<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Willow Park</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002372</td>
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<tr>
<td>Centre county:</td>
<td>Dublin 11</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>St Michael's House</td>
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<tr>
<td>Provider Nominee:</td>
<td>Maureen Hefferon</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Karina O'Sullivan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>5</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times

From: 09 June 2017 10:30
To: 09 June 2017 20:00

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

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<th>Outcome</th>
<th>Description</th>
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<td>02</td>
<td>Communication</td>
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<td>05</td>
<td>Social Care Needs</td>
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<td>06</td>
<td>Safe and suitable premises</td>
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<td>07</td>
<td>Health and Safety and Risk Management</td>
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<td>Safeguarding and Safety</td>
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<td>General Welfare and Development</td>
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<td>Medication Management</td>
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<td>Statement of Purpose</td>
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<td>14</td>
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<td>17</td>
<td>Workforce</td>
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<td>18</td>
<td>Records and documentation</td>
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Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this designated centre. This inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

How we gathered our evidence:

As part of the inspection, the inspector visited the centre, met with five residents and spoke with three staff members. The inspector viewed documentation such as, support plans, recording logs and policies and procedures. Over the course of this inspection, residents communicated in their own preferred manner with the inspector. Residents allowed the inspector to observe their daily life in the designated centre. This included meal times and activities.

Description of the service:
This designated centre is operated by St Michael's House, a company registered as a charity. St Michael's House is governed by voluntary board of directors to whom the CEO (Chief executive officer) reports. This centre is based in Dublin 11. Five residents resided in the centre at the time of this inspection. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The inspector found the service provided was in line with the statement of purpose. The designated centre aimed to provide residential accommodation for male and female adults over the age of 18 with intellectual disabilities who required a low to a high level of support, as outlined in the statement of purpose. The centre consisted of an extended single story house with six bedrooms, five of these were used by residents and one was used by sleep over staff members.

Overall judgments of our findings:
Thirteen outcomes were inspected against six outcomes were found to be moderately non-compliant. Four outcomes were found to be substantially compliant with three outcomes fully compliant. Areas of improvement included, risk management, medication management and healthcare management.

The service manager and frontline staff facilitated the inspection as the person in charge was on a day off.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
The inspector reviewed this outcome in relation to the non-compliances identified on the previous inspection.

The inspector viewed minutes of regular residents meetings taking place within the designated centre. During these meetings residents were consulted in relation to activities they would like to participate in during the evening and weekends. This included visiting friends, attending parties and meals out. Activity sampling was also evident. Staff members researched into activities and events occurring in the area so residents were informed and could choose what they wished to attend.

The inspector viewed evidence that residents had an input in to their finances. The inspector viewed support plans in place and also resident’s belongings were listed within their files. Residents required the support of staff in relation to money management. Records and balances of finances were appropriately maintained.

In relation to complaints the inspector viewed a folder within the designated centre this contained information in relation to complaints, no complaints were recorded as received in this centre.

No other components of this outcome was inspected.

**Judgment:**
Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Communication support needs for residents were met within the designated centre.

The centre had a communication policy in place. Staff spoken with were aware of the communication needs for residents and these were clearly described in the communication passports, support plans and all about me documents maintained on file for each resident.

The inspector viewed all residents' communication documents these outlined the methods of communication. This included things I like to talk about, how you can help me communicate, things I do not like, these areas were clearly explained in resident's files. The inspector observed that assistive equipment and supports were put in place to promote resident's communication such as, visual display boards and objects of reference. The inspector observed staff communicating with residents using the required augmentative communication methods during the day of inspection.

Residents were supported to develop and maintain personal relationships and links with the wider community. Families were also encouraged to get involved in the lives of residents.

Residents had access to radio, television, internet and information on local events.

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:**
Overall, the inspector found that improvements had been made in the area of social care since the last inspection. However, further improvements were required to ensure social goals identified for residents were reviewed in relation to the effectiveness of the goals set.

The inspector viewed four resident's files and three contained individual personal plans, the fourth file did not contain any individual personal plan. However, the inspector did view evidence that social care supports were provided to this resident. Staff informed the inspector the resident did not have a individual personal plan due to the current healthcare needs of the resident. How this decision was reached and who was involved in the decision making process was not evident.

