

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002376
Centre county:	Dublin 9
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	John Birthistle
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:	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 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: 26 April 2016 10:00 To: 26 April 2016 20:00

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the third inspection of this designated centre. The purpose of this inspection was to follow up on actions from the last inspection carried out in the centre in November 2014 and to monitor on-going compliance with the regulations. However over the course of the inspection other outcomes were reviewed as a result of issues identified.

Description of the service

This centre is operated by St Michael's House services and is situated in North Dublin. It comprises of a large detached two storey house in the community. It currently accommodates six residents and provides care to both male and female residents with varying and complex support requirements.

How we gathered evidence

Over the course of this inspection the inspector spent time with one resident and spoke with another resident about their hobbies. Some residents were unable to tell the inspector about their views of the quality of the service but the inspector observed interactions with staff and residents. A number of staff were met and documents reviewed included: personal plans, accident logs, restrictive practices and

fire evacuation procedures in the centre.

Overall judgment of our findings

Overall, the inspector found the provider had not taken adequate steps to address the social care needs of all residents in the centre. This had been an action from the previous inspection. The inspector found that some residents had limited opportunities to participate in activities of interest to them or to engage with their local community. In addition the inspector was not satisfied that appropriate arrangements were in place to ensure a safe evacuation of the centre at night time. This was addressed with a senior manager on the day of the inspection and steps were taken to address this issue. The inspector also found major non-compliances under social care needs, health and safety, safeguarding, and governance and management in the centre. Moderate non-compliances were found in safe and suitable premises, notifications, healthcare needs, medication management and workforce. The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end of the report.

After the inspection the senior manager was asked to submit documents to HIQA. However not all of the documents requested had been submitted at the time of this report. For example maintenance records for specific equipment used in the centre.

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 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:

Overall the inspector found that the actions from the last inspection had not been completed and significant improvements were required in order to meet residents' assessed social care needs in the centre.

The two actions from the previous inspection had not been implemented in that plans in place were not sufficiently specific to appropriately manage residents' needs, risk assessments and health care plans were not always linked and a plan for each identified need was not in place for all residents.

The inspector found that each resident had an assessment of need contained in their personal plans, however some information had not been updated in the assessment of need to reflect residents' changing needs and some parts of the support plans had not been updated since 2013. In addition, there was insufficient documentary evidence to support how some residents social care needs were being met. For example the inspector saw reports from an allied health professional completed in 2015 and 2016 stating that a resident required more activities, however there was no records to support how this had been fulfilled.

The inspector found that the lack of activity for some residents had been highlighted by a senior manager in January of this year and that while systems had been implemented to address this, the inspector found that this had not been fully implemented to date. For example activity timetables had been set up for residents who did not avail of external day services. When the inspector reviewed these they found that incomplete

records were maintained and therefore the inspector could not review how often these activities had taken place. In addition on the day of the inspection, the inspector observed that some residents were not activated for much of the day.

The inspector did see evidence in some plans where residents partook in activities. For example doing the mini marathon, art class and going out for lunch. In addition the inspector spoke with one resident who showed the inspector pieces of artwork they had completed.

Judgment:

Non Compliant - Major

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:

Overall the inspector found that the design and layout of the centre were for the most part suited for the stated needs of the residents. However improvements were required to ensure all residents had access to the communal spaces in the centre.

Not all aspects of this outcome were inspected. The inspector found that the centre was clean and well maintained. Some modernisation was required in the kitchen area, however the inspector was informed that this was being addressed.

Residents had their own bedrooms that were tastefully decorated and personalised. There were adequate toilet/ showering facilities There was a large kitchen/dining area/seating area. In addition to this there was a smaller communal room. However not all residents could access this due to mobility aids. In addition this room had a dual purpose, in that it was also used to store administration work. This had been highlighted at the last inspection of the centre but had not been addressed. The inspector was informed however that the provider had plans in place to address this issue.

Maintenance records were not inspected as part of this inspection. However the day after the inspection the service manager was asked to submit maintenance records for one specific piece of equipment. These had not been submitted at the time of this report.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there were policies and procedures in place for risk management and emergency planning in the centre, however significant improvements were required in fire safety in the centre and improvements were required in risk management practices in the centre.

