal plans were not available to the resident in an accessible format. The personal plans were kept in the residents personal file which was locked in a cupboard to which staff held the key.
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):

Findings:  
The centre is located in a residential suburb of Co Dublin. Its design and layout met the needs of the three residents.

The centre a terraced two storey building was home to three residents. The providers application requested registration for three residents. The inspector saw that the premises had adequate heating, lighting and ventilation.

Each of the three residents had their own bedroom, one resident chose to show the inspector their room, which had been decorated to meet their personal taste. The three upstairs bedrooms had restrictors on windows and all contained sufficient furnishings, fixtures and fittings to meet the individuals needs including storage space. The two upstairs bathrooms contained a shower, toilet and wash hand basin.

The communal areas included a well equipped kitchen come dining room from which a patio door lead into the garden. The garden and that of the centre next door (adjoined to this centre) was one large open rear garden shared between both houses. The inspector viewed the rear garden and found it was accessible to all residents and it contained a paved area where residents could enjoy dining outside. Car parking spaces were available in the front driveway.

None of the residents used assistive equipment.

Judgment:  
Compliant

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

Theme:  
Effective Services
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The health and safety of 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 including self harm. However, residents did not have individual risk assessment in place to reflect the care they were receiving. Risk-averse practices were taken by staff and as mentioned under outcome 1 these inhibited residents exercising independence and autonomy. For example, residents who had been self administrating their medications and were no longer doing so did not have a risk assessment in place to reflect the risks associated with them continuing to self administer.

The person in charge did not know how to respond to reported incidents and the inspector found there was no effective system for investigating and learning from all incidents and accidents. At the beginning of this inspection the inspector was informed that there were no incidents or accidents in the centre since the last inspection of May 2014. However, there had been a number of significant incidents which had occurred in the centre that placed residents at risk. For example, a number of incidents of theft/potential financial abuse had occurred but had not been recorded as incidents and therefore exact times, dates and patterns could not be identified. Risk-averse measures had been taken as mentioned under outcome 1 but the actual incidents had never been investigated.

There was an up-to-date health and safety statement in place. The emergency plan 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. All staff had completed fire training within the past year and those spoken with had a clear understanding of the procedure to follow. 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. Those spoken with had a clear understanding on what they should do if the fire alarm sounded and showed the inspector where the assembly point was located.

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):**
No actions were required from the previous inspection.

**Findings:**

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.

Residents spoken with stated they felt safe and secure in their home. They had an enclosed rear garden, all the exit/entry doors could be secured by them and the house was alarmed. Residents could lock their bedroom door if they wished.

All residents were independent with their personal needs. There was no use restraint used in the house.

There was a policy and procedure for the management of residents' monies and a procedure on personal possessions and it was adhered to by staff. Residents were currently facilitated by staff to manage their finances as mentioned in outcome 1. The records reflected monies held and receipts were available to reflect all monies spent, each resident had an individual bank account in their name. However, bank statements were not available to reflect one resident's personal bank accounts. The other two residents next of kin managed theirs and statements went to the family home. The staff and management team carried out regular audits on the management of the residents' account and the three residents petty cash boxes. However, as mentioned under outcome 7 the incidents of alleged theft/financial abuse had not been investigated.

**Judgment:**
Compliant

**Outcome 09: Notification of Incidents**

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

**Theme:**
Safe Services
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A record of all incidents occurring in the designated centre was not maintained. Quarterly reports had been submitted to the chief inspector in a timely manner. However, all three incidents of alleged financial abuse had not been notified to the Authority within three working days. One incident was notified 7 working days post the alleged incident had been reported to management the other two alleged incidents were reported on a quarterly return and not within 3 working days as per the legislative requirements.

Judgment:
Non Compliant - Major

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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. Residents had some opportunities for social participation, as mentioned under outcome 1 they had access to daycare facilities 3-5 days per week and residents spoken with explained it was their choice as to when and if they attended. If they decided to stay at home they generally planned their own day, however, some residents required a gentle reminder from staff to attend appointments. Those who were in employment traveled to and form work independently.

