

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Clew Bay
Centre ID:	OSV-0002334
Centre county:	Dublin 11
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Lead inspector:	Thomas Hogan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	8
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 following an application to vary registration conditions. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 01 February 2018 09:40 To: 01 February 2018 19:35

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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was an unannounced inspection to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted as part of the registered provider's assessment in response to an application which was made to vary the conditions of registration of this designated centre. The provider had submitted an application to merge two individual designated centres, each containing one unit, to become one designated centre made up of two units. This inspection was completed over one day by one inspector.

Description of the service:

The service provider had produced a statement of purpose which outlined the service provided within this designated centre. The centre was comprised of two houses, one terraced and one semi-detached, based in a suburban community setting in North Dublin. The centre provided residential services and supports to eight persons and at the time of inspection there were no vacancies.

How we gathered our evidence:

The inspector met with all eight of the residents availing of the services of the centre and spoke in detail with four residents. The inspector also spoke with two staff

members, the person in charge, the representative of the registered provider, and a fire officer employed by the organisation. Various sources of documentation, which included the statement of purpose, residents' files, centre self-monitoring records, policies and procedures, risk assessments etc., were reviewed as part of this inspection. Additionally, in assessing the quality of care and support provided to residents, the inspector spent time observing staff engagement and interactions with residents. A full walkthrough of the centre was completed by the inspector in the company of the person in charge. As the application received involved two designated centres merging to become one, the inspector followed up on a range of actions which had been issued at the time of the last inspections for both designated centres.

Overall judgment of our findings:

Eight outcomes were inspected against as part of this inspection and the inspector observed a high level of non-compliance with the Regulations. Four of the eight outcomes inspected against were found to be in major non-compliance with the Regulations, with two outcomes found to be in moderate non-compliance, one outcome found to be substantially compliant and one outcome was found to be compliant. 16 of the 27 actions followed up on from the last inspections by the inspector were found not to have been satisfactorily implemented.

Areas of concern identified during this inspection related to fire management, risk management, the absence of appropriate incident management, the safeguarding and protection of residents availing of the services of the centre, the absence of the identification of potential abusive experiences for residents, the safeguards around the use of restrictive practices in the centre, medication practices, and governance and management arrangements.

These findings, along with further details, can be found in the body of the 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 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 were supported to engage in meaningful activities and to live active roles in their local community with valued social roles, however, there were areas of improvement identified in both the assessment of needs and planning.

Comprehensive assessments were found to be in place for a selection of residents for which reviews of files were completed by the inspector. The assessments were found to have focused on the personal, social, and health care need of residents. Of the three files reviewed, however, the inspector found that no comprehensive assessment of need was completed in the previous 12 month period. In addition, it was not clear who completed or participated in the assessment process.

A review of personal plans in place to support residents with needs identified in the assessment process was completed by the inspector for a sample of three residents. It was found that residents had a suite of plans in place for needs such as bathing, personal hygiene, spiritual beliefs, attending appointments, finances, spending time alone in the designated centre, administering medications etc. The personal plans in place, however, did not guide staff sufficiently on the supports required by residents with regards to the individual need(s) outlined.

From a review of social activities and through discussions held with residents, the inspector found that residents participated in meaningful activities and lead active lives with valued social roles in their local community. Residents outlined to the inspector achievements such as recent overseas holidays and plans to travel abroad in the

summer to attend a wrestling convention in the United States. On the day of inspection, residents were observed sharing meals with friends from the local area, arranging to attend a local bar, and returning from a local fitness gym where they held membership.

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 that the health and safety of residents was not satisfactorily protected or promoted in the designated centre at the time of inspection.

A review of incidents and accident reports was completed by the inspector and it was found that the arrangements in place in the designated centre for investigating and learning from incidents involving residents were not satisfactory. A total of 22 incidents had taken place in 2017 and 2018 up to the date of the inspection. Four of these incidents related to slips, trips and falls of residents; four related to accidents (minor injuries); one related to a near miss; and 13 related to behaviours which challenge. The inspector found that seven of the 13 incidents which were classified as 'behaviours which challenge' potentially met the definitions of abuse as outlined in the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document. There was no evidence of appropriate follow up in the case of these seven incidents. This will be discussed further under Outcome 8 in this report.

