

**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-0002394
<b>Centre county:</b>	Co. Dublin
<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>	Karina O'Sullivan
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	7
<b>Number of vacancies on the date of inspection:</b>	1

## 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:
16 February 2016 10:00	16 February 2016 19:30
17 February 2016 09:30	17 February 2016 18:30

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 second inspection of this designated centre by the Health Information and Quality Authority (hereafter called HIQA). This designated centre was operated by St Michael's house a company registered as a charity. St Michael's House (hereafter called the provider) is governed by voluntary board of directors to whom the CEO (Chief executive officer) reports.

An application was made to the HIQA to register the centre for eight residents and a complete application had been received by HIQA.

The purpose of this inspection was to monitor compliance and inform a registration decision under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (hereafter called the regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the standards).

This designated centre provided residential supports to people with intellectual disabilities by providing a community based residential service. The aim of this designated centre was to support residents to "provide a homely environment where individuals are supported to live as independently as possible and make choices about their lives. To ensure a healthy and safe environment is maintained where everyone feels at home and secure" as outlined in the statement of purpose for the designated centre.

The person in charge facilitated the inspection. A service manager (person participating in management) attended a meeting at the beginning of the inspection and attended a feedback meeting at the end of the inspection.

The designated centre provided a residential service to 8 adults with 7 people residing within the centre at any given time. The designated centre consisted of a two storey house and an apartment. The apartment had two bedrooms used on a time share basis with one resident residing in the apartment at a time.

As part of this inspection, the inspector visited the house and met with some of the residents and staff members and reviewed questionnaires returned by residents and relatives. The inspector observed practice and viewed documentation such as personal plans, medical records, recording logs, policies and procedure, minutes of meetings and staff files.

Resident's spoken to communicated that they were happy living within this designated centre. Residents had access to social care supports participating in activities appropriate to their interests and preferences.

Over the course of the inspection the inspector found the residents, person in charge and staff to be courteous, supportive and helpful with the inspection process.

Overall, the inspector found that residents received a good quality service. The inspector found significant improvements in the areas of noncompliance as identified from the previous inspection. This had resulted in improvements to the quality of life for residents living in the centre. For example risk assessments had been completed in relation to self injurious behaviours with appropriate measures identified to safeguard residents from potential injuries. However some areas required further improvements including the assessment of the effectiveness of health and social plans implemented, and training provision for staff members. These and other areas identified are outlined in this report and within the subsequent action plan.

**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):**

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

**Findings:**

The inspector was satisfied that the privacy, dignity and rights including both civil and religious rights of residents were promoted. Residents were afforded the opportunity and encouraged to make choices and these choices were respected. Improvements were required in the area of resident's finances.

Two actions from the previous inspection relating to the policy and procedure for the management of complaints and the provision of privacy locks and or keys been made available to residents had been addressed satisfactorily.

The inspector found systems in place to consult with residents in a manner suitable to their needs and abilities. For example the use of photographs to identify staff members on the staff rota was available.

Residents were consulted in relation to the interior design of the designated centre. This included the colour scheme and the purchase of furniture and personal items for their bedrooms. Family members were also consulted in relation to this if the resident so wished.

Residents and relatives had access to the national advocacy service. The relevant contact information was displayed in the designated centre. Information was also prominently displayed on residents' rights in an accessible format.

Individual safes/ secure storage were provided in each resident's room.

Appropriate records were not maintained in relation to managing the residents' finances. While daily checks were carried out to ensure that balances were correct by two staff members. The inspector identified that the policy in circulation in the designated centre was not the most up to date policy pertaining to finances. The up to date policy identified that the person in charge was to conduct monthly audits of residents accounts this was not evident. For example one resident had their account audited in August 2015. This audit was delegated to another member of staff where the audit was conducted for the previous eight months. The inspector was also dissatisfied with the amount of money being held within the designated centre as the policy specified €150 however this was not being adhered to for example from the period of time 01 of January 2015 to the 13 of February 2015 €690 was present for one resident.

There was a local policy pertaining to resident's personal property, personal finances and possessions. The inspector found that this was not in operation as residents did not have any inventory of personal possessions over the value of €50 as identified in the policy.

One resident did not have a bank account however the person in charge identified the process currently underway to facilitate this and the inspector viewed evidence of this.

There was a complaints policy and procedure in place within the designated centre. The complaints procedure was displayed on the notice boards within the designated centre. The inspector viewed complaints within the designated centre, these included complaints from a family member pertaining to a resident wearing another resident's clothes. This complaint was dealt with in a timely manner and learning was identified from this incident. This was rectified through a discrete label being placed on the inside of residents clothes to avoid reoccurrence of this. Clear collaboration with all parties involved was evident.

