

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A Canices Road
Centre ID:	OSV-0002332
Centre county:	Dublin 11
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
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 inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 March 2017 09:30 To: 06 March 2017 19:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
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 unannounced inspection carried out in the centre in September 2016, to monitor on-going compliance with the regulations and to inform a registration decision.

Description of the Service:

The centre is operated by St. Michaels House (SMH) and is situated in North Dublin. It comprises of a six bedroom two storey house located, close to local shops and transport links. The centre provides care to seven female residents who have varied support requirements. Two of the residents access services on a time share basis. Care is provided using the social care model of support. There is access to nursing support through a 24 hour on call service provided by SMH.

How we gathered evidence:

Over the course of this inspection the inspector met six of the residents. The inspector spoke to four residents. One resident showed the inspector their room; another resident went through their goals for the year with the inspector. They said they were happy living in the centre and liked the staff there.

The inspector observed practices, met with staff, reviewed records such as: care plans, risk assessments, policies and procedures and fire records. The person in charge was present for most of the inspection. The provider, service manager and the person in charge attended the feedback meeting. Some additional information was requested at this from the provider and the person in charge the day after the inspection and this was submitted.

Overall findings:

Overall the inspector found that residents appeared well cared for in the centre and staff were observed to treat residents with respect. The inspector found that the needs and wishes of residents were being respected by staff and additional staffing was employed at short notice in response to an individual need on the day of the inspection. The centre was clean and maintained to a good standard.

Residents said that they were happy living in the centre and the provider had taken a number of steps to address the safeguarding concerns noted at the last inspection. One resident's needs could not be fully met in the centre and the provider was endeavouring to find a more suitable living arrangement for this resident.

On this inspection, the inspector found that some of the actions from the last inspection had not been fully implemented. One of the actions related to a review of staffing levels in the centre. The inspector found that staffing levels in the centre were not appropriate to meet the assessed needs of residents for some parts of the days.

In addition, the inspector found that significant improvements were required in fire safety management. In response to this, and the staffing levels in the centre, the inspector contacted the provider at the inspection to discuss these concerns.

Two outcomes were found to be in major non compliance with the regulations under health and safety and workforce. Two outcomes under safeguarding and social care were found to be moderately compliant. All of the other outcomes inspected were found to be compliant. The action plan at the end of this report outlines 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 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

The inspector found that residents had opportunities to engage in meaningful activities appropriate to their needs and preferences. However, improvements were still required so as to ensure that some residents' personal plans outlined the supports required in order to meet residents' needs and that continued improvements were made to ensure that one residents needs were met.

From a sample of personal plans viewed the inspector found that significant improvements had been made in this area since the last inspection. However, one assessment of need required improvements to reflect the assessed needs of the resident.

For example, one resident who went through their personal plan with the inspector had it recorded in their assessment that one area of need was not relevant for this resident. However, the resident spoke to the inspector about this area of need and talked about a number of supports in place to meet those needs. This was not recorded on their personal plan either.

Residents had an annual review completed and goals were set for the year. One resident spoke to the inspector about one goal that was progressing for them. Staff were also very familiar with this goal and records contained in the plan verified this.

However, this was not evident in some residents' plans. For example, the inspector asked to see the records of an annual review for one resident which was to include their

goals for the year and this was not available when requested.

There were support plans in place around residents' needs and staff spoken with were familiar with the needs of residents and the supports in place to meet those needs. However, one resident did not have any support plans included on their personal plan in order to guide practice.

Plans were reviewed regularly and a system had recently been introduced by the person in charge so as that all key workers reviewed personal plans on a weekly basis.

All residents attended a day service within the service and one resident was in open employment one day a week. At the last inspection one resident was not attending a day service in line with their preferences. However, additional staffing was in place some evenings in order to ensure that this residents' social care needs were met. This resident was also participating in some activities during the day with the support of staff in the centre.

One resident's needs could not be fully met in the centre as their assessed needs included recommendations for a more individualised support service. However, the provider was in the process of addressing this for the resident.

Residents' plans had been developed into an accessible format for them.