The inspector found that residents in one unit of the designated centre spent significant periods without staff supervision. In the case of one resident, a review of completed fire drills in the centre highlighted that they refused to evacuate on two occasions. The personal emergency evacuation plan in place for the resident did not satisfactorily outline the supports required by this resident during evacuation. In addition, there was no risk assessment completed for this resident with regards to evacuating from the designated centre given the fact that a refusal to do so had been identified on two separate occasions. There was also an absence of risk assessments for all residents who spent time alone in this area of the centre. These issues were brought to the attention of the representative of the registered provider at the time of inspection and written assurances were provided to the inspector which addressed these concerns.

In the case of another resident a personal emergency evacuation plan did not make

reference to their specific needs or what additional measures were in place to ensure the resident's safe evacuation in the event of a fire for example.

A full walkthrough of the designated centre was completed by the inspector and it was found that emergency lighting was not in place at one emergency exit of the designated centre. The inspector found that suitable fire equipment was provided in the centre and that there were adequate means of escape which were unobstructed at the time of inspection. There were prominently displayed procedures for the evacuation of residents, visitors and staff in the event of a fire.

A review of service records found that fire systems in place in both units of the designated centre were serviced on at least a quarterly basis.

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:

The inspector found that appropriate measures were not in place in the designated centre to protect residents from experiencing abuse. Incidents of potential abuse were not identified as such and as a result action was not taken to investigate these in line with national policy.

The inspector found that some staff were unfamiliar with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document. Improvement was required to ensure staffs awareness of this was increased.

A total of seven incidents which had occurred in the designated centre were identified by the inspector as potentially meeting the definitions of abuse outlined in the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document. There was a complete absence of any follow up of these incidents, and a review of the files of the residents affected indicated that there were no safeguarding

plans in place. HIQA were notified in the case of only one of these seven incidents. The inspector found that there was an absence of systems in place to ensure that residents were protected from abuse and that any disclosure, allegation or suspicion of abuse would be appropriately investigated and followed up on.

Staff training was reviewed and it was found that six staff members had not completed mandatory refresher training in the area of safeguarding vulnerable persons in the timeframes set out as being required by the registered provider. Despite this, two front line staff members spoken with by the inspector demonstrated satisfactory levels of knowledge of the types of abuse and the appropriate action to take in the event of a disclosure or allegation or witnessing or suspecting abuse to have taken place.

All four residents with whom the inspector spoke with confirmed that they felt safe in the designated centre. All interactions between staff members and residents observed by the inspector were considered to be respectful and warm. There was a policy in place in the designated centre for the provision of intimate care. In addition, there were policies in place for the provision of behavioural support and on the use of restrictive procedures and physical, chemical and environmental restraint.

A review of positive behavioural support measures in place found that two residents had positive behavioural support plans. In the case of one resident, the plan made no reference to behaviours or supports in place despite the resident having a long term restriction in place. The resident was restricted from accessing tea making facilities in the designated centre and the criteria for this restriction was not clear.

In the case of another resident, the inspector found that no positive behavioural support plan was in place to support this resident despite having a history of complex behaviours which resulted in a separate significant restrictive practice.

The inspector identified seven additional restrictive practices which had not been recognised as such. There were no risk assessments in place to outline any risks associated with reasons for restrictive practices being in place in the designated centre. In addition, there was an absence of evidence to demonstrate that restrictions in place were the least restrictive alternatives for the shortest durations.

Judgment:

Non Compliant - Major

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:

Overall, the inspector found that residents were satisfactorily supported to maintain and achieve good health, however, improvements were required in the area of health care planning to ensure appropriate guidance in place for supporting residents achieve and maintain best possible health.

The inspector found that residents had access to a wide range of allied health care services which reflected the health care needs of the individuals availing of the services of the designated centre. All residents were found to have access to general practitioners and pharmacies of their choice.