**Judgment:**  
Substantially Compliant

## **Outcome 02: Communication**

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

**Theme:**  
Individualised Supports and Care

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

**Findings:**  
The inspector was satisfied that residents were supported and assisted to communicate in accordance with residents' needs and preferences.

Resident's augmentative and alternative communication needs were identified within their personal planning documentation. Supports needed by residents were put in place such as the use of visual schedules and visual displays for meals and staff rotas and Lamh (manual sign system used by children and adults with intellectual disabilities and communication needs in Ireland).

Information pertaining to resident's communication was not consistent within the resident's file, on some occasions the person in charge printed out residents communications needs as this was not available within the file. The inspector was not satisfied that communication needs and styles were identified within the residents files especially when relief staff were required to work within the designated centre who do not have access to the computer.

However the inspector did acknowledge when information pertaining to resident's communication was available that it was very person centred. For example one resident had pictures of themselves using Lamh signs with an explanation of the most used signs evident within the file. Another file viewed identified that when a resident wanted to communicate they would walk up close to the other person. The inspector observed all of these interventions within the residents' files and also in practice over the two day inspection. Staff were aware of the communication needs of all residents and the inspector observed staff and residents communicating freely.

Residents had access to television, radio and wireless internet connection within the designated centre.

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

**Findings:**  
From the information available the inspector was satisfied that families and friends were encouraged to get involved in the lives of residents.

Staff outlined how they facilitated residents to maintain contact with their families. This included access to telephones, transport home/ visits and family invitations to events in the designated centre including significant life events such as birthday parties.

Regular contact with family members was evident between staff and their relatives in accordance with residents' wishes. For example if a resident's family member was in hospital then visits would be arranged or if a family member was in a nursing home the designated centre facilitated visits. The inspector viewed evidence of this within residents' files.

A sensory garden was recently completed with family members invited to attend and plant a tree with their family members within the designated centre.

Links were maintained within the community as residents participated in activities according to their individual interests such as spa treatments.

Visitors were welcomed within the designated centre and residents are building relationships among the local community including neighbours.

**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):**

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

**Findings:**

The inspector was not satisfied that the residents' contracts for the provision of services outlined the information as required within the regulations. Residents' contracts did not contain accurate information in relation to the fees charged to residents this was identified as an action on the previous inspection.

A sample of residents written contracts were viewed by the inspector, the agreements were not clear in relation to the services being provided and the fees required to be paid. For example some residents' contracts identified monthly fees however the person in charge identified that this charge was in fact weekly. Some contracts identified residents paid into a house fund when the inspector queried this contribution the person in charge identified that this was no longer in place. The staff mix identified within the resident's contract was not accurate and were different from one resident to another.

Additional charges such as activities including music was clearly outlined in the contracts viewed.



There were policies and procedures in place to guide the admissions process. The process was also described in the statement of purpose. There were no recent admissions to the designated centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspector was not satisfied all of the actions identified in the previous inspection had been achieved. The inspector did acknowledge that significant improvements had taken place in relation to the assessment of resident's needs. The area of concern to the inspector pertained to the assessment of the effectiveness of resident's personal plans.

The inspector did find that the wellbeing and welfare of residents was provided to a good standard. This was evident within the sample of residents' files the inspector viewed.

Each resident had a personal plan in place incorporating personal and social needs. These plans were personalised and reflected resident's individual requirements in relation to their social care needs. For example the use of a swing chair in the sensory garden.

Clear collaboration with the day services were evident for example one resident wanted to go house ridding and this resident was taken to one of the national horse shows. The inspector viewed clear communication of the residents' wishes with the day service. This involved staff collaboration from the day service and the designated centre to assist the resident to achieve their goals.

The inspector was satisfied that residents had plans in place however the details contained and the review of these plans did not take in to account the effectiveness of these plans. In some instances the information identified in the personal plans did not reflect actual practice. For example one resident identified meal preparation was an area they would like to increase their skills in. This was not evident within the eating, drinking and nutrition section nor was there any evidence of this goal being reviewed. Time frames were not evident for when actions identified were to be completed such as staff to make contact with the occupational therapist no time frame was specified. Therefore there was no evidence in relation to goals being met within timeframes. This was also highlighted during the previous inspection.