The inspector viewed evidence of collaboration with residents' day service to assist residents achieve their goals between their home and day service. For example, one resident wanted to be independent in taking off their coat and hanging it up, instead of staff members doing this for the resident. Clear levels of progression was evident from daily assistance to occasional verbal prompts. Another area identified related to a resident wanting to partake in a 5km walk, a plan was devised with steps to assist the resident to achieve this goal. There was also a tracker to monitor the level of progression, however, the plan devised did not match the tracker and no rationale was evident for why this goal was not progressed as planned. The inspector viewed another goal where a resident wanted to meet a friend from another centre for coffee or a meal. Contact was made with the other centre a few months ago, however, no follow up was completed in relation to this or why this goal had not progressed. Therefore, the inspector identified residents had goals set, however, the follow up and review of the effectiveness of the goals required improvement to identify how these areas were impacting on the quality of live for residents.

The inspector found residents had the opportunities to participate in meaningful activities appropriate to their interests and preferences. Some residents discussed these activities with the inspector, or showed pictures of past events they had attended. This included person-centred activities such as, music events, sporting events and visits to and from family and friends.

Four residents attended a day service and one resident had recently retired. This resident currently remained within the centre and staff assisted this resident to participate in social activities of their choosing. On the day of inspection this resident attended the community for their lunch with a staff member.
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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The action from the previous inspection was no longer relevant as the centre did not require to be wheelchair accessible.

However, during the course of the inspection, the inspector identified some internal walls required attention as the paintwork was damaged in places and black marks resembling mildew was present in the porch.

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

**Findings:**
The inspector found the centre was suitable for the number and needs of residents. Improvements had occurred since the previous inspection, however, further improvements were required in relation to the risk and fire management.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company, this was dated February 2017.
It was unclear if there was sufficient fire containment in the house, this was identified during the previous inspection. The action plan received by HIQA (health information and quality authority) identified all doors will be reviewed and where necessary fit intumescent strip seals and automatic door closures by January 2016. These were not evident on the day of inspection and the inspector asked to view the review completed, however, this was not available within the centre. Following inspection the service manager sent in a document dated 12 December 2016 where 11 items were identified along with people responsible for completing the items, however, no evidence of competition or follow up was evident.

The inspector found the action in relation fire evacuation had been addressed. The inspector viewed evidence of a fire drill dated 04 November 2017, all residents successfully evacuated the designated centre. Residents had PEEP's (personal emergency evacuation plans) in place to assist staff to safely evacuate all residents. The inspector viewed training records for nine members of staff and found staff members had received training in the area of fire.

The centre had an organisational risk management policy in place, which included the specific risks identified in regulation 26. The centre had a risk register, which recorded a number of risks within the house and the controls in place to address these. These included areas such as, aggression and violence, self harm, lone working and food safety. However, some of these required updating as the information contained within some of the assessments viewed related to a previous resident no longer residing in the centre.

The inspector also viewed individual resident's risk assessments in place, these related to areas such as, self injurious, using transport and accessing the kitchen.

The centre had a health and safety statement. The responsibilities of the various staff members within the organisation were outlined. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The centre had an emergency evacuation plan in place in the event of a fire, however, no other plans were in place for example, flooding or power failure. The plan viewed did not identify where residents would avail of overnight accommodation should the needs arise. Instead this plan identified two neighbours houses or other designated centres for temporary shelter.

The designated centre’s vehicle or the paperwork associated with it was not viewed during this inspection as the vehicle was being services and documentation was within the vehicle. This was subsequently sent to the inspector. The inspector viewed a sample number of staff member's documentation in relation to NCT (National Car Test) documents and insurance when using their own vehicle to transport residents.

There was a system in place to record any incident or accident within the designated centre, on the day of inspection no incident or accident recorded within the centre.

**Judgment:**
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 there were appropriate measures in place to protect residents from being harmed and to keep people safe. However, some improvements were required in relation to behaviour support plans, intimate care plans and restrictive practice.