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):

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

Findings:

The inspector found that there were systems in place in the centre to ensure that residents, visitors and staff were protected in the centre. However, significant improvements were required in fire safety and risk management in the centre.

There were policies and procedures in place for fire safety in the centre. A fire evacuation procedure was in place and residents had personal emergency evacuation procedures in place that outlined the supports required in the event of an evacuation of the centre.

However, staff were unable to tell the inspector about how they could safely evacuate residents from the centre when only one staff member was present. This included night time evacuations, as only one member of staff was present.

The inspector contacted the provider to highlight this concern. In response, the provider took the interim measure of deploying additional staffing to ensure two staff were available at all times until the evacuation procedure and supports required by residents was appropriately identified.

Fire safety equipment and environmental fire safety checks were being completed on a monthly basis by staff.

Intumescent fire strips and cold smoke seals were in place on all doors in the centre. The provider was taking measures as part of a service wide improvement plan to ensure that fire doors would be in place in the centre. This was still in progress.

A system had been introduced in the centre to review incidents in the centre. The minutes of these reviews were viewed by the inspector and the records demonstrated that agreed actions from the reviews were being implemented into practice.

Individual risk assessments for residents had been reviewed since the last inspection. However, there were still some identified risks in the centre that had not been appropriately assessed and reviewed so as to ensure that all potential risks were mitigated in the centre. This included one risk which may impact one resident's safety in the centre.

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):

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

Findings:

Since the last inspection the provider had implemented measures to address

safeguarding concerns found at the last inspection of the centre. Measures included additional staff were employed in the evening times. One resident was availing of respite every second weekend in another designated centre belonging to SMH. This resident was met by the inspector and they said that they were very happy with this arrangement. The provider had also submitted a proposal to the HSE in order to look at providing a more individualised type of support for one of the residents in the centre. This was still in progress.

The inspector found that while incidents were still occurring in the centre, one resident spoken with said that the frequency of events had reduced in the centre. Residents and staff had completed safe guarding training in the centre. There were measures in place for residents to raise concerns about these issues and residents were met regularly to support and discuss concerns. This was on going in the centre.

Behaviour support plans had been updated since the last inspection and staff spoken with were clear about the interventions in place to support residents. All staff had either undertaken training in behaviours that challenge or were in the process of completing it.

There were a number of restrictive practices used in the centre. However, staff were not clear about the implementation of one environmental restrictive practice that had been reviewed since the last inspection and according to the person in charge had been removed. On speaking with staff the inspector found that one staff said they still used this restrictive practice and another said they did not.

In addition, some other practices in the centre had been assessed as not being considered restrictive practices. However, the inspector found that two interventions were potentially restrictive and needed to be appropriately assessed and reviewed.

This included that use of a beam on one resident's bedroom and chemical restraint that was prescribed in response to behaviours of concern. The inspector acknowledges that the person in charge had referred one of these practices to the service restrictive practice committee who had reviewed it and not considered it to be restrictive.

In addition, the records in place to review restrictive practices in the centre did not demonstrate whether part of the review included whether the least restrictive practices were being used. This had been an action from the last inspection.

Intimate care plans had been reviewed since the last inspection and while staff were clear about the supports required for residents, not all of the details were included in the plans in order to guide practice for all staff, particularly agency of relief staff.

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):

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 a referral made for one resident to an allied health professional had been completed and followed up on. No other aspects of this outcome were inspected.

Judgment:

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:

There were procedures in place for medication management practices in the centre.

The inspector found that the actions from the last inspection had been completed and there were protocols in place for prescribed as required medications in order to guide practice. Staff had received training in the administration of two prescribed medications used in the centre.

A sample of prescription sheets and administration sheets viewed were found to contain the appropriate information. One medication required clarity around the times of administration, and the person in charge submitted information pertaining to this after the inspection confirming they had sought clarity from the prescribing doctor.

Two medication incidents had occurred in the centre since the last inspection. These had been reported to a senior nursing manager and the records demonstrated that appropriate follow up actions were taken.

Judgment:

Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There were management structures in place in the centre and staff were aware of the reporting structures in place in the centre.

