Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A Bettystown Ave
Centre ID:	OSV-0002365
Centre county:	Dublin 5
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Michael Farrell
Lead inspector:	Anna Doyle
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
15 September 2016 09:30	15 September 2016 18:45

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of the designated centre. The purpose of this inspection was to follow up on actions from an announced registration inspection carried out in the centre in March 2015 and to monitor ongoing compliance with the regulations.

Description of the Service:
The centre is operated by St. Michaels House (SMH) and is situated in North Dublin. It comprises of a seven bedroom two storey house located, close to local shops and transport links. The centre provides care to both male and female residents who have an intellectual disability, some of whom have mobility and healthcare needs. Care is provided using the social care model of support.

How we gathered evidence:
Over the course of this inspection the inspector met five of the residents. One resident was out for the day and was visiting family. One of the residents met formally with the inspector and stated that they were very happy living in the centre

and talked about a variety of activities they were involved in. Some of the residents were unable to express their views on the quality of care provided in the centre. One resident was supported by staff to show the inspector a communication tool that they were developing on a computer tablet. The inspector observed practices, met with staff, reviewed documentation such as: care plans, medical records, risk assessments, policies and procedures and fire records. Since the last inspection an interim person in charge and a new provider nominee had been appointed. Both of whom attended the feedback meeting.

Overall findings:
Overall the inspector found that residents were well cared for in the centre and that the provider was for the most part meeting the requirements of the regulations. The actions under outcome 1, 4, 6, 13 and 18 were followed up from the last inspection. However, no other aspects of these outcomes were inspected against at this inspection. While most of the actions from the last inspection had been implemented, two were still in progress and one had not been fully implemented.

One major non-compliance was found in relation to medication practices in the centre. Two outcomes were found to be moderately non-compliant under health and safety and governance and management. Five outcomes were found to be substantially complaint with some improvements required in social care needs, healthcare needs, workforce and documentation. The remaining four outcomes were judged to be complaint. The action plan at the end of this report addresses the improvements required.

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

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

Theme:
Individualised Supports and Care

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

Findings:
The inspector found that the action from the last inspection had been implemented as respite was no longer provided in this centre.

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

Findings:
The inspector found that the actions from the last inspection had been completed in that the Admissions Policy had been reviewed and it now included a procedure on admissions to the centre.

Since the last inspection one resident had transitioned into the centre and respite was no longer provided in the centre.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The inspector found that the action from the last inspection had been implemented in that all residents had a care plan in place that contained an assessment of need for each resident.

The inspector viewed a sample of care plans and found that residents had an assessment of need in place that had been reviewed within the last year. The service had developed a new assessment of need template and the person in charge and staff were in the process of reviewing all residents care using this assessment. This work was in still in progress.

Residents had an annual review completed that included the attendance of the resident and their representatives. Goals were set for residents and the inspector saw examples of goals to improve community inclusion for residents. For example one resident who attended Mass regularly was joining a group in the church. Another resident had been involved in a local walk and talk group. Residents accessed all community facilities including hairdressers, shops and some were due to begin a Pilates class the following week.

The inspector found that some goals had been developed to improve resident's independence in areas such as personal care and communication. One resident was assisted by staff to show the inspector a new communication tool that they were developing on their computer tablet. The resident had recently been able to use an application on the tablet to order a meal in a restaurant independently. However, improvements were required to ensure that these goals were being reviewed so as to

assess their effectiveness.

Parts of residents' plans were in an accessible format and the inspector spoke to one resident who was being supported to develop their own plan in an accessible format.

All of the residents attended a day service attached to SMH.

One resident had been admitted to the centre since the last inspection. An assessment of need had been completed on their admission. There were records to show that this resident had requested the move, knew the residents in the centre before transitioning and had been supported by an independent advocate as part of their transition process. However, there were no records to confirm that residents living in the centre had been consulted about this process.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
The inspector found that all of the actions from the previous inspection had been implemented with the exception of one; however, this action was in progress.