The inspector viewed two behaviour support plans, one was dated August 2015, the inspector viewed a piece of paper stuck on to this document stating this was reviewed on the 28.10.2016 and an update plan would be available. The inspector asked to view the updated plan, however, staff members were not aware of such plan. The inspector asked if staff were aware of what aspects were changed within the plan, however, some staff members were not fully aware of what changes were made. The other behaviour support plan viewed was dated July 2016, this plan referred to support strategies contained within the resident's behaviour support plan dated 2015. These plans made no reference to when PRN (a medicine only taken as the need arises) medication was to be administered. The inspector viewed a third document which outlined when the resident was to be administered a PRN medication, however, this document did not correspond with the two behaviour support plans, nor was this signed by any members of the multidisciplinary team. Therefore, these documents were not guiding staff members consistently and effectively in the provision of this aspect of care for residents. Evidence that behavioural plans were reviewed at least annually was also not available for all plans viewed.

The inspector found intimate care support plans were in place for various aspects of intimate care provision for residents requiring them. However, the information contained within some plans was not consistently documented throughout the residents file. For example, for one resident their intimate plan outlined the night-time care requirements included that the resident liked to have their pyjama's on by 23:30hrs, the inspector viewed other documents within the resident's file where this was identified as 21:30hrs. The inspector asked staff members what time this resident would normally be dressed for bed and was informed the resident would usually be dressed for bed around 21:00hrs. It was unclear to the inspector which was the preferred time for the resident.
and also staff members were not guided appropriately as plans identified different times.

The inspector identified the management of unexplained bruising sustained by residents required clarity within the centre. The inspector viewed evidence of this within one residents file when a resident was referred to the GP (General Practitioner). Other staff members identified all unexplained bruising would be sent to the designated officer for screening first. Staff members would take photographs of the bruises and send these to the designated officer. The inspector found this inconsistent approach and lack of guidance available within the centre to guide staff members could lead to inconsistent approaches being adopted by staff members in relation to this matter.

The inspector acknowledged the improvements in relation to the reduction of environmental restrictions which had taken place since the previous inspection. However, during the inspection, the inspector identified an alert system was in operation in for one resident. The inspector requested evidence where this product was prescribed for the resident from medical perspective, however, this was not available. In the absence of the devise being prescribed for the resident, this intervention should be notified to HIQA as a restriction in accordance with the organisations and HIQA guidance documents.

CCTV (closed circuit television) was also used within the centre and recorded, the inspector requested to view the rationale for this system and the policy in place, however, neither documents were available within the centre.

The inspector found staff members spoken with were clear in relation to the reporting structure in place should all allegation of abuse arise. The inspector viewed training records for nine members of staff and found all staff members had received training in the area of adult protection and safeguarding training. Residents spoken with where also clear should they observe or experience aspects of service delivery in an inappropriate manner that they would report this to.

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development
Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
The general welfare and development needs of resident’s were promoted within the centre. Residents were afforded opportunities for new experiences, social participation, education and training in accordance to the needs and preferences of residents.

The inspector spoke with and observed residents, staff and viewed documentation and found that residents were provided with suitable activities. This was in line with resident’s goals, preferences and relevant to their needs. Staff members outlined how support was provided to residents to pursue a variety of interests including swimming, cinema, walking and meals out.

The inspector found residents attended day services and residents were also facilitated to have a day off from day services if the resident wished. One resident had recently retired from their day service and staff were facilitating activities from the designated centre for this resident such as, visiting gardens where this resident used to work.

The inspector viewed residents' profiles and these contained relevant information in relation to activities residents participated in. Some residents discussed their hobbies in relation to music.

The inspector also viewed evidence of bereavement programmes facilitated within the centre, since the previous inspection one resident had died. However, pictures of this resident remained in the centre and family members continued to visit residents and some residents showed the inspector photographs of their friend who used to live with them.

**Judgment:**
Compliant

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

**Findings:**
Improvements were required in the area of healthcare management to ensure each resident was supported to achieve the best possible health.

The inspector viewed four residents' assessments, these included both social and health assessments in eight areas. This included communication, social support, emotional wellbeing, general health, physical and intimate care support, safety, environment and
rights. From these assessments an action plan was developed.