The person in charge attended the centre on the day of the inspection. They were interviewed at an earlier date by HIQA and were found to be suitably qualified. Since the last inspection they had been allocated protected time of six days over a four week period on a consistent basis so as to ensure effective governance of the centre. This had been an action from the last inspection.

Supervision was due to commence for all staff. This was in place for two new employees who had started in the organisation and the person in charge intended to roll this out for all staff in the coming year. Staff spoken to felt supported in their role and regular staff meetings were being held in the centre. This had been an action from the last inspection.

An unannounced quality and safety review had been completed for the centre along with an annual review.

Judgment:
Compliant

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

Theme:

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

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

Findings:

The inspector found that there was insufficient staff available during some parts of the days in order to meet the needs of residents.

As part of the actions from the last inspection the provider had committed to completing a review of the staffing levels in the centre so as to ensure that residents assessed needs were being met. This had not been completed.

The inspector found that there were times during the day where only one staff member was present in the centre. Given that one resident's assessed needs required one to one supervision in the centre at all times, the inspector was not satisfied that the other residents' needs could be met in the centre when only one staff member was available.

The inspector spoke with two staff members and the person in charge who said that when only one staff was present in the centre that this staff was responsible for all aspects of care and service provision including medication administration, while also providing one to one supervision.

It was also observed on the morning of the inspection that while the staff member assigned to this resident maintained one to one supervision for this resident. One other resident, who remained in bed, could not be supported if they chose to get up.

The inspector contacted the provider to seek assurances from them to employ additional staffing in the centre during these times until a full staff review had been completed. The provider agreed to this.

Since the last inspection two new staff had been employed in the centre and another new staff was in the recruitment process. The use of agency had reduced in the centre and the person in charge was endeavouring to employ regular relief in the centre. All staff spoken to felt that these additions were improving the quality of care for residents.

There was a planned and actual rota in place that included the full names of staff employed in the centre. This had been an action from the last inspection.

Issues arose at the inspection regarding one external taxi company that was used in the centre on a regular a basis, regarding Garda vetting procedures. The provider submitted information to HIQA the day after the inspection confirming that Garda vetting had been completed for this person.

Personnel files were not reviewed as part of this inspection. The inspector was informed that no volunteers were employed in the centre.

Judgment:

Non Compliant - Major

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):

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

Findings:

The inspector found that the policies and procedures required under schedule 5 of the regulations were now in place in the centre. No other aspects of this outcome were inspected against.

Judgment:

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

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-0002332
Date of Inspection:	06 March 2017
Date of response:	06 April 2017

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:

Information recorded on one assessment of need was not correct and did not reflect the needs of the resident.

1. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive

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

assessment, by an appropriate health care professional, of the health, personal and 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:

The PIC will meet with all key workers and will review each assessment of need to ensure that all are current, and accurately reflect the health, personal and social care needs of each resident.

The PIC will further ensure that all associated support plans will inform and assist all staff members to comprehensively meet these needs, in line with best practice.

The PIC will introduce a bi-monthly monitoring system, whereby assessments of need and associated support plans will be reviewed with each key worker, and will be revised in line with changing need.

The relevant documentation will be available for inspection in the centre.

Proposed Timescale: 12/05/2017

Theme: Effective Services

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

One residents' needs could not be fully met in the centre.

2. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

The PIC, Service-Manager (PPIM) and supporting clinical team have met six times in the past year, to discuss the required supports for this resident. A further meeting is scheduled for 07-06-'17.

The following supports have been put in place.

A business case was submitted to the HSE On 21-12-2016 to request the necessary funding to provide an individualised service for this resident.

Commencing on 10-02-2017 the resident has been availing of lone respite care in a designated centre, with staff support for two weekends per month (six nights).

On alternate weekends, the resident is assigned additional staff on a 1-1 basis for five hours each day (Saturday and Sunday)

Additionally, the resident is assigned four hours per evening, on two evenings per week, to further support their needs.