There was a lack of training in life training skills provided to residents. The inspector noted an ethos of 'doing for' rather then 'doing with' had crept into the centre, residents had been more independent with managing aspects of their life during the last inspection. The inspector observed that staff were doing things which residents could potentially do for themselves. For example, residents told the inspector that staff set the house alarm at night time, however they appeared to be capable of doing this themselves with or without supervision.

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 the health care needs of residents were being met. As mentioned under outcome 5, 2 residents had assessments completed and these were updated within the past year. The resident and multi-disciplinary team members had been involved in these assessments. Residents with health care needs had a health care plan in place.

The inspector reviewed two resident files and saw evidence that they were facilitated to access their General Practitioner (GP), seek appropriate treatment and therapies from health care professionals when required. There was evidence that the allied health services were availed of promptly to meet residents needs. Completed referral forms were available for review in files and written evidence of relevant reviews were also available. However, the inspector noted that one health care professional, an epilepsy nurse specialist reviewed a resident in June 2015 and recommended that the resident's weight be monitored, however, there was no evidence that this had been done. There was no weight recorded for the resident in question.

Residents had a full medical review at least once per year and had their medications reviewed on a regular basis.

Residents told the inspector they had a choice of food. They were assisted by staff with the purchasing, preparation, cooking and serving of meals. The inspector observed residents independently getting their own breakfast. Residents had a choice of meals and were actively involved in choosing the weekly menu. They confirmed they had access to adequate quantities and a good variety of nutritious food to meet their dietary needs. Healthy snacks were also available.

**Judgment:**
Non Compliant - Moderate

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

Findings:
The inspector found that practices regarding drug prescribing was in line with best practice. However, the dispensing and administration practices required review to ensure they were meeting the needs of residents. The inspector was informed that the method by which medications were being dispensed had changed in December 2014 and since this change had been implemented the person in charge decided it was no longer safe for residents to self administer their medications. There was no evidence to indicate that the residents were involved in discussions with the pharmacist prior to the change been agreed and implemented. When the method of dispensing medications was implemented residents were told they could no longer self administer their medications, . one resident told the inspector that he had been told it was now too dangerous for him to self administer his medications. However, staff confirmed their had been no attempt to educate the three residents on how to self administer their medications using the new system and as mentioned under outcome 7 no risk assessment had been completed prior to this decision being made on their behalf.

The inspector saw records which showed that all medications brought into and out of the centre were checked by a member of staff and an audit was completed on the delivery of these medications to the centre. However, the inspector noted that the weekly and monthly audits of medication counts were inaccurate and had been for a period of time and although reviewed on a regular basis by the person in charge all discrepancies had not been identified and therefore not reported. Those that had been identified in the early part of the year were reported to nurse manager on call and the service manager on a medication error form. In January 2014 the nurse manager on call, following review of a number of errors had recommended that two staff complete medication checks when medication supplied to the centre are being checked in. However, the person in charge stated he was not aware of this written recommendation and therefore it had not been implemented.

Safe Administration Medication (SAM) guidelines were available and followed by staff. All staff had up-to-date SAM training in place. However, guidelines in residents personal files had not been updated as the related to residents self administrating their medications.

The inspector saw that each of the residents had their prescribed medications reviewed by their GP on a regular basis.

The storage of medications also required review. Medications were locked in a cupboard in the kitchen which was accessible to visitors and family and the warmest room in the house, which was not the best location to store medications.

Judgment:
Non Compliant - Moderate
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:
The statement of purpose had been revised since the last inspection and a copy was submitted to the Authority and reviewed prior to this inspection. It included details of the services and facilities provided. However, the ethos of the centre, promoting ones independence, was not reflective in practice as detailed in this report. It did contain most of the information as 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. However finer details required review, for example, in some areas it referred to six residents and in other areas referred to the house next door.

A copy of the statement of purpose was available to residents in the house and the person in charge confirmed a copy had been sent to each residents next of kin.

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

Findings:
There was a clearly defined management structure. However, it was not effective. The
provider was aware that there were issues regarding poor management of the centre. The inspector was informed that this had been brought to the attention of the provider on a number of occasions by the service manager, but the issues relating to poor management had not been addressed.