Since the last inspection the provider had undertaken to ensure that one piece of equipment was maintained and in good working order, that a shower was available upstairs in one of the bathrooms and that a deep clean of the premises was completed. All of these actions had been completed.

However, one action had not been fully implemented. This related to a bathroom downstairs that was dark and not appropriately decorated. The inspector found that while this had not been implemented to date, they were shown documents to support that this work had been assessed and was awaiting approval from the provider.

Judgment:
Substantially 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 found that the actions from the last inspection had been implemented and that there were systems in place to protect residents, staff and visitors in the centre. However, improvements were required in relation to fire safety in the centre.

Since the last inspection the provider had undertaken to ensure that the fire equipment including; emergency lighting and the fire alarm, was appropriately maintained. The inspector found that all fire equipment had been serviced in the centre and the records of this were available in the centre. However, there were no fire doors in the centre so as to ensure fire containment, specifically at the kitchen/dining area in the centre.

Fire drills were occurring in the centre and there was evidence that learning was implemented to improve these. For example the person in charge had concerns around the time frames that it took to evacuate all residents from the centre when only one staff was available at night. In response they had consulted with the fire officer in the organisation who had identified actions to be taken. On the day of the inspection the fire officer attended a staff meeting being held in the centre to review the actions and discuss fire drills with staff. The person in charge informed the inspector that the fire officer had advised to consult other allied health professional on the matter to assess whether other aids may assist with the evacuation of one resident and the inspector was informed that this was arranged for the following week.

However, the inspector was not assured that residents who remained alone in the centre for short periods would respond appropriately to a fire in the absence of staff in the centre as no fire drills had been completed to assess this.

Residents had personal egress evacuation procedures were in place that detailed the support they required. These were to be reviewed if necessary, once the fire officer had completed their review of fire drills.

The inspector found that the person in charge had responded appropriately to two incidents that had occurred in the centre. A detailed risk assessment had been completed to guide practice and reduce the likelihood of a further reoccurrence.

There was a risk management policy in place along with a health and safety statement for the centre. The person in charge had completed risk assessments specific to the centre and from the sample viewed they were detailed to include adequate control measures to reduce risks in the centre.

Residents had individual risk assessments contained in their personal plans and they were reviewed appropriately.

There was no transport available in the centre. Some staff used their own cars to transport residents and the person in charge had an up to date insurance policy for these and was awaiting one document in relation to the road worthiness of one car used.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
The inspector found that the actions from the last inspection had been completed and that there were systems in place to protect residents from suffering harm in the centre.

Since the last inspection the provider had undertaken to ensure that a review would be completed on one restrictive practice in the centre so as to ensure that alternatives had been considered so that the least restrictive practice was being implemented. The inspector viewed records from allied health professionals who had completed a review of bedrails for one resident and found that an alternative least restrictive practice would not meet the residents' needs.

In addition the inspector viewed records where referrals had been made to the service approval committee on the use of restrictive practices in the centre. The restrictive practices referred included, bedrails and lap straps. This was in line with the service policy. Risk assessments had also been completed in relation these. The inspector was satisfied that the restrictive practices were required to support residents needs in the

centre.

The inspector was informed that there were no other restrictive practices in the centre however, the person in charge did discuss one piece of equipment being used in the centre that may be considered restrictive and intended to refer this to the service approvals committee for advice.

There was a policy in place on safeguarding vulnerable adults and all staff had signed this as read. All staff were trained in safeguarding vulnerable adults, however this refresher training had not been provided to include the HSE guidelines. The inspector was informed by the person in charge and the provider at the feedback meeting, that the service was currently addressing this and that refresher training would be rolled out for all staff later in the year.

Staff spoken to were clear about what to do in the event of an allegation of abuse. One resident said that they would speak to staff if they felt unsafe in the centre.

There was a policy in place on behaviour support. Residents behaviour support plans had been recently updated and from the sample viewed were detailed in order to guide practice. There was access to psychology in the centre and one resident spoke to the inspector about the supports they had in place to assist them with anxieties they had. This included training they had received on mindfulness.