Residents were found to have had annual medical checks completed and assessments in the form of a 'comprehensive assessment of need' and 'wellbeing reviews' were made available to the inspector. In some cases, the inspector found that the assessments were not completed in the 12 month period prior to the inspection.

A review of four resident files found that a range of identified medical conditions did not have corresponding health care support plans in place. Some examples of conditions which did not have a health care support plan in place included testicular cancer, epilepsy, deep vein thrombosis, and bipolar affective disorder. Having reviewed the health care support plans which were in place, the inspector found that some plans did not guide the practice of staff and were not reviewed for their effectiveness on at least an annual basis. There was no evidence available of multidisciplinary inputs for reviewing health care support plans.

A front line staff member spoken with by the inspector demonstrated high levels of knowledge regarding the health care needs of residents. The staff member demonstrated detailed knowledge of the actions to take to support residents with medical conditions in emergency situations.

The inspector observed meals being served in one unit of the designated centre and found that it was a positive and social event. There were a range of choices available to residents and the food being served appeared nutritious, appetising and was available in sufficient quantities.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

The inspector found that residents were potentially put at risk by some medication management practices in the designated centre.

In one unit of the designated centre the inspector observed that the medication cabinet was left opened and unattended for an extended period of time.

A review of medications contained in a medication cabinet found that four items were outside of the listed expiry dates. In one case a medicinal product found in the cabinet had an expiry date of July 2015 listed. In another case medicinal products which had been purchased privately by a resident at considerable cost were found to be outside of their listed expiry dates due to the absence of a rotation of stock items. The person in charge provided assurances to the inspector that the resident would be reimbursed in full for the costs incurred as a result of this matter.

The inspector found from a review of medication prescriptions and administration records that there were medications prescribed which had not been signed as having been administered. While it was explained to the inspector that the medication had been administered in another area of the service, there was an absence of systems in place to ensure appropriate oversight and recording of this administration.

The processes and safeguards around residents self administering were not clear. There was a 'self administration of medication checklist' completed and on file, however, no risk assessment was available. A staff member outlined to the inspector that another resident did not have the capacity to self administer their medication, however, despite this, and in the absence of any risk assessment or assessment of capacity with regards to this matter, the resident was found to self administer medications while on specific outings such as attending football matches. In the cases of all other residents, there were no capacity or risk assessments found to have been completed with regard to the self administration of medication.

The inspector found that PRN medication (medication only taken as the need arises) prescribed to residents did not have the specific criteria for administration outlined.

Judgment:

Non Compliant - Major

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that there was a written statement of purpose in place in the designated centre at the time of inspection. Some areas of non-compliance were found within this document and the inspector provided the person in charge and representative of the registered provider with an opportunity to rectify these during the inspection. A revised statement of purpose was made available to the inspector and this revised document was found to contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector found that the management arrangements in place in the designated centre at the time of inspection did not ensure that the service delivered was appropriate and effectively monitored, with appropriate action taken to address issues of concern.

Two individual reports of the annual review of the quality and safety of care and support in the designated centre, each relating to one of the two previously independent designated centres, were made available to the inspector. The reports related to the periods of August 2015 to August 2016 in one case and September 2015 to August 2016

in the second instance. No reports were made available for the period from August 2016. Overall, the inspector found that the reports were not of a satisfactory standard and failed to identify any of the concerns found by the inspector at the time of inspection. While some areas for improvement were identified in the available reports, in one instance an action of "replacement of windows" had not been completed at the time of inspection despite a target date of 31 January 2017 being listed.

A report of a six monthly unannounced visit to the designated centre with regards to the safety and quality of care and support provided in the designated centre by a person nominated by the registered provider was made available to the inspector. The unannounced visit was completed on 23 October 2017 and examined areas such as: assessments of need, emergency planning, training, accidents and incidents, complaints, on-call supports, review of restrictive practices, risk assessments, medication management, money management, notifiable events, governance and management, transport, and previous reports. At the time of this unannounced visit a 'unit health and safety review' was also completed. From both of these processes a total of five actions were identified as being required. The assessments failed to identify any of the substantial concerns found by the inspector relating to the safeguarding of residents from potential abusive experiences, fire safety and the appropriate management of risk, medication management, and concerns relating to the governance and management of the designated centre.