The inspector was not satisfied with some of the goals set for example one resident had a goal pertaining to a resident being assisted to their wardrobe and asked to choose their clothes for the day. The inspector identified that this was not a social goal as residents should be afforded choice in respect to the clothes they wear on a daily bases.

The inspector viewed one residents plan in a picture format which was made accessible for the resident however no other plan was in an accessible format for residents.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that designated centre was suitable and safe for the number and needs of residents.

The designated centre consisted of a two storey house and an apartment. The house had seven bedrooms one for staff members when on sleepovers and the apartment had two bedrooms used on a time share basis with one resident residing in the apartment at any given time. The designated centre was located in close proximity to the town centre.

In the main house there was an open plan kitchen/dining room and sitting room on the ground floor. There were four bedrooms on the ground floor for residents two of which were ensuite. On the first floor there were three bedrooms all were ensuite which included one bedroom for staff.

The designated centre had a garden to the back and side of the house had recently been re landscaped to incorporate elements of sensory integration.

The inspector identified areas within the premises that required attention. The person in charge had logged the areas prior to the inspection including the painting of a door and also the replacement shelves for the refrigerator. The inspector also identified the lack of hot water within the designated centre this was logged to the maintenance department during the inspection.

The inspector found that the designated centre meet the requirements of Schedule 6 in the regulations. For example, the designated centre was suitably heated, had suitable kitchen and laundry facilities while adequate private and communal accommodation was available.

**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):**

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

#### **Findings:**

The inspector was not satisfied that the health and safety of residents, visitors and staff was promoted within the designated centre. Areas identified in the previous inspection had been addressed with the exception of the safety statement, while completed, had no completion or review dates identified. In addition improvement was required in the management of fire safety.

The inspector viewed evidence of checks and services of the fire detection, alarm system, emergency lighting and equipment being conducted by a fire professional all of which had been recently inspected. There were provisions for daily checks to be conducted in relation to escape routes, fire equipment, fire alarm and emergency lighting. However three staff members were awaiting fire training.

Fire drills had taken place for each resident within the designate centre. The inspector was not satisfied in relation to the actions following one drill on the 11.01.2015 when a resident kept returning back to the designated centre. There was no evidence of any actions taking places following this drill and the next drill did not take places until the 07.03.2015. The inspector was not satisfied with this practice as this was not reflected in the resident's risk assessment. There was no evidence of training or education in the form of more drills being conducted with this resident evident within the designated centre.

The inspector viewed a sample of personal evacuation plans for residents and these included any particular arrangements that a resident may require such as the use of mobility aids or evacuation sheets.

There were policies and procedures in place for risk management and emergency planning these contained sufficient details to guide staff in the procedure to follow in the event of possible emergencies such as flood or power outage. Emergency plans identified a centre to temporarily relocate residents to an area of safety however, plans did not outline the arrangements for alternative overnight accommodation if required. The location specified in the plan was only utilised until such time alternative accommodation was sourced.

Inspectors reviewed the risk management policies and procedures and found them to meet the requirements of the regulations. There was a system in place to identify, examine and manage potential hazards in the designated centre. This was evident through the risk register viewed within the designated centre. Any potential or real risks for the residents had been assessed such as the storage of chemical and manual handling.

Individual risk assessments had been developed for residents in areas such as manual handling and self injurious behaviours. Risk assessments defined risks and outlined the control measures to be implemented to minimise risks.

Two staff members had not attended training in moving and handling.

The vehicle used to transport residents was insured, had an up to date certificate of roadworthiness and all staff members who drove the vehicle were qualified to do so. The wheelchair lift in the vehicle had been serviced within the last year.

The inspector also observed procedures were in place for safe food storage and preparation. Temperature checks were completed for refrigerator, freezer and cooked foods. Colour coded chopping boards were available for use and there was an up to date policy available on food safety.

The inspector reviewed records of incidents in the designated centre. Appropriate immediate action had been taken in all incidences with additional control measures implemented to prevent reoccurrence.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that measures were in place to safeguard and protect residents from being harmed or suffering abuse. However improvements were required in relation to the use of restrictive practices.

There was a policy on and procedures in place for, the prevention, detection and response to abuse. All staff had received training on safeguarding. Staff members spoken to were clear on the actions to take in the event of an allegation, suspicion or disclosure of abuse and the reporting mechanisms to follow in accordance with the policy for the designated centre. There was a designated person to deal with all reported allegations or disclosures of abuse.