The inspector found, some healthcare conditions were not identified within the assessment despite a support plan in place for the condition. The inspector also identified some healthcare areas were identified within the assessment, however, no support plan was present in relation to the specific healthcare need. This was identified and discussed with the service manager on the day of inspection.

The inspector found the details contained within some of the plans developed did not guide staff effectively for example, a mobility plan viewed made no reference to the resident requiring orthotics and physiotherapy exercises. The inspector located this information elsewhere within the residents file. Therefore, staff members were not guided effectively to ensure the resident received the prescribed care provision and if these supports were effective for the resident.

The inspector found some information was not available within the designated centre, for example, a resident with a diagnosis of high cholesterol required a blood test twice a year. The inspector asked staff members when this was last obtained, however, this information was not available within the centre. The inspector identified this did not ensure this aspect of the resident's healthcare was managed effectively as staff were unable to identify when the next blood test was required or when the previous one was obtained or the results of the previous test.

The inspector viewed another plan where a resident was required to drink two liters of fluid per day, the plan identified if the intake was less than this for three consecutive days the nurse manager on call was required to be contacted. The inspector viewed the recording chart for this and noted the plan was not followed, for example, no record was maintained from 01 June 2017 to 09 of June 2017 nor was there any rationale for why this had occurred. The inspector also viewed evidence of fluid intake at 600ml, 400mls and 1200mls on three consecutive days with no action taken. The fluid balance when recorded was never totalled and staff were unsure who was required to complete this. On the day of inspection, the inspector observed the resident drinking 800mls.

The inspector found the review process in place for areas identified required improvement to identify the effectiveness of the interventions implemented to ensure these were having a positive impact on residents healthcare needs.

The inspector viewed some epilepsy plans in place to guide staff members in effective delivery of care in relation to seizure management. The plan identified the resident required a neurology appointment in January 2017. However, staff members were unable to confirm if this occurred.

Residents had access to a G.P. (general practitioner), speech and language therapist, however, the inspector viewed evidence of one resident awaiting physiotherapy in relation to access in the community review since 2016. The exact date was not available within the centre, however, this information was included in the resident risk assessment dated 23 November 2016

Residents requiring modification to the texture of their food was outlined in the
residents files. The inspector viewed feeding, eating, drinking and swallowing (FEDS) assessments in place for some residents. However, one plan viewed dated April 2016, contained the incorrect name of the resident and also referred staff to implement the resident’s dietetic guidelines. Four members of staff had signed this document. The inspector requested to view the guideline referred to; however, these were not present as the resident was not on a dietetic diet. The inspector found this could potentially lead to confusion among staff members particularly as relief staff were required to work within this area.

Regarding food and nutrition the inspector found residents participating in mealtimes within the centre in accordance with residents' preferences in relation to food choices. Residents participated in cooking in accordance with their own preferences. Some residents informed the inspector they preferred to do other household activities within their home instead and their preference was respected such as laundry.

The inspector viewed user-friendly menu selection of refreshments and snacks were available for residents outside mealtimes within the designated centre.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

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

**Findings:**
The inspector found the medication management system within the designated centre required significant improvement in relation to the management and administration of medication.

On the day of inspection, the inspector found some PRN medicine was not available within the centre.

Another PRN medication contained inaccurate information in relation to the amount of medication required to be administer compared to the administration sheets. The inspector found the incorrect dosage was administered to the resident on a previous occasion from checking the administration sheet against the stock received sheet. Staff identified they decided to administer a reduced dosage to the resident.

No guidance was available in relation to the administration of some PRN medicine. The
inspector found staff members were not always guided effectively and consistently in the administration of medication. For example, residents were prescribed two medications for constipation without guidance for staff on which to administer first or if both medication could be administered together.

The inspector viewed administration sheets and found some medication was not administered as prescribed in relation to PRN medication. This was highlighted to staff members on the day of inspection.

The centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. However, the inspector found this policy was not always adhered to within the designated centre.

The inspector crossed checked balances of some medication and found accurate records maintained.

Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received.

There was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the centre, however, there was no evidence of learning from these incidents to mitigate the risk of future reoccurrences.