The inspector found that there was an absence of management systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

While there was a clearly defined management structure in place in the designated centre, the inspector was not assured that all staff could demonstrate sufficient knowledge of the legislation and their statutory responsibilities. This was brought to the attention of the representative of the registered provider at the time of inspection. There were no formal supervision arrangements in place to support key persons in management positions, however, meetings regarding operational matters of the designated centre were held on average every two months.

The inspector spoke with two staff members regarding the management and governance arrangements in place in the designated centre, and despite confirming that formal supervision arrangements in place for staff members were not regular or in line with recommended frequency, both staff members stated that they felt supported in their role by the person in charge.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the

needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

The inspector found that while some areas of improvement related to Outcome 17 - Workforce were evident since the time of the last inspection, further areas of non-compliance were identified at the time of this inspection.

The inspector was not assured that, in the absence of formal assessments of risk, there were appropriate staff numbers employed in both areas of the designated centre at all times. In one area of the designated centre no staff were employed on weekdays from 11:00am until 16:00pm, and at weekends from 11:00am on Fridays until 16:00pm on Mondays. While there was staff support available at times from the second area during these periods, the arrangements in place presented potential risks to the safety of residents.

A review of staff training found that all mandatory areas of staff training had been completed by all staff employed in the designated centre. An exception to this was in the area of safeguarding vulnerable persons training which was discussed in Outcome 8.

The inspector reviewed staff rotas and found that a previous action relating to this area had not been satisfactorily implemented. The staff rotas were not clear and contained "2015" as a date despite containing planned and actual rostering data for the time period of the inspection. The person in charge confirmed that on three occasions in a one week period of the actual staff rotas reviewed by the inspector that staffing levels dropped below the minimum required levels.

The representative of the registered provider confirmed that no volunteers were employed in the designated centre.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Thomas Hogan
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-0002334
Date of Inspection:	01 February 2018
Date of response:	13 April 2018

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:

Comprehensive assessments of need were not completed for at least three residents in the 12 months prior to the inspection.

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:

- 1.The Person in Charge will ensure key workers will complete assessments of need on an annual basis.
- 2.The Person in Charge will meet with each keyworker and identify what actions are required to ensure each resident has an up to date comprehensive assessment of need.
- 3.Minutes of the meetings with keyworkers identifying actions required will be available in the designated centre for review.
- 4.The Person in Charge will review the assessments of need when they are updated/ developed to ensure completeness and accuracy.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

The personal plans in place did not guide staff sufficiently on the supports required by residents with regards to the individual need(s) outlined.

2. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

- 1.The Person in Charge will as part of the review with keyworkers identify support plans that require updating or developing.
- 2.The Person in Charge will meet with each keyworker and identify what actions are required to ensure each resident has the appropriate and up to date support plans in place and reviewed annually or as required.
- 3.Minutes of the meetings with keyworkers identifying actions required will be available in the designated centre for review.

Proposed Timescale: 30/04/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

1. There was no review of incidents and accidents completed in the designated centre

to identify trends and guide future practice.

2. There were no individual risk assessments in place for some residents where a concern had been highlighted.

3. Risk assessments were not reflective of current risks in the designated centre.

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:

1. The person in charge, in conjunction with the Health and Safety manager will review accidents and incidents that have occurred in the designated centre to identify any trends and agree actions to prevent further occurrence as appropriate. Ongoing review at 6 monthly unannounced audit inspection by PIC and service manager

2. Minutes of the review will be kept and available in the designated centre. Any actions identified will be included in the Quality Improvement Plan in the centre and will be reviewed with the service manager on a monthly basis to ensure their implementation.

3. The Person in Charge will review risk assessments in place and develop/update them as appropriate.

4. The Person in Charge will discuss the Risk assessments with each staff member to ensure implementation/understanding of risks. The PIC will ensure this is a regular agenda item at staff meetings.