The inspector viewed policies on the use of restrictive practice, the provision of behavioural support and the provision of personal intimate care. However the policy in relation to restrictive practice was not fully implemented within the designated centre for example all restrictive practice was to be reviewed annually as identified within the policy. The person in charge could not provide evidence of this for instance the use of a device for a resident when travelling on transport was reviewed in February 2016. There was no other evidence of review available to the inspector with the exception of April 2014. Another resident had a physical restraint identified within their behavioural support plan when the inspector requested evidence of this being approved and reviewed as outlined in the policy, this was not available until the second day of inspection. The inspector was provided with an interim approval for the use of the physical restraint with a resident for the duration of two months from the date of inspection. The inspector viewed the training record for staff and identified that two staff members had not received training in positive behaviour support.

The inspector also viewed evidence of the person in charge referring restrictive practices to the internal committee however significant periods of time was evident for example a referral was made in April 2015 and approval was not granted until February 2016.

The inspector was informed and viewed evidence of positive aspects in relation to reducing the use of restrictive practice where a resident's use of a restrictive device was reduced to a less restrictive alternative. This was achieved through reviewing the use of the device and implementing alternative arrangements. For example innovative measures were put in place to remove the use of a full body harness required during transport, by providing alternative transport therefore reducing the length of travel time and therefore reducing anxiety levels allowing the use of a less restrictive harness to be used.

The inspector reviewed three behaviour support plans these clearly outlined the support measures to prevent and respond to incidences of behaviours that challenge. Included in these plans were early physical signs for staff to become familiar with in order to prevent the resident's behaviour from escalating into self injurious or physical behaviour. Identified triggers clear verbal phrases were outlined to assist staff members to engage in a consistent approach to behavioural management.

The inspector reviewed eight questionnaires submitted to HIQA by residents and relatives which outlined that residents felt safe in the designated centre and relatives their family members were safe within the designated centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied with the practice in relation to notifications of incidents. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents.

**Judgment:**

Compliant

**Outcome 10. General Welfare and Development**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that the general welfare and development needs of resident's were promoted. Residents were afforded opportunities for new experiences, social participation, education, training and employment.

There was a policy in place on access to education and learning. Residents' personal achievements were valued and proactively supported in the centre, for example, art and crafts work completed by residents was on display in the designated centre.

Developmental goals were established for residents to support the development of new skills, for example, independent money management skills and independent living skills. Residents were also supported to maintain skills already learned, for example, food preparation skills and self - care skills.

The person and charge and support workers outlined how support was provided to residents to pursue a variety of interests including cooking and baking. Resident's also engaged in community activities including horse ridding.

The inspector viewed residents' profiles and these contained relevant information in relation to activities residents participated in.

**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):**

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

**Findings:**

The inspector was satisfied that the actions identified in the previous inspection had been achieved however, other concerns were identified in the following areas in a sample of files viewed:

- Residents had bowel monitoring in place the inspector was unable to ascertain how effective this intervention was as monitoring was not completed effectively for example the inspector viewed records for one resident and out of 16 days 10 days had no recordings. It was unclear as to why this type of monitoring was required when the resident had no diagnosis of constipation.
- Hypothyroidism was identified within a support plan, however this was not evident within the residents current health needs as this section of the plan was blank.
- Within another resident's plan maintain a healthy weight was identified however the resident's weight was not identified or being recorded and regular dietician reviews were identified as actions. The inspector was unable to see how this plan was being reviewed in relation to the effectiveness. While the plan was reviewed on the 15.02.2016 no details were included in the review.
- A resident requiring ileostomy care had a support plan in place however the inspector was unable to identify if this plan was adhered to, as there was lack of monitoring in relation to the interventions outlined in the residents plan.
- A resident requiring fluid restriction due to their diagnosis had a clear multidisciplinary plan developed. However the inspector viewed two plans within the residents file and both contained conflicting information for example one identified daily fluid intake to be 800mls per day and the second plan identified 1000mls. The inspector spoke to staff members about this and staff were not clear in relation to which plan was to be implemented for the resident the inspector was not satisfied with this practice.
- Staff within the designated centre had made a referral for one resident who required a sensory assessment this was not completed despite the referral being made in September 2013. The inspector was not satisfied with the time frame for this assessment to be conducted.

The inspector viewed an epilepsy management plan. The medications the resident was prescribed including emergency medication were in place for the resident and staff were trained in the usage of the medication.

Residents had access to a general practitioner and on the day of inspection residents were undergoing annual health assessments.