All staff had completed fire training in the centre and residents had personal emergency evacuation plans (PEEP's), contained in their personal plans. However the information contained in these was inconsistently recorded and therefore would not guide practice. Fire drills had been completed in the centre however, issues identified at these had not been followed up on. The inspector spoke to staff and found that they were not fully aware of the procedures to follow at night time for a fire evacuation when staffing levels were reduced.

In addition the inspector found that the fire evacuation procedures did not fully detail the supports in place to safely evacuate some residents from the centre. The inspector was therefore not assured that residents could be evacuated in a timely manner from the centre. In response to these findings the inspector met with the service manager to outline concerns. The service manager agreed to carry out a supervised evacuation of the building and to submit the findings to HIQA the following day. The report submitted to the inspector found that additional control measures were required in order to mitigate all risks and the service manager planned to discuss the findings with the fire officer in the service.

There was a risk management policy in place and the centre had completed environmental risk assessments in the centre. However some of the risks in the centre had not been identified. For example under the risk assessment for manual handling, the use of hoists had not been recorded and the control measures in place to mitigate risks on their use.

Residents had individual risk assessments in place however, there was inconsistent information recorded in them that did not link with residents' assessed needs. For example risks had been identified at a recent staff meeting for one resident. When the inspector spoke to staff, they informed the inspector that the issue had been referred to

an allied health professional for advice. However staff were unclear what interim control measures were in place to mitigate the risks to this resident. In addition support levels outlined in resident's assessment of need did not reflect the supervision levels required in the residents individual risk assessment.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there were measures in place to protect residents being harmed or suffering abuse, however improvements were required in the use of restrictive practices in the centre and intimate care plans.

There was a policy in place for the prevention, detection and response to abuse. Staff spoken to were aware of what to do in the event of an allegation of abuse.

There was a policy in place for the provision of behaviour support. Two staff had not received any training in this area. In addition behaviour support plans were not in place as required or were not updated in line with changing needs of residents. Some support plans had not been reviewed since 2014.

There were a number of restrictive practices used in the centre. However the inspector saw records of an audit that had been completed in the centre where part of the action plan had been to refer some restrictive practices been used in the centre to the service committee for approval. There were no records to support that all of these had been completed. In addition some restrictive practices used in the centre were not notified to HIQA.

The inspector also found that restrictive practices were not been effectively reviewed in the centre and there was no evidence that other less restrictive alternatives had been tried. For example some of the bedroom doors had bolt locks placed at the top of the doors. Some of the residents who were wheelchair users could not access this without

staff support. The option to provide more suitable alternatives had not been considered. In addition it was not clear to the inspector why one restriction that was impacting on other residents in the centre was in place during the day, as the risks associated with this restrictive practice were still present at night when the restrictive practice was not in use. This was discussed at the feedback meeting.

Residents had intimate care plans in place however they were not detailed enough to guide practice. For example all supports required for residents were not included in the plan.

Judgment:
Non Compliant - Major

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:
Overall the inspector found that a record of all incidents were maintained in the centre, however, some notifications had not been submitted to HIQA since the last inspection.

The inspector found that some incidents of restrictive practices had not been notified. For example a gate was in place in the kitchen that was locked. In addition no quarterly notification had been submitted for the centre in Dec 2015.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

Findings:

Overall the inspector found that there were significant deficiencies in documentation that meant not all residents identified needs were being addressed.

The inspector found inconsistencies contained in residents plans and therefore could not assess whether all healthcare needs were met. For example not all residents identified needs were included in their assessment. Some needs identified in the assessments had no support plans in place to guide practice. On speaking to staff, some were unclear of one residents' healthcare needs.

An annual review had not taken place for all residents in order to review the effectiveness of personal plans since the last inspection in 2014. In addition the minutes from one annual review that had taken place for a resident was viewed by the inspector and it was found that some needs had not been updated in their personal plans.