Staff were observed to treat residents with dignity and respect. There were intimate care plans that detailed supports to be given around intimate care. The inspector also found that residents were being supported to promote independence in this area. For example a piece of equipment had been purchased for one resident that allowed them to carry out one area of personal care independently.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
The inspector found that residents were supported to achieve best possible health. However, improvements were required so as to ensure that health action plans were in place for all health care needs.

Samples of residents' personal plans were viewed and an assessment of need was in place outlining residents healthcare needs. The assessments were currently being updated with the implementation of a new assessment of need for all residents. The inspector did see some new health action plans that had been developed to support residents and they were detailed to include all supports being provided.

In addition the interventions outlined in the support plans were being implemented and staff were clear about these interventions. However, while some health care needs had no support plans in place to guide practice, the records from allied health professional showed that residents' healthcare needs were being met.

Meal times were not observed by the inspector. However, one resident spoken with told the inspector that meals were chosen at weekly residents meetings and that residents were supported to prepare meals if they wished. The resident also stated that alternatives were available if they did not want meals prepared on the day. Residents were also involved in buying their weekly groceries online.

Personal plans contained information on the advice of dieticians in accordance with the residents needs.

Judgment:
Substantially Compliant

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 the actions from the last inspection had been implemented. However, significant improvements were required in a number of areas so as to ensure that each resident is protected by the policies and procedures of the organisation.

Since the last inspection the provider had undertaken to ensure that all creams/liquids had the opening date recorded, that medications for disposal were stored separately and that medications were stored in an appropriate area in the centre. The inspector found that all of the actions had been addressed.

There was a policy in place for medication practices in the centre; however, it did not include a procedure on the disposal of medication. The person in charge stated that the

policy was currently being reviewed to include this and the provider had a copy of the approved policy at the feedback meeting.

All staff had completed training in the safe administration of medication and one staff was due to complete a refresher course this month. However, there were no records to indicate that training had been provided to staff for the method of administration of two prescribed medications in the centre.

The inspector viewed a sample of prescription sheets and medication administration sheets and found a number of areas that required improvement. These included:
- There were no clear indications for the use of three as required (PRN) medications prescribed for one resident and the PRN protocol in place to guide practice did not include all of the prescribed medications.
- The medication on the prescription sheet did not match the label on the blister pack. For example the generic name was written on the prescription sheet and the trade name of the medication was on the blister pack supplied.
- Short term medication prescribed that had been due for discontinuation after one week had been signed as given after the date of discontinuation.

A number of medication errors had occurred in the centre. The person in charge had a tracker system in place on medication errors in the centre, however there was no review process in place to identify trends so as to improve and guide practice for staff.

For example from a sample viewed, two medication omissions had occurred for one resident that related to medication that had been prescribed by a doctor out of hours. This medication had not been administered by staff as the medications were not charted on the prescription sheet. This had resulted in poor medication practices in that staff had written the medication on the prescription sheet themselves. On review of the policy the inspector found that there was no policy in place around the practice staff should follow for of out of hour's prescriptions.

The inspector was informed that there were no controlled drugs prescribed in the centre.

There were no residents self medicating in the centre, although one resident told the inspector that they had the opportunity to do this for a short time but preferred for staff to manage this support for them.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The inspector found that a copy of the statement of purpose was available in the centre that contained all of the requirements as set out in Schedule 1 of the regulations. The person in charge was also in the process of developing this into a user friendly format for residents.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall the inspector found that there were effective governance and management structures in place so as to ensure the oversight of the quality and care of residents in the centre. However, some improvements were required. In addition the inspector found that the actions from the last inspection had been completed in that the documents outstanding in relation to fire and planning compliance had been submitted to HIQA.

Since the last inspection an interim person in charge had been employed in the absence of the person in charge. This had been notified to HIQA at the time. The interim person in charge had been in place since May 2016 and was present over the course of the inspection. They were interviewed at the inspection and were found to be suitably qualified, very knowledgeable of the regulations and had set clear objectives to improve the quality of care for residents in the centre. For example they informed the inspector that one objective was to promote community inclusion for residents and there were records confirming this.