The inspector found residents participating in meal times within the designated centre in accordance to the resident's personal choice. Residents assisted staff in meal preparation and participated in menu planning. The inspector viewed user friendly menu selection and weekly shopping lists. Refreshments and snacks were available for the residents outside mealtimes within the designated centre.



Residents requiring modification to the texture of their food was clearly outlined in the residents file and staff were knowledgeable in relation to the implementation of resident's food requirements. The inspector viewed evidence of assessments and reviews taking place in relation to feeding, eating, drinking and swallowing (FEDS).

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

The inspector was satisfied that the actions identified in the previous inspection had been achieved as significant progress had occurred however, other areas of concern were identified in relation to the following:

Reviewing and monitoring of medication management practices was not effective within the designated centre. The inspector viewed an annual audit conducted by a staff member nominated by the person in charge. This audit identified areas where practice in the designated centre was not in accordance with the policy on medication management. However the inspector queried what action was taken following the audit and the person in charge outlined that areas identified were not yet implemented these included prn (Pre re nata as required medication) medication not being counted weekly. Therefore the inspector was not satisfied that medication audit results were being used to enhance and improve practice.

Lack of local guidelines for when the designated centre had one staff available as the policy outlined two staff to sign in relation to medication. The inspector viewed evidence in recording sheets where this did not occur due to one staff member being available this was not in accordance in the organizations policy.

There was a policy in place which provided comprehensive and clear guidance to staff on areas such as medication administration, refusal, medications requiring strict controls, disposal of medications and medication errors.

Safe storage facilities were provided for medication within the designated centre.

The inspector viewed staff files and found one staff member required medication management training.

The inspector viewed a medication incident which had occurred previous to the inspection. The volume of errors had decreased in the past year due to the implementation of individualised medication package supplied by the local pharmacy. The inspector viewed evidence of staff meetings with medication errors being discussed and the change to the new system.

The inspector also viewed clear evidence in residents files pertaining to medication and additional requirements for example if a resident was to be administered medication prior to meal times this was clearly evident within the appropriate section of the residents file to alert staff effectively.

**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 inspector was satisfied the statement of purpose met the requirement of the regulations.

Minor amendments were required in relation to the inclusion accurate staff numbers, admission criteria and the fees residents were required to pay. These were subsequently provided following the inspection.

However an action identified in the previous inspection remained outstanding in relation to the statement of purpose been available for residents in an assessable format.

**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:**

The inspector was not satisfied with the overall governance and management structure in place within the designated centre, while actions from the previous inspection were achieved other areas of concern were identified.

The provider had nominated a sufficiently senior person to conduct visits to the designated centre at least once every six months and produce a report. The inspector was provided with a copy of the report and noted that it did not identify timeframes in which to address areas of noncompliance or who was responsible for completing the required actions. While some of the actions had been completed others remained outstanding without any clear guidance of when these would be achieved for example behaviour forms to be analysed to identify trends. Other areas were left blank within the report such as information on the auditing of a service users assessment and support plan. The inspector viewed an annual review of the quality and safety of care within the designated centre.

The person in charge remained the same since the previous inspection and from discussions, interview and information provided, the inspector found that the person in charge demonstrated sufficient knowledge of the legislation and her statutory requirements. Staff spoken to stated they felt supported by the person in charge. The person in charge was employed on a full time basis and also availed of protected time built into the roster. The person in charge was supported by a regional manager. The person in charge also met with peers on a two monthly basis as part of the larger St. Michael's House management support system.

The management structure was clearly defined which identified the lines of authority and accountability. The person in charge reported to a service manager (person participating in management) and meetings took place every two month. The service manager was also available to the person in charge for support on a daily basis. The service manager met with the provider nominee on a fortnightly basis and outstanding issues pertaining to the centre were discussed at these meetings.

Arrangements were in place for staff supervision however this was not completed consistently.

The person in charge was engaged in the governance and management of the designated centre on an ongoing basis including managing staff resources, managing an allocated budget and completing training needs analysis.

**Judgment:**

Non Compliant - Moderate

**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 inspector found that the person in charge was aware of the requirement to notify HIQA of any absence over 28 days.

Appropriate deputising arrangements were in place should the need arise.

**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 inspector found the designated centre was resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

There were adequate staffing and financial resources to support the residents in achieving their individual personal plans.

The designated centre had its own transport available to support residents in social and healthcare needs. The provision of this transport had brought about significant improvement for residents in relation to reducing the time spent travelling to their respective day services.