The person in charge was in post since 2007, he worked full time and was a qualified social care worker. He was a team leader and a 'train the trainer' for the organisation. He was involved in the governance, operational management and administration of two designated centres and was aware of his legislative responsibility as the person in charge. However, he was not managing both centres effectively. This was evidenced with the lack of compliance found during the course of this inspection. The inspector held the view that the person in charge had been given more responsibility then he could cope with, taking into consideration the level of experience he had as person in charge.

The person in charge had a good knowledge of the three residents' living in the centre, having worked with them for a number of years. He was supported in his role by a team of social care workers who worked between the two centres. However, the allocation and supervision of staff was not being managed appropriately (as outlined further under outcome 17) to ensure the needs of residents were met.

The person in charge reported to a Service Manager who reported to a Regional Director (also nominated person on behalf of the provider). The service manager had provided the person in charge with adequate support, both formal and informally over the first 8 months of 2015. In addition the number of management days allocated to the person in charge, on the monthly roster had been increased since the last inspection from 4 to 6 per monthly roster. The person in charge told the inspector he had not received training to enable him to manage the centre effectively. For example, he was now named complaints person but had never received training in the management of complaints.

The nominated person on behalf of the provider had not attended the centre for some period of time although there was evidence that issues regarding management of the centre had been reported to him on a number of occasions.

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 and issues were identified for improvement. The inspector noted that all issues had been addressed by the person in charge. An annual review of the service had been completed in June 2015, this included the residents and their representatives views of the service. However, although it provided positive views on areas of practice such as review of complaints, incidents, medication management and provision of care needs. The findings of the review were not reflective of the inspectors findings of this inspection.

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 his absence.

As mentioned under outcome 14, two social care workers with the required experience and qualifications had been nominated to manage the centre in the absence of the person in charge. They were both met during this inspection and were deemed fit to take over 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 sufficiently resourced. However, as mentioned under outcome 14 the resources could have been managed more effectively to ensure the needs of residents were met in accordance with 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The numbers and skill mix of staff were adequate to meet the needs of the three residents. Staffing levels included the person in charge and seven social care workers.

The number of support hours provided to the residents in the house appeared to be adequate. Each resident had been teamed up with a member of staff who acted as their key worker supporting them in ensuring their social care needs were met. However, staff were not been enabled to carry out this role effectively as staff allocated as keyworkers to residents were not being rostered to work in the house with residents on a consistent basis. For example, one keyworker worked 4-5 shifts the remaining two worked 1-2 shifts per monthly roster. This meant staff were not being facilitated to carry out their role as keyworker effectively.

The roster was not reflective of the hours worked by staff in the house. The inspector observed that staff names and hours they worked were the same on the roster for this house and the adjoining house so it was not always clear what hours staff were in which house. All staff were not signing documents using the their surname as it appeared on the roster.

The inspector reviewed staff training records and saw evidence that the majority of staff had up-to-day mandatory training in place and those spoken with had a good knowledge of procedures to follow. However, those with expired training had dates for refresher booked. Staff had not received recent training on how to facilitate residents to develop and implement their social care plans.

There were no volunteers working in the centre.

Supervision of staff was not adequate. Staff had one supervisory meeting with each staff member in 2015 this was not in line with the organisational policy which stated supervisory meeting would be completed every 4-6 weeks. The lack of supervisory meetings was reflected in the fact that the person in charge was not aware that all three residents did not have comprehensive assessments available for review and that all
three residents did not have their personal social care plan reviewed or implemented in the past year.

Staff had access to a copy of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults With Disabilities) Regulations 2013. However, although the Authority had carried out three inspections between this centre and the adjoining centre their was a high level of non compliance as outlined in this report. The inspector found the lack of leadership, ineffective management, inconsistent supervision of staff and most importantly the lost of focus on the actual residents had lead to this level of unexpected and unacceptable level of non compliance for a low dependency centre.

The recruitment process was not reviewed on this inspection as it was reviewed on the last inspection and staffing levels had not changed since then.

**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 not available for review and not all records were maintained in a manner so as to ensure ease of retrieval. For example, a number of documents in the resident files had the incorrect house address on them. In addition, records of complaints were not available, records of personal plans were not detailed enough and a recurring pattern of theft had not been recorded.