There were clearly defined management structures in place. The person in charge reported to a service manager and the service manager reported to the provider nominee. Since the last inspection a new provider nominee had been appointed. They were interviewed at an earlier date by the inspector and were found to be suitably qualified and knowledgeable of their responsibilities under the regulations. They attended the feedback meeting and both staff and residents confirmed that the provider had visited the centre since they had taken up the position in July of this year.

Monthly staff meetings were held in the centre and one was scheduled on the day of the inspection. The person in charge met with the service manager every six weeks and stated that the service manager was available for advice and support anytime.

An annual review had not been completed for the centre. The last unannounced visit to the centre had occurred Sep 2015. However the inspector was informed that the service manager had scheduled one for July of this year and this had to be postponed as there were no staff in the centre on the nominated day due to a resident requiring medical attention.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
The inspector found that the staff skill mix was appropriate to meet the residents needs; however, improvements were required to ensure that adequate staffing was available some evenings so as to ensure that the assessed needs of residents were met in the centre.

The person in charge had recently reviewed rosters in the centre and had changed shift patterns in order to meet residents' needs. In addition they were currently reviewing the number of part time staff employed in the centre so as to promote and ensure consistency of care for residents.

However, the person in charge had also raised concerns with the service manager around adequate staffing levels in the evening times in order to meet residents' needs. For example one resident required two staff to assist them with personal care in the evening time. This meant that other residents could not be supported to attend community activities some evenings. The inspector acknowledges that the service manager had agreed to review this with the person in charge at their next meeting.

Nursing support was available to the centre both during the day as required and on an on-call basis for out of hours support and advice.

All staff had completed mandatory training. Staff spoken to felt supported in their role and supervision had started for all staff with the person in charge and the records were maintained by the person in charge. The inspector viewed a sample of these meetings and found that they were very detailed so as to ensure that staff could exercise their personal and professional responsibilities on the quality and safety of care in the centre. Some staff had raised concerns around the ability to complete necessary documentation in the centre and the person in charge showed the inspector steps they were taking to address this.

There was a planned and actual rota in the centre. Some agency/ relief staff were employed in the centre but this was not on a consistent basis as part time staff employed in the centre covered staff sick leave and annual leave in the centre.

There were no volunteers employed in the centre. Staff personnel files were not reviewed as part of this inspection.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
The inspector found that two of the actions from the last inspection had been fully implemented and that one still required improvement.

Since the last inspection the provider had undertaken to ensure that all of the policies as set out in Schedule 5 of the regulations were in place in the centre. One of these policies was still outstanding and this related to the provision of information for residents. The actions also included that the admission policy would be reviewed and maintenance records for emergency lighting in the centre would be in place. Both of these actions had been completed.

Judgment:
Substantially Compliant

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:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A Bettystown Ave
Centre ID:	OSV-0002365
Date of Inspection:	15 September 2016
Date of response:	03 October 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 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' goals were being not being reviewed so as to assess their effectiveness.

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

1. 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:
The daily reports used in the centre have been amended to include goal tracker records for each resident's goals. Included in the tracker is an evaluation box, where staff can track the effectiveness of each goal.

Proposed Timescale: 20/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no records available to support that residents had been consulted about the admission of one resident to the centre.

2. Action Required:
Under Regulation 25 (4) (d) you are required to: Ensure the discharge of residents from the designated centre is discussed, planned for and agreed with residents and, where appropriate, with residents' representatives.

Please state the actions you have taken or are planning to take:
Currently there are no vacancies in the centre. Procedures are now in place to ensure that consultations with residents in relation to new admissions are documented.

Proposed Timescale: 20/09/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A bathroom downstairs still required redecoration.

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

Please state the actions you have taken or are planning to take:
Funding of the refurbishment of the bathroom was sanctioned and will take approximately 6 weeks to complete. This includes the replacement of tiles and the

application of a water resistant sheath around the showering area. The piping from an old bath will be removed and new flooring to be fitted.

Proposed Timescale: 14/11/2016

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:
There were no fire doors in the centre.

4. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
The PIC has confirmed with St. Michael's House Technical Services that all doors in the centre are modified half hour fire doors. It is planned to upgrade these doors to achieve an FD30S standard.

Proposed Timescale: 30/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no fire drills carried out so to ensure that some residents would respond to a fire alarm when they remained in the house without staff support.

5. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
An unannounced fire drill was carried out on the 29/09/16 while two residents were alone in the centre. The alarm was raised by using a panel located in the adjoining centre. There were no issues identified during the drill. It is planned to carry out similar drills every six months.

Proposed Timescale: 30/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no health action plans contained in some residents' plans that outlined the supports required to meet those needs.

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

Please state the actions you have taken or are planning to take:
The PIC together with individual keyworkers will review each resident's assessment of need to identify any required health support plans.

Proposed Timescale: 31/10/2016

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:
There were no clear indications for the use for three as required (PRN) medications prescribed for one resident and the PRN protocol in place to guide practice did not include all of the prescribed medications.

The medication on the prescription sheet did not match the label on the blister pack. For example the generic name was written on the prescription sheet and the trade name of the medication was on the blister pack supplied.

Short term medication prescribed that had been due for discontinuation after one week had been signed as given after the date of discontinuation.

The policy did not give any guidance for procedures to be followed with out of hour prescriptions in the centre.

There were no records to indicate that staff had been trained in the administration of two prescribed medications.

There was no effective review of medication errors in the centre in order to identify trends and inform practice.

7. 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:
1) There were no clear indications for the use for three as required (PRN) medications prescribed for one resident and the PRN protocol in place to guide practice did not include all of the prescribed medications:

The PRN medications identified have been reviewed by St. Michael's House doctor and guidelines are now in place. Completed

2) The medication on the prescription sheet did not match the label on the blister pack. For example the generic name was written on the prescription sheet and the trade name of the medication was on the blister pack supplied:

To ensure that the auditing system requirements are fully complete - each blister pack and Patient Information Chart used during auditing process will in future specify and identify the molecule/generic name; as well as the proprietary brand names; as reflected on the prescription sheet. This will provide a comprehensive trail for the safe recognition and auditing of medication. 30/10/2016

3) Short term medication prescribed that had been due for discontinuation after one week had been signed as given after the date of discontinuation:

This error was identified at the time and a drug error form was completed.

4) There was no effective review of medication errors in the centre in order to identify trends and inform practice:

The St. Michael's House drug error questionnaire and medication management audit tool are now in place in the centre. Combined, they provide staff with a tool to evaluate and learn from all drug errors. Drug errors are a standing agenda item on the monthly staff meeting. Completed

5) The policy did not give any guidance for procedures to be followed with out of hour prescriptions in the centre:

Guidance for staff in relation to out of hour's prescriptions is provided in St. Michael's House safe administration of medication manual. This document is now in the centre and it is planned that staff will receive training on 25/10/16 in relation to this.

6) There were no records to indicate that staff had been trained in the administration of two prescribed medications:

Training is scheduled for the administration of the identified medication on 25/10/16 with the St. Michael's House Health and Medical trainer.

Proposed Timescale: 30/10/2016

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:** An annual review for the centre had not been completed. **8. 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:** It is planned to complete the 2016 Annual review for the house in January 2017.
Proposed Timescale: 27/02/2017
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** An unannounced quality and safety review of the centre had not been completed since September 2015. **9. Action Required:** Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. **Please state the actions you have taken or are planning to take:** An unannounced six monthly quality and safety review was completed on 22/09/16.
Proposed Timescale: 30/09/2016

Outcome 17: Workforce
Theme: Responsive Workforce **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There was inadequate numbers of staff available in the centre some evenings to ensure that all residents' needs could be met.

10. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The PIC and Service manager will review the level of staffing in the evenings against residents aims and goals and will endeavour to meet all needs.

Proposed Timescale: 30/10/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no policy on the provision of information to residents in the centre.

11. 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:
St. Michael's House is developing a policy on the provision of information for residents.

Proposed Timescale: 01/02/2017