However this impacted on staff resources within the designated centre as staff were required to drive this bus taking lengthy periods of their day travelling to various day centres. In some instances the person in charge had to fulfil this role. The inspector viewed evidence that this was a concern by staff in relation to time management. This was evident in minutes of staff meetings with the person in charge and the regional manager. Staff identified attributed this as a reason as to why they did not have sufficient time to allocate to resident's plans.

However, while the evidence showed that the revised use of resources was benefiting the residents as described the inspector was concerned the practice was not linked to the assessment of staffing requirements and therefore the sustainability of this practice was not adequately considered.

**Judgment:**  
Substantially 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):**

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

#### **Findings:**

Overall there were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. However mandatory training requirements were not provided for some staff working in the designated centre, and staff did not receive adequate formal supervision.

The designated centre was staffed by social care workers with one staff on duty during the day and one staff on duty over night in a sleep over capacity. The staff team had significant changes in the past number of months with nine new members of staff commencing in the designated centre since January 2015. Members of staff spoken to identified that the designated centre had been challenging place to work due to the high turnover of staff and due to relief staff members not being familiar with the residents

within the designated centre. However the periods required for relief staff in the past month had significantly reduced. The inspector viewed evidence of this within the actual rosters viewed. On the day of inspection the person identified that the designated centre had two vacancies however staff had been recruited to these posts and were awaiting start dates.

There was an actual and planned rotas which was reflective of the staff on duty on the day of inspection. The roster was managed ensure the effective deployment of staff in the delivery of a safe and quality service to residents. There was a shift leader indicated on the roster for each shift when the person in charge was not on duty.

Staff were observed to deliver care and support in a respectful manner and review of personal plans indicated all care had been provided in a timely manner.

The inspector reviewed records of staff training. All staff had not completed mandatory training in areas such as fire safety, manual handling and safe administration of medication.

Training had also been provided to some staff in food safety, first aid, and hand hygiene. The education and training provided were reflective of the care and support needs of residents as per the statement of purpose.

Staff spoken to were knowledgeable on the policies and procedures relating to the general welfare and protection of residents, for example, fire evacuation procedures and safeguarding procedures. Staff members spoken to were also aware of the regulations.

The inspector reviewed records of staff supervision. The supervision provided was not consistent across the staff team for example one staff member had not received supervision since May 2015.

There were effective recruitment procedures in place in the designated centre including the checking and recording of all required information.

Staff records had recently been checked at the main service headquarters and all the requirements of Schedule 2 had been met.

There were no volunteers employed in the designated centre.

**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 inspector was not satisfied that the documentation required by the regulations was maintained in the designated centre improvements were required to ensure all the policies and procedures as per Schedule 5 of the regulations were in place and subject to review.

The management of service users monies was present in the designated centre this was dated November 2012 and for review in November 2017 when the inspector queried this policy the person in charge sourced another version of this policy dated November 2012 and this document was reviewed in 2014 with another review due in 2017.

Duplication also occurred in relation to the use of restrictive practices as the inspector was presented with a draft policy dated July and subsequently was presented with an approved policy dated July 2015. The inspector was not satisfied that versions of the same policy was in operation as this could lead to staff being miss guided in their practice if using an inaccurate document.

While there was an admission policy this did not include the process should a resident be temporary absent from the designated centre as outlined in schedule 5 of the regulations,

Policy on monitoring documentation of nutritional intake was outdated since October 2015.

Two policies were not present within the designated centre in relation to pertaining to staff training and development and provision of information to residents. Local guidelines had been developed on residents' personal property, personal finances and possessions within the designated centre however this was not in operation.

The person in charge provided the inspector with an internal memo pertaining to the schedule 5 documents and plans were under way to rectify these areas of concerns.

The inspector found systems were in place to ensure that medical records and other records, relating to residents and staff, were maintained in a secure manner.

The inspector viewed some of these records and noted incomplete and inaccurate recordings for the some items. For example within the sample viewed health care needs was blank within the residents file however this resident had a support plan in place of an element of their health care needs. Other areas of concern included lack of reviews being documented pertaining to residents goals while some reviews were taking place it was difficult for the inspector and person in charge to establish when these occurred and no date or follow up actions were identified.

A directory of residents was maintained in respect of each resident in the designated centre.

All of the required records as per Schedule 4 of the Regulations were maintained in the centre.

The inspector reviewed documentation submitted as part of the application to register, and determined that there was an up to date insurance policy in place for this proposed designated centre.

**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:***

Karina O'Sullivan  
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-0002394
<b>Date of Inspection:</b>	16 February 2016
<b>Date of response:</b>	4 April 2016

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

Resident's personal possessions were not accounted for within the designated centre.