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.
There was a directory of residents which contained most of the required information. The inspector noted that it did not include the nights residents were not residing in the centre, although residents told they inspector that they did stay sometimes in their family home.

The centre had some of the written operational policies as outlined in schedule five available for review. However, they did not have a policy on access to education, training and development or on the provision of information to residents.

**Judgment:**
Non Compliant - Major

**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 McKeivitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Michael's House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002364</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>02 September 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>08 October 2015</td>
</tr>
</tbody>
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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:
Resident’s privacy and dignity is not respected in relation to his or her personal and living space.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident’s privacy and
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:**
• The PIC will organise for the relevant allied health professionals to provide training support to the Service users in the area of dignity and respect.
• The Service users will be supported to develop house rules by the PIC.
• The PIC will support the Service Users to review and amend rules as required.

**Proposed Timescale:** 30/11/2015

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not supported to manage their own financial affairs as detailed in the report.

**2. Action Required:**
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

**Please state the actions you have taken or are planning to take:**
• The PIC will arrange for training for the Service Users to enable them to manage their own financial affairs.
• Each Service User will have their own Money box which will be stored in a double locked press in their bedrooms.
• Service users will be supported by staff to check their boxes on a daily basis.

**Proposed Timescale:** 30/11/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Complaints were not dealt with promptly. They were not dealt with within 28 days as outlined in the complaints policy.

**3. 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 registered provider has arranged for the designated complaints officer for St Michael’s House to review all outstanding complaints for the designated centre under the complaints policy.
• The provider nominee will undertake to address all recommendations made by the
complaints officer.
• The registered provider will arrange training for staff to improve practises in the management of complaints in accordance with organisational policy.
• The registered provider will ensure that all new complaints will be dealt with within the timeframe set out in the policy.
• The PIC will be supported by the designated complaints person to develop and maintain a record of complaints, details of any investigation and outcomes and actions in accordance with organisational policy having regard to the Health Act (2013) Regulations
• The record of complaints will be reviewed a part of the unit audit by the PIC and Service Manager.

**Proposed Timescale:** 30/11/2015

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complainants were not informed promptly of the outcome of the complaint.

4. **Action Required:**
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
• All complainants will be informed promptly by the Registered Provider of the outcome of each complaint and within the agreed timeframe as per the complaints policy.

**Proposed Timescale:** 28/09/2015

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The nominated complaints person was not maintaining a record of all complaints including details of the investigation into each complaint, the outcome of each complaint, any action taken on foot of each complaint and whether or not the resident was satisfied with the outcome.

5. **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:
• The registered provider has arranged for the designated complaints officer for St Michael’s House to review all outstanding complaints for the designated centre under the complaints policy.
• The provider nominee will undertake to address all recommendations made by the complaints officer.
• The registered provider will arrange training for staff to improve practices in the management of complaints in accordance with organisational policy.
• The registered provider will ensure that all new complaints will be dealt with within the timeframe set out in the policy.
• The PIC will be supported by the designated complaints person to develop and maintain a record of complaints, details of any investigation and outcomes and actions in accordance with organisational policy having regard to the Health Act (2013) Regulations
• The record of complaints will be reviewed a part of the unit audit by the PIC and Service Manager.

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person nominated to oversee the management of complaints was not doing so. There was no recorded evidence to show that this person had or was carrying out this role.

6. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
• The registered provider has arranged for the designated complaints officer for St Michael’s House to review all outstanding complaints for the designated centre under the complaints policy.
• The provider nominee will undertake to address all recommendations made by the complaints officer.
• The registered provider will arrange training for staff to improve practices in the management of complaints in accordance with organisational policy.
• The registered provider will ensure that all new complaints will be dealt with within the timeframe set out in the policy.
• The PIC will be supported by the designated complaints person to develop and maintain a record of complaints, details of any investigation and outcomes and actions in accordance with organisational policy having regard to the Health Act (2013) Regulations
• The record of complaints will be reviewed a part of the unit audit by the PIC and Service Manager.

Proposed Timescale: 30/11/2015
### Outcome 02: Communication
**Theme:** Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector observed that some staff used inappropriate language when addressing a resident.