The inspector found the signature bank within the centre was completed.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
The inspector found the statement of purpose did not fully meet the requirement of the regulations as it did not contain some of the information as required within Schedule 1. The inspector was provided with an updated document at the end of the inspection by the service manager. However, on review of this document post inspection the document did not reflect the registration information within the document.
Judgment:
Substantially Compliant

### Outcome 14: Governance and Management

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

### Theme:
Leadership, Governance and Management

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

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

### Findings:

Overall, the inspector found there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision and quality of the service delivered. Improvements were required to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The inspector found there was no auditing taking place in relation to the quality of service delivered within the designated centre. The inspector found more effective oversight was required to ensure efficient governance and management was facilitated within this designated centre. For example, the management of medication, risk management and healthcare provision.

There was an annual review of the quality and care completed in this centre dated December 2016, however, this was not available within the designated centre the service manager provided a copy to the inspector.

There was a person nominated on behalf of the provider to carry out an unannounced visit on a six monthly basis. This reviewed the safety and quality of care and support provided in the centre. The inspector viewed one completed on the 02 and 08 June 2016 and another one was completed on the 11 November 2016. The later document was not available in the centre, the service manager provided this document to the inspector on the day of inspection. An action plan was generated with a completion date, however, the inspector found these were proposed completion dates with no evidence of follow up was to ensure areas were completed as proposed. The inspector noted within the document dated June 2016 one resident's plan was in progress this was also identified within the November document. One the day of inspection this remained under development.

The person in charge was on a day off on the day of inspection. The service manager
and frontline staff facilitated this inspection. The person in charge was supported in their role by a service manager.

The inspector viewed minutes of team meetings within the centre dated for 2016 and 2017. Areas discussed included policies relating to the centre health and safety and information sharing in relation to Dementia care provision from another designated centre.

The person in charge met with the service manager to discuss areas relating to the designated centre and the inspector viewed minutes dated 27 March 2017.

**Judgment:**
Non Compliant - Moderate

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**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 there was appropriate staff numbers and skill mix employed within the centre. Improvements were required in relation to the staff rota, to ensure relief staff member's full names were present on the rota.

The inspector found the actual and planned rota was maintained within the centre.

The inspector viewed training records for nine members of staff and all had received training in the required areas.

**Judgment:**
Substantially Compliant

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**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 reviewed this outcome in relation to the non-compliances identified on the previous inspection. One of the two actions had been achieved.

The inspector identified some of the Schedule 5 policies present in the centre were not the current documents available within the organisation. Therefore, these did not guide staff members effectively for example, behaviour support policy was dated 2013, the management of residents money was dated 2012 and the complaints procedure was present in two different versions within the centre.

Over the course of the inspection, the inspector viewed the directory of residents and found this document did not contain all the information as specified in Schedule 3. The date of admission and the name and address of any authority, organisation or other body which arranged the resident's admission to the centre was not contained within the document. The directory also contained information in relation to four residents despite five residents residing within the centre.

The inspector also found elements of residents assessments were blank, for example, the assessment for feeding, drink and swallowing contained a section for staff to identify if a support plan was required this section was blank, despite a plan in place for the resident. Other elements of assessments viewed were blank and did not provide information in relation to whether a support plan was required.

The inspector also identified within the risk register a different centre was referenced instead of this centre.

**Judgment:**
Non Compliant - Moderate

**Closing the Visit**
At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Karina O'Sullivan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Michael's House</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002372</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>09 June 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>07 July 2017</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

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

Personal plan reviews did not assess the effectiveness of each plan in place.

One resident has no personal plan and how this decision was reached and who was involved in the decision making process was not evident.

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:**
1. The person in charge will arrange for training in the development of Person Centred planning for all staff.

2. Personal plan reviews will be tabled as an agenda item at staff meetings.

3. The person in charge will ensure that personal plans are reviewed with each resident’s key worker at least quarterly. Each review will assess the effectiveness of the plan and take into account changes in circumstances and new developments.

**Proposed Timescale:** (1) October 2017 (2) Next staff meeting TBC (3) July 30th 2017

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**Proposed Timescale:** 31/10/2017

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some internal walls required attention as the paintwork was damaged in places and black marks resembling mildew present in the porch.