Residents were observed at some mealtimes, however the inspector observed that meal times were not a very social experience for some residents. For example one resident was observed having their meal alone while a number of staff were present in the kitchen. On another occasion the same resident was having their evening meal and a staff member who was also having their meal with the resident, was interacting with other staff members and not the resident.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there were policies and procedures in place for medication management in the centre, however improvements were required in a number of areas.

The inspector reviewed a number of residents' prescription sheets and medication administration sheets (MAS) and found a number of discrepancies:

- There were no photographs of residents on either the prescription sheet or the MAS
- One prescribed medication and one prescribed ointment had not been signed by staff on the MAS.
- As required medications (PRN) had not been reviewed.

- It was not clear on one resident's prescription sheet why a PRN medication was being administered. This medication was prescribed the night before a specific intervention was to take place.

The inspector reviewed medication errors over the last four months and found that one error had not been notified to the senior manager in line with the service policy. In addition one medication error had no follow up and the form was not completed in full.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that the governance and management systems in place were not effective, so as to ensure the quality of care of the residents was monitored and developed on an on-going basis.

The inspector found that since the last inspection no annual review for the centre had taken place. In addition only one unannounced quality review had taken place in the centre last year. The inspector reviewed this and found that the recommendations from this had not been implemented.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that for the most part there were appropriate staff numbers and skills mix to meet the assessed needs of the residents, however improvements were required in a number of areas.

The inspector found that some staff had not been provided with the necessary training in order to meet the assessed needs of residents. For example staff had not received training in percutaneous endoscopic gastrostomy (PEG) feeds. In addition two staff had not completed training in management of behaviours that challenge and some had no training in first aid contrary to the stated mandatory training as outlined in the statement of purpose for the centre.

Staff spoken to stated that they felt supported in their role and informed the inspector that monthly staff meetings were held. On reviewing the minutes of the meetings the inspector found that they were not occurring monthly. Staff also stated that they had supervision with the person in charge however, there were no minutes to verify this and the inspector was informed that it was usually done informally.

The inspector also found that staff spoken to had a reasonable knowledge of the residents needs. However some staff did not have sufficient knowledge around some residents needs. This was discussed at the feedback meeting.

There was a planned and actual rota in place. However at specific times of the day the assessed needs of the residents were not being met. Some residents did not attend day services and these residents had social goals and activities of preference identified within their plans. However, these goals were not being adequately met.

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:

Anna Doyle
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 report¹

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002376
Date of Inspection:	26 April 2016
Date of response:	05 July 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:

The assessment of need did not reflect the changing needs of residents

1. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

1. A full review of all seven assessments of needs has commenced, carried out by the individual residents key worker and being reviewed by the PIC and Service Manager. This review will ensure all assessment of needs documentation contains all residents identified needs in accordance with the above requirement. 30/7/2016
2. Assessments and resulting Support Plans have commenced for every identified area of need in each residents file, and will be checked on a quarterly basis by the PIC to ensure accurate and current plans are in place. 30/9/2016
3. All residents have been assessed and where a Positive Support Plan is required, referrals have been made to the psychologist. 30/7/2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

There was insufficient evidence to support how residents social care needs were being met.

2. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

1. A complete Social Care assessments have commenced for all residents. 30/7/2016
2. All staff have been re-inducted into the correct use of the locations Activity Planner. 30/6/2016
3. A comprehensive Meaningful Day recording system will be implemented which will record all residents social activities and their lived experience of the activities. 30/7/2016

Proposed Timescale: 30/07/2016

Theme: Effective Services

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

Recommendations from an allied health professional had not been implemented.

3. 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:

1. The PIC will support all staff to review all recommendations in resident's assessments of need and implement same. 30/9/2016
2. There will be a set agenda item on monthly staff meetings to discuss all recent recommendations from allied health professionals, ensuring all staff are aware of the changing support needs of all residents on a continuous basis. 30/6/2016
3. Handover from shift to shift with documentation to ensure follow through in respect of recommendations on a daily basis. 30/6/2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Some interventions contained in personal plans had not been reviewed annually.