The PIC will review the roster in order to assign a further three hours per day on two weekday mornings, to this resident for the purpose of further facilitating their social and personal development support needs. This will commence on 02-05-2017. A full review of the resident's weekly plan will be carried out prior to the implementation of these additional supports.

Weekly psychology supports are in place for this resident.

Monthly psychiatry supports are in place for this resident.

Clinical guidelines are updated as required.

The Registered Provider, the PIC, relevant staff and the clinical team, will explore alternative living options for this resident, in line with their needs, expressed wishes and available resources.

Supporting documentation will be available for inspection in the centre.

Proposed Timescale: 01/07/2017

Theme: Effective Services

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

There were no records on one residents plan to demonstrate that an annual review had taken place for the resident.

3. Action Required:

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

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

The PIC will ensure that comprehensive annual reviews for each resident will be completed by May 12th. The relevant documentation will be available for inspection in the centre. A monitoring system will be introduced, whereby the PIC will review all residents' personal plans on a bi-monthly basis.

Proposed Timescale: 12/05/2017

Theme: Effective Services

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

One resident had no support plans in place around their assessed needs in order to guide practice.

4. 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:

(a) The PIC will review the assessments of need for each resident, and will ensure that the identified support needs and appropriate interventions are accurately documented in associated support plans, in order to guide staff practice.

(b) Work has commenced on the support plan for the resident in question.

Proposed Timescale: (a) May 12th 2017 (b) April 6th 2017

Proposed Timescale: 12/05/2017

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 identified risks in the centre had not been appropriately assessed and reviewed so as to ensure that all potential risks were mitigated in the centre.

5. Action Required:

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

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

The registered provider has re-assessed the risks in the centre, and has introduced further control measures, which will eliminate the identified risks.

The appropriate supporting documentation has been submitted to the Positive Approaches Management Group, and has been approved.

The relevant documentation will be available for inspection in the centre.

Proposed Timescale: 05/04/2017

Theme: Effective Services

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

Staff were unable to tell the inspector about how they could safely evacuate residents from the centre when only one staff member was present.

6. 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:

The registered provider has conducted a comprehensive fire safety review of the centre, and all relevant documentation has been reviewed and revised.

Fire safety refresher training has been provided for the staff team.

A successful simulated evacuation was conducted during the course of this training. This focused particularly on the needs of one resident, who was present. This was conducted by one staff member, and was observed by the remainder of the team, in the presence of the fire safety officer.

The fire safety officer was satisfied that one staff member could safely evacuate the residents in the centre if and when required.

The relevant supporting documentation was submitted to the Inspector on 16-03-2017.

This documentation will be available for inspection in the Centre

Proposed Timescale: 16/03/2017

Theme: Effective Services

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

Fire doors were not in place in the centre.

7. 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 registered provider has upgraded the fire doors in the centre.

For one resident who has a history of non-compliance with fire drills an FD30 [Fire door] has been installed in her bedroom.

All remaining internal doors have been fitted with batwings [cold-smoke seals], and 15mm x4mm acoustic fire and smoke seals. These, when closed, provide a sufficient level of fire containment to allow safe evacuation in line with the providers fire safety policy.

Proposed Timescale: January 2017--Complete.

Proposed Timescale: 31/01/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Two interventions in the centre were potentially restrictive and needed to be appropriately assessed and reviewed. This included the use of a beam on one residents bedroom door and chemical restraint that was prescribed in response to behaviours of concern.

It was not clear whether one environmental restriction was being implemented in the centre.

8. 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:

All restrictive practices in the centre, including physical, chemical or environmental, will be reviewed at least bi-annually by the PIC, the Psychologist and the Psychiatrist, and will be further reviewed by the PAMG at least annually, to ensure that they are applied in accordance with national policy and evidence based practice.

Proposed Timescale: 27/04/2017

Theme: Safe Services

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

The records in place to review restrictive practices in the centre did not demonstrate whether part of the review included whether the least restrictive practices was being used.