#### 7. 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:
The registered provider will provide training for staff to ensure that communication with Service users is done in a respectful and professional manner in accordance with the organisation's Communications Policy.

**Proposed Timescale:** 30/11/2015

### Outcome 03: Family and personal relationships and links with the community
**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The visitors policy did not reflect if the free flow of residents and staff via the rear patio door was in accordance with residents' wishes.

#### 8. Action Required:
Under Regulation 11 (1) you are required to: Facilitate each resident to receive visitors in accordance with the resident's wishes.

Please state the actions you have taken or are planning to take:
- The PIC in consultation with the residents of the designated centre will review the visitor’s policy to ensure that it represents the views of each of the residents
- The PIC in consultation with the residents, organised for a door bell, already installed at the back door to ensure that all visitors to the unit are announced. This is to stop the free flow between the designated centre and the centre next door.

**Proposed Timescale:** 31/10/2015

### 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
Residents have a written agreement but they do not reflect the actual fees they were paying.

9. 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 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 of the designated centre are now paying the appropriate weekly rent.
- The PIC will ensure that the amount of rent paid is reflected in their contract of care and in their rental agreement.

Proposed Timescale: 09/10/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One residents contract of care does not include the fees to be charged.

10. 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 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:
- The PIC will review all contracts of care to ensure that they reflect accurately the rent and the service that is being provided by the designated centre. The contract of care will also include any additional rental agreements entered into by the residents.

Proposed Timescale: 09/10/2015

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:
A comprehensive assessment was not available for each of the three residents.

11. Action Required:
Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.
Please state the actions you have taken or are planning to take:
- The PIC will ensure that each of the Service Users has a comprehensive assessment of need.
- The assessment of need will be developed with the Service users in conjunction with the appropriate health care professionals.

**Proposed Timescale:** 30/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
One resident’s personal plan had not been reviewed within the past year.

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

Please state the actions you have taken or are planning to take:
- The PIC will ensure that the Service Users are supported by their key worker to review their personal plans annually or more frequently if required.
- The PIC will ensure that the relevant health care professional are available to support the Service Users as part of the personal plan review process.
  The PIC and Service Manager will audit the personal planning review process as part of the Unit audit.

**Proposed Timescale:** 30/11/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Records did not reflect effectiveness of resident personal plans, if goals had been achieved or within what timescale.

**13. 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:
- Service users will be actively involved in developing their own personal plans. The PIC will ensure that all personal goals are recorded.
- Documentation will be in place in the designated centre to reflect this process.
- Outcomes will be discussed between the PIC, service user and key worker in the context of agreed timeframes.
- All personal plans will be retained in an accessible format with each resident holding
a copy of their respective plan.

**Proposed Timescale:** 30/11/2015

### 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 was not reflected in practice as arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents were been followed.

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

Please state the actions you have taken or are planning to take:
• The Registered provider will provide training for the PIC and all staff to ensure they have the requisite understanding and competency to implement the risk management policy.
• The PIC will be supported to develop a system for recording and reviewing serious incidents or adverse events involving Service Users.
• All incidents will be reviewed, trends analysed and identified and corrective actions taken by the PIC and Service Manager at their regular meetings.

**Proposed Timescale:** 28/11/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk control measures were not proportional to the risk identified and the adverse impact that mitigating measures might have on the resident's quality of life had not been considered.

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

Please state the actions you have taken or are planning to take:
• The Registered provider will provide training for the PIC and all staff to ensure they have the requisite understanding and competency to implement the risk management policy.
• The PIC will be supported to develop a system for recording and reviewing serious
incidents or adverse events involving Service Users.

- All incidents will be reviewed, trends analysed and identified and corrective actions taken by the PIC and Service Manager at their regular meetings.

**Proposed Timescale:** 28/11/2015

### Outcome 09: Notification of Incidents

**Theme:** Safe Services

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

Resident’s money which went missing was not reported as suspected alleged financial abuse and as it was not recorded or investigated within 3 working days of the occurrence in the designated centre it was not known if it was an allegation, suspected or confirmed, financial abuse or theft of the resident money.