#### 1. 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

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

possessions and, where necessary, support is provided to manage their financial affairs.

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

- Personal possessions completed by keyworkers in line with unit policy
- Local policy in place to ensure rent payments do not build up in line with organisational policy while awaiting the set up of a bank account.
- Agreement with the family involved that the residents disability allowance will be paid into this account and a standing order set up by the finance manager to make rent payments.

**Proposed Timescale:** 31/03/2016

**Theme:** Individualised Supports and Care

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

One resident did not have a bank account.

**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:**

- Finance manager will follow up on the opening of one residents bank account

**Proposed Timescale:** 31/08/2016

**Theme:** Individualised Supports and Care

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

Audits were not conducted in accordance with the organizations policy pertaining to residents' finances.

**3. 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:**

- PIC to allocate monthly management hours to complete audits in line with organisational policy

**Proposed Timescale:** 31/03/2016

## 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:**

Some residents did not have information pertaining to their communication style within their file.

### **4. 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:**

- PIC will ensure all communication needs are identified, documented and stored in residents green files.

**Proposed Timescale:** 31/03/2016

## 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:**

Resident's contracts did not outline the exact fees paid by residents.

### **5. 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:**

- New contracts of care with revised fee's and staff mix to be drawn up and sent to families to sign.
- To be sent to families by 04/04/16
- Returned by families, signed and in green files by 30/04/16

**Proposed Timescale:** 30/04/2016

**Theme:** Effective Services

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

Information stated pertaining to the skill mix of staff was different in some resident's contracts.

**6. Action Required:**

Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident's assessed needs and the statement of purpose.

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

- All contracts of care will be updated as per action 5.

**Proposed Timescale:** 30/04/2016

**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:**

Some residents' plans were not accessible to the residents.

**7. Action Required:**

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

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

- Work underway to make these accessible for all residents.
- IP meetings were held in February where goals were set.
- PIC will ensure all keyworkers have made the goals accessible to each residents based on their communication needs

**Proposed Timescale:** 30/05/2016

**Theme:** Effective Services

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

Reviews of personal plans did not take into account the effectiveness of the plan or reflect changes in the residents' needs.

**8. 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:**

- Discussed at staff meeting on 15/03/16
- Individual staff support session with PIC scheduled for April
- Additional support in personal planning to be provided to newer staff members by PIC
- System put in place for keyworkers to effectively track goals
- Training to take place, all staff to have completed this by April 19<sup>th</sup>
- One residents goals will be reviewed

**Proposed Timescale: 30/04/2016****Theme: Effective Services****The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Timeframes for those responsible for assisting residents to attain their goals was not evident in some of the plan viewed.

**9. 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:**

- To be discussed at staff meeting 12/04/16
- Individual staff support sessions scheduled for April
- Monthly keyworker checklist in place to ensure all goals are achieved within agreed timeframes.
- the PIC will review monthly check list to ensure all goals are tracked.

**Proposed Timescale: 30/04/2016**

## 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 emergency plan did not specify where residents would receive overnight accommodation should the need arise.

**10. 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:**

- Two local hotels identified, contact details and address's are included in the unit emergency plans.

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

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

Adequate arrangements were not implemented when one resident did not adhere to the fire procedure when a fire drill was conducted.

**11. Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

- Additional measures put in place and documented on residents fire evacuation plan
- PIC will review all fire drills and communicate any learning to all staff, fire evacuation plans will be updated to reflect these changes.

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

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

Some staff had not received fire training.

**12. Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control

techniques and arrangements for the evacuation of residents.

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

- Date for training was in place at time of inspection and due to be completed on 31/03/16

**Proposed Timescale:** 31/03/2016

### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Some staff had not received training in relation to the implementation of interventions outlined in one resident's behavioural support plan pertaining to physical restraint.

#### **13. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

- Training scheduled for end of June 2016.

**Proposed Timescale:** 30/06/2016

**Theme:** Safe Services

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

The use of restrictive devices were not reviewed in accordance with the designated centre's policy.

#### **14. Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

- PIC to put a system in place to track when referrals are sent, what follow up is required and ensuring they are back within a reasonable time frame. Ensuring approval is always up to date.

**Proposed Timescale:** 30/04/2016

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

Lack of evidence of residents receiving appropriate health care needs due to health care plans not assessing the effectiveness of the plans in place.