**2. Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
The Register Provider will request the technical services dept to carry out the works outlined. Works to be completed.

**Proposed Timescale:** 30/07/2017

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**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place in the centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies required improvement, in the area of location risk management and a system for responding to emergencies.
3. 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 will put systems in place, for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

A review of all risk assessments will be carried out and updated

Emergency evacuation procedures for the centre will be updated to include the researching of local hotels and associated contact information, to facilitate night-time evacuation to a hotel if required.

Proposed Timescale: 30/07/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear if the arrangements for containing fires within the designated centre were adequate.

4. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The Registered Provider will commission the installation of intumescent strips on all bedroom and kitchen doors. Magnetic door closures will be fitted initially to the kitchen door.

Proposed Timescale: 30/07/2017

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some plans were not reviewed at least annually in relation to the therapeutic interventions available for residents.

5. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic
interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will ensure that all therapeutic interventions are reviewed at least annually. Existing plans in consultation with the relevant clinicians will be reviewed and updated as required.

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<th>Proposed Timescale: 30/07/2017</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The use of some restrictive practice including chemical and environmental required review to reflect evidence based practice and the organisations policy.

**6. 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:**
The Registered Provider will ensure that all restrictive procedures are reviewed by the relevant Clinicians and are applied in accordance with national policy and evidence based practice.

The CCTV policy for the centre has been updated and submitted to the Authority (June 15th 2017)

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<th>Proposed Timescale: 30/07/2017</th>
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<tr>
<td><strong>Theme:</strong> Safe Services</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff members were not guided appropriately in their role to respond to behaviour that is challenging. As plans were not detailed enough to guide practice and several documents exited with different information for staff members to follow.

**7. Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
The Person in charge will make contact with the relevant Clinicians, and will request
that all positive behaviour support plans are updated, in order to guide staff practice in responding to behaviours that challenge. The Person in charge will further ensure that there is one clear plan in place for each resident, to ensure consistency of approach.

**Proposed Timescale:** 30/07/2017  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Staff members were not guided in relation to the management of unexplained bruising sustained by residents, the inspector was informed of two different approaches.

8. **Action Required:**  
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**  
The person in charge will ensure that the reporting of any suspicion of abuse or harm to a resident, is done in a consistent manner, in accordance with the provider's safeguarding policy.

**Proposed Timescale:** 30/06/2017  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Some intimate care plans required updating to reflect actual practice within the centre.

9. **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 person in charge will develop a system to ensure that all staff keep residents' intimate care plans updated, to ensure that the information contained therein, is reflective of each individual's needs.

**Proposed Timescale:** 30/07/2017

**Outcome 11. Healthcare Needs**
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some medical treatment recommended for some residents was not evident, for example, fluid intake, information in relation to the practice of cholesterol management and mobility plans did not make any reference to physiotherapy interventions recommended.

FEDS assessment referenced resident and information not relevant to the resident using the plan.

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

Please state the actions you have taken or are planning to take:
1. The person in charge, in consultation with the Health and Medical Trainer and Training dept will develop a training plan for the team to ensure all health care conditions are identified and relevant plans in place and regularly reviewed.
2. The person in charge will ensure that all recommended medical treatment is adhered to. The Person in charge will further ensure that all support plans reference medical \ clinical interventions where relevant. All plans will be individualised to the relevant resident.
3. Files will be reviewed and documentation updated and made easily accessible.

Proposed Timescale: (1) Training complete by Sept 15th (2) (3) July 30th 2017.

Proposed Timescale: 15/09/2017
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Access to allied health professionals was taking seven months for example physiotherapy in relation to community access.

No evidence of neurology appointment.

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

Please state the actions you have taken or are planning to take:
The person in charge will ensure that residents attend all scheduled medical \ therapeutic appointments and that a clear and consistent reminder system is put in place to guide staff in this regard.
**Proposed Timescale:** 04/07/2017  
**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Appropriate healthcare for some residents was not provided and outlined within their plans. Some healthcare conditions were not identified within the assessment despite a support plan in place for the condition. Other healthcare areas were identified within the assessment, however, no support plan was present in relation to the specific healthcare need.