**16. Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

- The Registered provider will provide training for the PIC and Staff in relation to reporting any allegation of financial abuse in accordance with the organisations policy on safeguarding and service user finance policy.
- The PIC will notify the Chief Inspector of the allegation of financial abuse/thief on the appropriate form in accordance with the Health Act (2013) regulations.
- The PIC will ensure that any future allegation is brought to the attention of the registered provider as per Policy and to the Authority in accordance with the Health Act 2013 regulations.

**Proposed Timescale:** 30/11/2015

### 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:**

Staff did not support residents to maintain their independence.

Residents were not been provided with or given access to opportunities for further training which would potentially increase their level of independence.

**17. 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:**
• The Registered Provider will ensure staff have the relevant training in order to Support the Service Users to maintain and develop their independence.
• The PIC with the support of the relevant health care professionals will support the Service users to complete a Service User's strength and supports inventory, which will help identify supports the Service user requires to enable greater independence.
• The PIC and Key worker will work with the Service Users to access the identified supports.
The PIC and Service Manager will review as part of Unit Audit

Proposed Timescale: 30/11/2015

Outcome 11. Healthcare Needs
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not facilitated the resident to receive the treatment recommended by a health care professional following review.

18. Action Required:
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
• The PIC will ensure that all recommended medical treatment is recorded and that staff put supports recommended by health care professionals in place for Service Users.
• The PIC will review Service Users files monthly to ensure that all treatments are being followed up on.
• In response to one recommendation as agreed with the service user, a weighing scales has been purchased and weight is recorded as medically indicated.

Proposed Timescale: 28/09/2015

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:
Residents were not supported to manage their own medication, in line with their wishes and capacity.

19. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.
Please state the actions you have taken or are planning to take:
• The registered provider will provide training for staff to build capacity and support Service users in the safe self-administration of their medication.
• The PIC with the support of the relevant health care professional will ensure individual assessment of each Service User to establish their ability to administer their medication. The assessments will be carried out in line with the policy for self Administration of Medications by Service Users.
• Any training and or supports for Service Users identified will be provided.
• The PIC and Service Users will review on a regular basis.

Proposed Timescale: 30/11/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medications were not being stored in the most appropriate room in the house.

20. Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
• The double locked press in the kitchen/dining room will be removed and a smaller double locked press will be located in each individual resident’s bedroom for storage of medication.

Proposed Timescale: 30/10/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The residents had not been consulted before dispensing changes had been agreed between the pharmacist and the person in charge.

21. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
• The PIC will consult with the Service Users prior to any change in the method of dispensing.
• A record will be kept on file in the centre reflecting such changes. These will be
signed by the Service Users once changes have been understood and agreed.

**Proposed Timescale:** 28/09/2015  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Audits completed by staff were not accurate and were not being reviewed in detail by the person in charge or the service manager hence all medication errors were not been identified or reported.

**22. Action Required:**  
Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:  
- The Registered provider will provide training to all staff in the designated centre in managing medication safely as per policy.
- The PIC will put in place a system to ensure good practises in line with organisational policy.
- The PIC will audit Medications weekly.
- These systems will be reviewed by PIC and Service Manager as part of the unit audit.

**Proposed Timescale:** 30/11/2015  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Recommendations made by the nurse manager on call had not been seen and therefore not implemented by the management team.

**23. Action Required:**  
Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:  
- The PIC will put in place a system to ensure good practice in line with policy.
- The PIC will develop a communication system in the unit to ensure all recommendation by health care professionals are communicated and implemented.

**Proposed Timescale:** 30/11/2015
**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 as outlined under schedule 1.

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

**Please state the actions you have taken or are planning to take:**
- The existing statement of purpose will be reviewed by the PIC to ensure that it meets the requirements as set out in schedule 1.
- The PIC will review the designated centres statement of purpose to ensure that the information contained in the statement of purpose refers to the designated centre only.
- The PIC will send the updated revised version of the Statement of Purpose to the Authority.

**Proposed Timescale:** 30/10/2015

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**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:
The person in charge could not ensure the effective governance, operational management and administration of the designated centre.