**15. Action Required:**

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

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

- Need for detail on reviewing plans to be discussed at staff meeting 12/04/16
- Individual staff support sessions scheduled for April 2016
- Bowel charts to be removed from residents files if they are independent in the area of toileting.
- All health care plans reviewed and amended where required.

**Proposed Timescale:** 30/04/2016

**Theme:** Health and Development

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

Resident's medical treatment was not fully outlined within the residents file to guide staff effectively in implementing the appropriate care interventions such as ileostomy care.

**16. 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:**

- Discussed at staff meeting, staff will update support plans where required and amend/update health support plans after every medical appointment.
- Keyworkers will ensure all old support plans are removed from the residents active file.
- Additional supports to be given to new staff who are key working residents. Individual support session scheduled for April 2016.
- Recording chart to document illeostomy care carried out now filed in the residents active file.



**Proposed Timescale: 30/04/2016**

**Theme: Health and Development**

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

Resident requiring a sensory assessment was outstanding since September 2013.

**17. Action Required:**

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

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

- Contact made with the Occupational Therapy Department manager by PIC
- Head of OT to allocate a staff member to carry out a review of sensory needs and have report in place by 31/06/16.

**Proposed Timescale: 30/06/2016**

**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:**

Lack of appropriate actions following areas identified in medication management audit.

**18. 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:**

- PIC has discussed this issue with the staff member who is delegated the task of the medication management audit and system now in place to alert the PIC when an issue arises with the audit. The PIC has allocated management time to review the medication management audit.

**Proposed Timescale: 31/03/2016**

**Theme:** Health and Development

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

The organisation's policies pertaining to medication management was not fully implemented within the designated centre.

**19. 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:**

- Local policy in place to guide staff should a second member of staff be unavailable to carry out audits.
- To be discussed at staff meeting 12/04/16

**Proposed Timescale:** 12/04/2016

**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 had not been made available in a format assessable to residents this was previously identified in 2014.

**20. Action Required:**

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

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

- Communication review for the unit to take place in May/June 2016.
- Allocated time to be provided to a delegated staff member to work with residents to develop the accessible statement of purpose.
- Residents guide is in place in an accessible format until this time

**Proposed Timescale:** 13/07/2016

## 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:**

Audits conducted did not specific plans with specific time frames and roles of staff members identified in order to improve systems within the designated centre.

**21. Action Required:**

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

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

- PIC to ensure all documents and actions required, who will complete these and are tracked using a new system.
- All incidents will be analysed to look for trends/themes
- The Audit will include actions outstanding, who is responsible for completing same within a time frame.

**Proposed Timescale:** 30/05/2016

**Theme:** Leadership, Governance and Management

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

There was a lack of consistency in relation to supervision and performance management of staff members within the designated centre.

**22. 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:**

- PIC has allocated protected time for supervision meetings with all staff. This is clearly identified on the roster.

**Proposed Timescale:** 01/04/2016

## Outcome 16: Use of Resources

**Theme:** Use of Resources

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

Resources pertaining to staffing levels did not take into account that staff were absent from the designated centre travelling to various daycentres.

**23. Action Required:**

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

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

- Roster review taking place on 05/04/16, this will include a review of time allocated for transport.

**Proposed Timescale:** 30/04/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

Some staff had not undertaken mandatory training.

**24. 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:**

- Fire safety training to took place on 31/03/16

**Proposed Timescale:** 31/03/2016

**Theme:** Responsive Workforce

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

Lack of supervision for staff members.

**25. 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:**

- Support sessions scheduled in April and protected time allocated for all staff members.
- The PIC will allocate management hours for staff supervision, this will be clearly identified on rosters.

**Proposed Timescale:** 30/04/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Some of the schedule 5 policies were not available to staff.

**26. Action Required:**

Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

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

- The registered provider is currently updating some policies, memo provided to inspector on the day of inspection with details of same.
- Any new policies will be discussed at staff meetings as they are released and copies made available for all staff in the unit policies folder.
- All duplication of policies will be removed from the designated centre.
- All schedule 5 policies will be made available to all staff at staff meeting.
- All staff will sign when read and understood; the sign sheet will be stored in the policy folder.

**Proposed Timescale:** 30/05/2016

**Theme:** Use of Information

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

Some of schedule 3 documents for some residents within the designated centre were not available.

**27. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

- Roll out of a new system called all about me is underway. All staff will have completed initial training by 19th April 2016. Documents will then be amended and updated.
- Individual supports put in place for newer members of staff in completing documentation required in April by PIC.

**Proposed Timescale: 30/06/2016**