5. The Person in Charge will review the risk assessments annually and/or as required and include on the designated centre risk register.

Proposed Timescale: 10/04/2018

Theme: Effective Services

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

Emergency lighting was found not to be in place at one emergency exit of the designated centre.

4. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

The Person in Charge contacted Technical Services and emergency lighting at the one emergency exit is now in place.

Proposed Timescale: 05/02/2018

Theme: Effective Services

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

There was an absence of evidence to demonstrate that all residents would evacuate the designated centre in the event of a fire if no staff were present.

5. Action Required:

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

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

- 1.Roster reviewed to ensure staff presence for individual resident when in designated centre.
- 2.Fire risk assessment reviewed with Fire safety officer and Person in Charge
- 3.Fire drill conducted and all residents evacuated safely

Proposed Timescale: 26/02/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

1. Positive behavioural support plans were not in place for all residents with identified needs.
2. Positive behavioural support plans which were in place did not address all behavioural needs of residents.

6. 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:

- 1.The Clinical psychologist for the centre and Person in Charge will meet to review the positive support plans of resident to include any criteria for the use of restrictive practice. All plans will utilise the least restrictive alternative, to manage the behaviour of concern. The up to date behavioural support plans will be available for review in the designated centre.

2.The centre Clinical psychologist and Person in Charge will meet with staff team to draw up a positive behaviour support plans to address complex behaviours. The up to date behavioural support plans will be available for review in the designated Centre.

3.Supports will be provided by the clinical psychologist to residents in relation to the impact the behaviours of one resident is having on their emotional health.

Proposed Timescale: 30/04/2018

Theme: Safe Services

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

1. Seven restrictive practices in place in the designated centre at the time of inspection were not recognised as such.
2. The criteria for the use of restrictive practices were not clear.
3. There were no risks identified through risk management plans for any restrictive practice in place in the designated centre.

7. Action Required:

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

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

- 1.The Person in Charge will familiarise himself with the St. Michael's House "Policy on the Use of Restrictive Practices (2016)" and thereafter will meet with a member of the Organisation's Positive Approaches Monitoring Group to:
- 2.Complete an audit of all restrictive practices in use in the centre
- 3.Identify the learning needs of the staff team in relation to restrictive practice and agree a date for presentation by a member of Positive Approach Management Group (PAMG) to the team.
- 4.Agree an action plan regarding completion of any outstanding assessments, trials of less/non-restrictive alternatives, supporting paperwork e.g. clinical guidelines and risk assessments, requests for approval by PAMG etc that are identified through the audit as required
- 5.The restrictive practice audit tool and associated actions will be available for review in the centre. The actions will be included in the Quality Enhancement Plan for the centre and this will be reviewed monthly by the Service Manager and PIC to provide assurances that the actions agreed are being implemented.

Proposed Timescale: 30/04/2018

Theme: Safe Services

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

There was an absence of evidence available to demonstrate the identification and alleviation of the cause of residents' behaviour; and that the least restrictive procedure, for the shortest duration necessary, was used.

8. Action Required:

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

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

1. The Clinical psychologist and Person in Charge will review and update the positive behaviour support plans in place to ensure they identify and demonstrate that they seek to alleviate of the cause or resident's behaviour.

2. If restrictive practices are identified as being required to support the resident(s) the Person in Charge with support from the clinical psychologist will seek approval for the use of these restrictions from the Positive Approaches Monitoring Group (PAMG). The PAMG require documented evidence about: the need and rationale for the restriction, who, how and in what circumstances it is used, what alternative less/non-restrictive practices have been considered, a plan in place to monitor, review and, where possible, fade/reduce the level of restriction in use and that the restriction is used for the shortest duration possible,

Proposed Timescale: 30/03/2018

Theme: Safe Services

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

1. The person in charge was not aware of the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document, or the requirements outlined within.

2. There was an absence of appropriate follow up of seven incidents which occurred in the designated centre which potentially met the definitions of abuse.