4. Action Required:

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

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

1. Assessments and resulting Support Plans will be checked on a quarterly basis by the PIC to ensure accurate and current plans are in place. 30/9/2016
2. All Behaviour Support Plans are being reviewed and all prescribed interventions are being implemented with a record of same in place. The PIC will oversee the review of the residents assessments of needs and all required changes which are scheduled to occur every quarter. 30/9/2016
3. A full review of residents Personal Plans will take place on an annual basis, with the PIC reporting back to the Service Manager on the review process and findings. 30/9/2016

Proposed Timescale: 30/09/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

One communal room was not accessible to some residents in the centre and the communal room was being used to store administration equipment.

5. Action Required:

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

1. This room has now been cleared of administrative items and is in use by residents who wish to use this area as a communal living space.

Proposed Timescale: 30/05/2016

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:

Some environmental risks had not been identified in the centre.

Individual risk management plans for residents had inconsistent information listed in them

There were no control measures in place for an identified risk for one resident

6. 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:

1. The use of hoists has now been included in the DC's Risk management documentation, including control factors to mitigate risks involved in the use of same.
2. All Risk management plans are being reviewed through the assessment of needs. On completion the risk areas will become evident and assessments drawn up, from this information the support plans will be informed.

Proposed Timescale: 30/07/2016

Theme: Effective Services

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

Issues identified at fire drills had not been addressed.

7. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

1. The PIC has reviewed all Fire Evacuation Drill records for the past twelve months and has identified all issues arising. These have been brought to the attentions of all staff. 30/6/2016
2. A Subsequent fire evacuation refresher has been carried out by St Michaels house fire officer. 12/5/2016
3. Concise evacuation plans for all the residents, issues addressed and reflected in residents respective Personal Emergency Evacuation Plans. 30/6/2016

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

Staff were not fully aware of the fire evacuation procedures for residents at night.

8. 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:

1. A complete descriptive night time fire evacuation drill procedure is in place in this DC and all staff have been re-inducted into this procedure. 30/4/2016
2. A walk through of this night time drill has taken place at a staff meeting to ensure staff are aware of the requirements of this procedure. 12/5/2016
3. Evacuation refresher was carried out by St Michaels house fire officer. 12/5/2016

Proposed Timescale: 12/05/2016

Theme: Effective Services

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

Residents' PEEP's had inconsistent information recorded in them.

Fire evacuation procedures did not fully detail the supports residents required in an evacuation of the centre.

9. 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:

1. The six residents PEEPs have been reviewed to accurately reflect support needs and also included any issues arising at the last two evacuation drills.

Proposed Timescale: 30/05/2016

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:

Two staff had no training in the management of behaviours that challenge.

10. 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:

1. The two staff members are scheduled to attend this training. 30/11/2016
2. Behavioural management briefing for all staff has been arranged in the designated Centre by Psychologist on 19th July. 19/7/2016

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

There was no effective review process in place for restrictive practices used in the centre.

11. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

1. A full audit of all restrictive practices has taken place in this DC, and all identified restrictions have now been referred to the organisations restrictions review committee. This committee reviews all restrictions in place on an ongoing basis.
2. Ongoing review of restrictive practices by the PIC, recording the use of same and documentation to support the withdrawal of restrictions where appropriate.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

Restrictive practices were not referred to the service committee for approval.

12. 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:

1. A full audit of all restrictive practices has taken place in this DC, and all identified restrictions have now been referred to the organisations restrictions review committee

Proposed Timescale: 30/07/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

A quarterly notification had not been submitted to the Authority for Dec 2015.

Some incidents of restrictive practices used in the centre had not been notified to the Authority.

13. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

1. All restrictive practices in place in this DC have now been notified to the authority.

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:

Some residents had no annual review completed since the last inspection.

Staff were not clear around the assessed needs of one resident.

Not all identified healthcare needs were included in the assessment of need.

Some identified health care needs had no support plans in place to guide practice.

14. 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:

1. Annual reviews are being completed for all seven residents. 30/7/2016
2. There is now a system in place whereby changing support needs of all residents are discussed at monthly staff meetings ensuring all staff are aware of each residents changing needs. These meetings are recorded. 30/6/2016
3. A full review of all seven assessments of needs has commenced, carried out by the individual residents key worker and reviewed by the PIC and Service Manager. This review will ensure all assessment of needs documentation will contain all residents identified health care needs in accordance with the above requirement. 30/7/2016
4. Assessments of all health care needs and resulting Support Plans have commenced for every identified area of need in each residents file, and will be checked on a quarterly basis by the PIC to ensure accurate and current plans are in place. 30/9/2016

Proposed Timescale: 30/09/2016

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 photographs of residents on either the prescription sheet or the MAS

One prescribed medication and one prescribed ointment had not been signed on the MAS.