9. 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:

The PIC has met with the psychologist to review all environmental restrictive practices in the Centre. The outcome of this review is that all current restrictive practices are appropriate to support the identified needs of the residents. One further practice, which had not previously been deemed restrictive by the registered provider, was

identified as being restrictive by the Authority. The relevant paperwork has been submitted to the PAMG for this practice, the practice is deemed to be the least restrictive and has been approved. All restrictive practices in the centre will be reviewed at least bi-annually by the PIC, Psychologist, and Psychiatrist.

The PIC has discussed the PRN prescribed medications for one resident in the centre, with the prescribing psychiatrist, and with the medication management review committee, which is chaired by the medical director.

The prescriptions were deemed by both the psychiatrist and the medication management review committee, to be appropriate therapeutic interventions, prescribed to meet the identified support needs of this resident.

The PIC has met with the Psychologist, to review the resident's positive behaviour support (PBS) guidelines to accurately reflect the residents PRN support needs and guidelines.

Supporting documentation will be available for inspection in the centre.

Proposed Timescale: April 4th 2017 / Complete

Proposed Timescale: 04/04/2017

Theme: Safe Services

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

Intimate care plans in place required more detail in order to guide practice for all staff.

10. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

The PIC will review all intimate care support plans to ensure that they accurately reflect the support needs and preferences of each resident, in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Proposed Timescale: 12/05/2017

Theme: Safe Services

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

Additional measures were required to ensure that the actions agreed by the provider

would be implemented so as to safeguard all residents in the centre.

11. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

The PIC, the Service-Manager (PPIM) and the supporting clinical team have met six times in the past year, to discuss the required supports for this resident. A further meeting is scheduled for 07-06-'17.

The following supports have been put in place.

A business case was submitted to the HSE On 21-12-2016 to request the necessary funding to provide an individualised service for this resident.

Commencing on 10-02-2017 the resident has been availing of lone respite care in a designated centre, with staff support for two weekends per month (six nights).

On alternate weekends, the resident is assigned additional staff on a 1-1 basis for five hours each day (Saturday and Sunday)

Additionally, the resident is assigned four hours per evening, on two evenings per week, to further support her needs.

The PIC will review the roster in order to assign a further three hours per day on two weekday mornings to this resident, for the purpose of further facilitating her social and personal development support needs. This will commence on 02-05-2017. A full review of the resident's weekly plan will be carried out prior to the implementation of these additional supports.

Weekly psychology supports are in place for this resident.

Monthly psychiatry supports are in place for this resident.

The PIC, the relevant staff and the clinical team, will explore alternative living arrangements for this resident in line with her needs, expressed wishes and available resources.

Safeguarding training was provided to the remaining residents over a four week period, one X one hour session per week, during January and February 2017. In the course of this training, all residents were supplied with a photo-ID card of the designated officer, which outlines her role, and contact details.

A local safeguarding policy will be devised by the PIC and the psychologist, and will be implemented for the centre

The recent roster review addressed times in the centre when only one staff member was present with two residents, one of whom requires 1-1 staffing.
The following changes have been implemented.

With immediate effect, the morning transport is being supplied by a specific named taxi driver who has been HSE Garda vetted, and for whom Garda vetting documentation has been further submitted on behalf of the registered provider.

The transport department on behalf of the Registered Provider has taken steps to outsource this transport to an external approved agency. The assigned transport staff will be Garda vetted by the registered provider and will attend induction training provided by the registered provider. This will include,

- An introduction to the organisation.
- An overview of organisational policies and procedures.
- Safeguarding training
- Manual handling training.

Supporting documentation will be available for inspection in the centre.

Proposed Timescale: 03/07/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staffing levels in the centre were not adequate at all times to meet residents assessed needs in the centre.

12. 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:

In addition to the actions already outlined in paragraphs 11-13 under action 11. and to ensure that all residents in the centre are safeguarded, the weekend roster has been amended to reflect that the 11.00-20.00 shift has been replaced with an 8.00 -20.00 shift on Saturdays and Sundays, in order to meet the assessed needs of all residents.

Supporting documentation for all of the above will be available for inspection in the centre.

Proposed Timescale: Proposed transport changes—July 3rd 2017.

Weekend roster updated on April 2nd 2017

Proposed Timescale: 03/07/2017