3. There were no safeguarding plans in place for residents.

9. 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:

1. The Registered provider has updated the Policy and Procedures for the protection of adults from Abuse and Neglect in March 18. The PIC has a copy of the updated policy in the Designated centre. All staff have been notified. This Policy is reflective of and

faithful to the National Policy in respect of the responsibilities and procedures that must be fulfilled and followed. As per the service level agreement between St. Michaels House and the HSE, SMH have their own Safeguarding Policy.

2. The Designated Officer will review all seven incidents to assess if the incidents meet the threshold for abuse as defined in both SMH and the National Policy on the Protection of Vulnerable Adults.

3. Having completed the review described above, the Designated Officer will work with the PIC to put safeguarding support plans in place for those residents who require it. The relevant plans will be completed by Thurs 15th March 2018.

4. The Designated officer will attend the staff meeting to discuss St. Michaels House Policy & Procedures for the Protection of Vulnerable Adults.

Proposed Timescale: 10/04/2018

Theme: Safe Services

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

Staff training was reviewed and it was found that six staff members had not completed mandatory refresher training in the area of safeguarding vulnerable persons in the timeframes set out as being required by the registered provider.

10. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

All staff to complete training in safeguarding by 30 March 2018.

Proposed Timescale: 30/03/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

1. Health care support plans were not in place for all identified health care needs.

2. Some health care support plans did not appropriately guide staff practice.

11. Action Required:

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

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

- 1.The Director of Nursing and an assigned CNM2 will carry out comprehensive nursing assessments on all residents. This will commence on March 14th 2018.
2. The medical Director will support the PIC and the staff team to guide the practice of staff in identifying medical conditions and develop corresponding health care plans.

Proposed Timescale: 30/04/2018

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:

In one unit of the designated centre the inspector observed that the medication cabinet was left opened and unattended for an extended period of time.

12. 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 Health and medical trainer completed a review of the Safe Administration of medication (SAM). The report is available in the designated centre
- 2.The Health and medical trainer will attend a staff meeting to confirm actions and review policies including safe storage of medication
- 3.The PIC will randomly check that the medication press is locked at all times.

Proposed Timescale: 10/04/2018

Theme: Health and Development

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

1. There was an absence of systems in place to ensure appropriate oversight and recording of the administration of all medications.
2. The inspector found that PRN medication (medication only taken as the need arises) prescribed to residents did not have the specific criteria for administration outlined.

13. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

- 1.The Health and medical trainer completed a review of the Safe Administration of medication (SAM). The report is available in the designated centre
- 2.The Health and medical trainer will attend a staff meeting to confirm actions and review policies including Safe administration and recording of medication
- 3.All staff members will faithfully follow the SAM policy in relation to administration and recording of medication.
- 4.Risk assessments have been completed by the Health and Safety officer and PIC. They are available for review in the Designated Centre
- 5.PRN Medications have been reviewed and recommendations made by the Health and Medical Trainer. MAS sheets amended to reflect recommendations.

Proposed Timescale: 10/04/2018

Theme: Health and Development

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

A review of medications contained in a medication cabinet found that four items were outside of the listed expiry dates. In one case a medicinal product had an expiry date of July 2015 listed.

14. Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

- 1.The Health and medical trainer completed a review of the Safe Administration of medication (SAM). The report is available in the designated centre
- 2.The Health and medical trainer will attend a staff meeting to confirm actions and review policies including audit and disposal of medication
- 3.The PIC audited all medications and systems and discarded as per policy medications out of date

Proposed Timescale: 10/04/2018

Theme: Health and Development

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

Risk assessments and assessments of capacity were not completed with regards to the self administration of medication in the designated centre.

15. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

1.The PIC with the support of the Health and Medical Trainer has developed Risk assessments and Capacity Assessments for all residents who partake in the Self administration of medication.

Proposed Timescale: 30/04/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The inspector was not assured that the person in charge demonstrated sufficient knowledge of the legislation and their statutory responsibilities.

16. 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:

1.One to One mentoring process will be implemented with the current PIC The mentor identified currently works as a Programme Director in the Open Training College and has extensive experience of tutoring and mentoring students in management topics and the HIQA regulations.. The mentor will work with the PIC to increase his understanding of the role and responsibilities of managing a designated centre and implementing the requirements of the HIQA reports. This process will continue weekly for 4 weeks and fortnightly for 2 months, followed by review.