**12. 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 Registered Provider will advise the relevant clinicians to review assessments and plans for all residents, to ensure that all assessments of need, are fully reflective of the support needs of each individual resident, and that the appropriate corresponding support plans are in place to guide staff practice.  
A review of all plans will be carried out by the clinicians, the PIC and the team.

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**Proposed Timescale:** 30/08/2017

**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:**  
The inspector found some PRN medicine was not available within the centre.

One PRN medication contained inaccurate information in relation to the amount of medication required to be administer compared to the administration sheets. The inspector found the incorrect dosage was administered to the resident on the previous occasion.

No guidance was available in relation to the administration of some PRN medicine.

Some administration records viewed recorded some medication was not administered as prescribed in relation to PRN medication.

The inspector viewed medication incidents which occurred within the designated centre, however, there was no evidence of learning from these incidents to mitigate the risk of future reoccurrences.
13. **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. The person in charge will work with the relevant Doctor and Psychiatrist to ensure that prescriptions for all PRN medication are clearly outlined, to ensure that the correct dose is administered as prescribed, and that clear guidelines are in place to guide staff practice in this regard.

2. The person in charge will further ensure that all medication errors are discussed and reviewed at staff meetings, to ensure review and learning for all team members.

3. The person in charge, in consultation with the Health and Medical Trainer will provide training to the PIC and team on the administration of medication

Proposed Timescale: (1&2) July 30th 2017 (3) Sept 15th

**Proposed Timescale:** 15/09/2017

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**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

The **Registered Provider** is failing to comply with a regulatory requirement in the following respect:
The registration information was not contained within the document.

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

**Please state the actions you have taken or are planning to take:**
The statement of purpose has been updated to reflect the registration information as set out in schedule 1 of the Health Act 2007 (Care and support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The amended statement of purpose will be submitted to the Authority.

**Proposed Timescale:** 07/07/2017

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**Outcome 14: Governance and Management**
### Theme: Leadership, Governance and Management

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

The post of the person in charge of the centre was not full time, the person held a reduced hours contract.

**15. Action Required:**

Under Regulation 14 (2) you are required to:

- Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The Registered Provider will consult with the Person in Charge regarding the increase of her contract to full time hours. In the interim, additional management time will be allocated to the PPIM who is based in the Centre, to ensure appropriate governance and supervision.

**Proposed Timescale:** 30/09/2017

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### Theme: Leadership, Governance and Management

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

Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**16. Action Required:**

Under Regulation 23 (1) (c) you are required to:

- Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The Registered Provider will ensure that tasks from the action plans of 6 monthly audits are reviewed and implemented. That a system of monitoring is introduced to provide a safe environment appropriate to the residents needs.

**Proposed Timescale:** 30/06/2017

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### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The staff rota, did not contain the full names of staff members working within the centre to cover relief shifts.

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

**Please state the actions you have taken or are planning to take:**
The person in charge will ensure that the full name and grade of every staff member is accurately reflected on the roster. This will include all relief staff.

**Proposed Timescale:** 04/07/2017

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### Outcome 18: Records and documentation

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some of the Schedule 5 policies present in the centre were not the current documents available within the organisation.

18. **Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will ensure that all policy documents present in the centre are up to date, and that all staff are familiar with their contents.

**Proposed Timescale:** 04/07/2017

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**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The directory of residents in the centre was not maintained up to date and some of the required information was not contained within the document.

19. **Action Required:**
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will ensure that the directory of residents is updated to include...
all information which is required to be included in the document.

**Proposed Timescale:** 05/07/2017  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Elements of some residents assessments were blank and did not guide staff members in the provision of care.

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

**Please state the actions you have taken or are planning to take:**  
1. The person in charge will arrange for training in the development of effective assessment of needs for all residents.

2. Assessment of needs documents will be tabled as an agenda item at staff meetings

The Registered Provider will ensure that all assessments of need are completed and reviewed, to accurately reflect the support needs of each resident, and that related support plans are devised to guide staff practice.

**Proposed Timescale:** 30/07/2017