As required medications (PRN) had not been reviewed.

It was not clear on one resident's prescription sheet why a PRN medication was being administered.

One medication error record had not been completed in full and there were no records to show that this medication error had been followed up on.

One medication error had not been reported to a senior member of staff.

15. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered

as prescribed to the resident for whom it is prescribed and to no other resident.

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

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

1. Photographs of residents are now attached to their respective medication administration sheets. 30/5/2016
2. All prescribed treatments have been signed off and this will be checked on a daily basis by the shift supervisor, all discrepancies will be addressed with the individual staff. 30/5/2016
3. All PRN medication is under review and all PRN medication shall have a written protocol in place, outlining, among other things, what the PRN has been prescribed for. 30/5/2016
4. Staff have been re-inducted into the medication management policy including the steps to follow in the event of a medication error. 12/5/2016
5. All medication errors shall be discussed at staff meetings and reviewed in order to provide learning in consistent safe administration of medication, minutes of which shall be provided to the service manager for review. 30/5/2016

Proposed Timescale: 30/05/2016

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:

Only one unannounced quality review of the centre had taken place since the last inspection.

The actions identified at the unannounced quality review of the centre had not been implemented.

16. 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:

1. An unannounced Quality Review has occurred on the 18/4/2016 and the second is scheduled for the last quarter of this year. 30/10/2016
2. An annual review has taken place and is available for inspection. 30/6/2016
3. Quality improvement plan has been developed and actions being addressed. 30/10/2016

Proposed Timescale: 30/10/2016

Theme: Leadership, Governance and Management

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

There was no annual review completed in the centre.

17. Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

1. An Annual Review has been completed.

Proposed Timescale: 30/06/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The assessed social care needs of resident were not being met.

18. 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:

1. The roster of this location is under review to ensure all residents needs are meet by ensuring staff are rostered at the times residents require supports. 30/5/2016
2. Meaningful day programme in place which addresses the social activities for each resident. 30/6/2016
3. Daily handover from shift to shift with documentation to address specific needs for each resident. 30/6/2016
4. Records of day service activities are maintained in the residents green files for review. 30/6/2016

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Some staff did not have training on the use of PEG feeds in the centre.

Two staff had no training in behaviours that challenge.

Not all staff were trained in First Aid.

19. 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:

1. St Michaels are sourcing trainers in Enteral feeding. Staff have been prioritised for this training when it is available. Staff information sharing organised for the 28th July re; care of the resident with Enteral feeding requirements. On Site briefing by external nutrition company representative on maintenance of the pumps on the 28th July. 28/7/2016 {Briefing} and Trained in Enteral feeding by the 30/12/2016
2. The two outstanding staff who required training in the management of behaviours that challenge are scheduled to attend same end of year. Behavioural management briefing for all staff on unit 19th July. 19/07/2016 {Briefing} and 30/11/2016 PBSP training
3. Five staff are booked for refresher training in first aid. 30/8/2016

Proposed Timescale: 30/12/2016

Theme: Responsive Workforce

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

There were no records available to ensure that staff were appropriately supervised in the centre.

Some staff did not have sufficient knowledge around some residents healthcare needs.

20. 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:

1. Staff meetings are now recorded, The PIC is implementing a staff supervision system whereby each staff member will meet the PIC on a tri monthly basis to consider supervision needs and discuss any issues arising, these meetings shall be recorded and retained for review when required. 10/09/2016
2. There is now a system in place whereby changing support needs of all residents are discussed at staff meetings ensuring all staff are aware of each residents changing needs. These meetings are recorded. Daily handover of information from shift to shift in a written format Highlighting for staff specifics pertaining to the resident for that day. 30/6/2016

Proposed Timescale: 10/09/2016