2.Increase in the number of management hours

Proposed Timescale: 13/03/2018

Theme: Leadership, Governance and Management

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

The inspector found that there was an absence of management systems in place in the designated centre to ensure that the service provided was safe, appropriate to

residents' needs, consistent and effectively monitored.

17. 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:

1.The Director of Service will schedule a meeting to review the management systems in place in the designated centre. The purpose of the review is to identify additional appropriate management systems that will support service users to live as independently as possible while providing strong governance management. This review will include the need for additional management time in the designated centre, scheduling of a range of internal audits, scheduling of staff supervision and support meetings and will identify a range of internal support staff to support the implementation and sustainment of the updated management systems.

2.Minutes of the review meeting will be available for inspection. The actions identified at the review meeting will be recorded in the Quality Enhancement Plan and this will be reviewed monthly to ensure actions are consistently implemented.

Proposed Timescale: 30/03/2018

Theme: Leadership, Governance and Management

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

No annual review of quality and safety of care and support in the designated centre was completed for the period from August 2016.

18. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The Service Manager on behalf of the registered Provider has begun the process of developing the annual review for the centre. It will be available for review in the centre.

Proposed Timescale: 31/03/2018

Theme: Leadership, Governance and Management

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

The inspector found that a completed six monthly unannounced visit to the designated centre by a person nominated by the registered provider failed to identify any of the

substantial concerns found at the time of inspection.

19. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- 1.The Director of Service will review the two previous 6 monthly inspection reports to identify what issues were not identified and consider why this is so.
- 2.The Director of Service will organise for an interim 6 monthly review to be completed and the focus of the interim six-monthly review will be the implementation of the actions committed to in this Action Plan.
- 3.All actions in this plan will be included in the Quality Enhancement Plan which will be reviewed monthly by the PIC and Service Manager.

Proposed Timescale: 30/06/2018

Theme: Leadership, Governance and Management

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

The arrangements for supervision of staff at all levels required improvement.

20. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

- 1.The Registered Provider introduced a Supervision and Support Policy in 2017. The PIC will familiarise themselves with the content of the policy and the requirements set out in the policy. A member of the HR team will support the PIC to implement the Policy and in addition the training and development Department will provide training to support the implementation.
- 2.A schedule of supervision meetings for frontline staff will be developed and will begin in March 2018. Minutes of supervision meetings will be maintained confidentially in the designated centre.
- 3.Supervision and support for the PIC will be formally introduced on 6th March 2018. It will be based on operational management issues in the centre as well as individualised support for the PIC to carry out the roles and responsibilities of Person in Charge of a designated centre. Minutes of the support meetings will be available in the designated centre

Proposed Timescale: 30/04/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

1. The inspector was not assured that, in the absence of formal assessments of risk, there were appropriate staff numbers employed in both areas of the designated centre at all times.
2. On three occasions in a one week period of the actual staff rotas reviewed by the inspector that staffing levels dropped below the minimum required levels.

21. Action Required:

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

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

1. A Roster review was completed on the 16th December 2017 to assess staffing requirement relating to the extra sleepover required in Clancy Ave. This review was conducted to ensure there were adequate staffing supports in both areas. This resulted in an increase from 5.3 staff to 6 staff which was implemented immediately.
2. The process of the recruitment of a Direct Support Worker to provide an individualised day service for one of the residents has commenced.
3. The Director of Service and administration manager will continue to review staff rosters to ensure adequate staffing levels.
4. A risk assessment will be developed and will identify actions required to reduce risks. The risk assessment will be available for inspection in the designated centre.

Proposed Timescale: 30/06/2018

Theme: Responsive Workforce

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

The staff rotas were not clear and contained "2015" as a date despite containing planned and actual rostering data for the time period of the inspection.

22. 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 has updated the roster to include 2018 as the date rather than 2015.

Proposed Timescale: 09/03/2018