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

**Please state the actions you have taken or are planning to take:**
- The Registered provider has identified a new PIC who has the relevant skills and experience to manage the centre.
- The New PIC will be supported by a Service Manager who also has experience in supporting Service Users in a low support house.
- The Current PIC will be supported through a performance Management process. The registered provider has identified a Service Manager to carry out this process. The Service Manager will report to the registered provider on a weekly basis through this process.
Proposed Timescale: 20/10/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not effectively addressed issues related to the operational management of the centre.

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

Please state the actions you have taken or are planning to take:
- The Registered provider has identified a new PIC who has the relevant skills and experience to manage the centre.
- The New PIC will be supported by a Service Manager who also has experience in supporting Service Users in a low support house.
- The Current PIC will be supported through a performance Management process. The registered provider has identified a Service Manager to carry out this process. The Service Manager will report to the registered provider on a weekly basis through this process.

Proposed Timescale: 20/10/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review did not reflect evidence that management of incidents, complaints, medication errors and other aspects directly linked to the management of the centre had been reviewed during this review completed in June 2015.

27. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
- The Service Manager and PIC will review the annual report and make the necessary changes to ensure that it reflects all aspects of service delivery this includes complaints, accidents and incidents, drug errors and the management of the service. This will enable the annual report to be used as a benchmarking tool.
### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff were not being facilitated to carry out their role as keyworker effectively as detailed in the report.

**28. 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:**
- The registered provider will provide training and education for staff in order for them to understand and to be effective in their role as key workers
- Training will be provided in areas detailed in outcomes 1, 5 and 12.
- Any additional training needs identified will be provided for.

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**Proposed Timescale:** 30/11/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The actual staff roster did not reflect the exact hours worked by staff in the centre.
The actual staff roster did not reflect the name some staff were using to sign documents.

**29. Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
- The PIC will ensure that there is a planned and actual roster maintained which reflects the actual hours worked by staff members in the designated centre.
- The PIC has changed the maiden name of one staff member on the roster to her marriage name. These rosters will be available in the designated centre for review.

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**Proposed Timescale:** 20/09/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The staff actual staff roster did not reflect the exact hours worked by staff in the centre.
30. **Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
- The PIC will ensure that there is a planned and actual roster maintained which reflects the actual hours worked by staff members in the designated centre.

**Proposed Timescale:** 20/09/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had not received training on the implementation of residents personal social care plans.

31. **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:**
- The registered provider will provide training and education for staff in order for them understand and to be effective in their role as key workers
- Training will be provided in areas detailed in outcomes 1, 5 and 12.
- Any additional training needs identified will be provide for

**Proposed Timescale:** 30/11/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not adequately trained to ensure they could implement the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

32. **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 members of the designated centre have been put forward by the PIC for the first phase of frontline Health Information and Quality Authority briefings which will take place in October 2015.
- Further training for all staff members of the designated centre is planned for 28th October 2015.
Proposed Timescale: 28/10/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not adequately supervised to ensure they were providing a high standard of care in line with the statement of purpose and in line with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013.

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

Please state the actions you have taken or are planning to take:
The PIC will hold individual support meetings with staff members on a Monthly basis. These meetings will be documented and made available in the designated centre for review.

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two policies were not available in the centre these included:
* A policy on access to education, training and development
* A policy on provision of information to residents.

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

Please state the actions you have taken or are planning to take:
• The registered provider is developing a policy on access to education training and development, 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 user’s access education, training and employment needs are met.

• The Policy Provision of Information to Residents 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.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records outlined in schedule 4 were not maintained, such as the date the residents were not residing in the centre and a record of all complaints.

**35. 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:**
- The PIC will ensure that all dates that residents are not residing in the designated centre are recorded in the directory of residents.
- The PIC will also ensure that a record of all complaints is kept in the designated centre.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A record of recurring pattern of theft was not being recorded.

**36. 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:**
- The PIC will ensure there is a system in place for the recording of all incidents of theft or any other incident that has adverse effect on Service Users.
- The PIC will ensure that all information is returned to the authority within the required time frame in accordance with the Health Act 2013 Regulations.
- The PIC will ensure that the registered provider is informed of any incident.
- The PIC and the Service Manager will review systems as part of the unit Audit.

| Proposed Timescale: 30/11/2015  |