Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Sallowood
Centre ID:	OSV-0002378
Centre county:	Dublin 9
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Karina O'Sullivan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor 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:	To:
15 September 2017 10:15	15 September 2017 20:50

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

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 all residents and spoke with four staff members and two family 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 9. Six residents lived 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 and physical disabilities who required 24 hour nursing support, as outlined in the statement of purpose. The centre consisted of a single story house with seven bedrooms, six of these were used by residents and one was used by sleep over staff members.

Overall judgments of our findings:
Twelve outcomes were inspected against and three outcomes were found to be moderately non-compliant. Eight outcomes were found substantially compliant and one outcome was fully compliant. Areas of improvement included, risk management and healthcare management.

The person in charge facilitated the inspection.

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):
No actions were required from the previous inspection.

Findings:
Residents were consulted and participated in decisions about the organisation of the centre. However, improvements were required in relation to the privacy and dignity of some residents due to practices within the centre.

The inspector found some of the routines and practices within the centre did not promote resident's independence or choice and in some instance staff members were not familiar with residents' individual preferences. For instances nightly checks were completed within the centre, some of these were hourly and the rationale for this practice was not evidenced based from the healthcare needs of residents.

During the course of the inspection, some residents showed the inspector their bedrooms. From engaging with residents and speaking with staff members, the inspector formed a view that residents were consulted in relation to the layout and decoration of their bedrooms. Choice was provided in relation to activities in accordance to the preference and individual capacity of each resident.

Staff members were observed on the day of inspection to provide care in a respectful and dignified manner. For example, when assisting residents with their meals, staff members sat beside residents and assisted them in accordance with residents' needs and preferences.

The inspector viewed minutes of residents' meetings and discussed these with one resident. From the minutes viewed residents were consulted and participated in decisions about the centre.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There were policies and procedures in place for admitting residents, including transfers, discharges and temporary absences of residents.

Since the previous inspection, one resident had transferred into the centre. The inspector viewed the transition plan in place during this period. This plan outlined the steps involved in the process. However, evidence that the criteria in relation to the admissions procedure, particularly in relation to the consultation process as outlined within the organisations policy, was not evident within the centre on the day of inspection.

Judgment:
Substantially 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:
Resident's wellbeing and welfare was maintained and residents had opportunities to participate in meaningful activities appropriate to their preferences. However, improvements were required in the review of personal plans for residents.

Each resident had a personal plan in place which included an up-to-date assessment of need. While personal plans were not in an accessible format for residents, the inspector found that this had not impacted on residents' knowledge of their personal plans. For example, one resident spoken with was clear about the information contained in their personal plan. They spoke to the inspector about their likes and dislikes and what activities they were currently involved in.

The inspector viewed four resident's files and each contained individual personal plans, these reflected the interests, needs and capacities of residents. Within the plans various goals residents wanted to achieve were identified in areas such as, music, activities and holidays. The inspector also viewed evidence where one resident decided not to partake in goals set and the rationale for this was recorded. From viewing the plan in place, the inspector identified that some plans were not reviewed to reflect changes in circumstances and new developments for residents. Overall, the review process was unclear as this did not always specify what was reviewed, instead a date and staff signature was included at the end of the document.

The inspector also identified the implementation of some person-centred approaches to bereavement within the centre in relation to residents and family members.

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):
No actions were required from the previous inspection.

Findings:
The centre was suitable and safe for the number and needs of residents. Improvements were required in relation to fire containment and risk assessments.

The centre had an organisational risk management policy in place, which included the specific risks identified in regulation 26. The designated 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 and needle stick injuries.

The centre had guidelines in place for the use of CCTV (closed circuit television) for security reasons, this document was dated 27 June 2016.

The inspector viewed local guidance for staff members to follow in the event of a missing resident, this was dated 09 June 2017. Staff members spoken with were familiar with the procedure.

The centre had a health and safety statement this was dated 2014. The responsibilities of the various staff members within the organisation were outlined. The statement referenced a wide range of policies and procedures which supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as, fire, adverse weather conditions, flooding and power failure. However, some of these required updating for example, in the event of a fire, overnight accommodation was not specified within the guidance for staff members.

The inspector also viewed individual resident's risk assessments in place, these included areas such as, mobility, self-harm and falls. The information contained within some of these documents were not reflective of practice and required updating.

The inspector viewed records of fire drills which demonstrated all residents evacuated the designated centre.

Residents had PEEP's (personal emergency evacuation plans) in place to assist staff to safely evacuate all residents. The mobility and cognitive understanding for each resident was accounted for within their plan.

Fire containment measures required improvement within the centre in relation to the instillation of smoke seals on doors and the placement of fire doors within the centre.

Certificates and documents were present to show the fire alarm, fire equipment and emergency lighting were serviced by an external company in 2017.

There was a system in place within the centre to record accidents and incidents to ensure preventative measures could be implemented in order to mitigate reoccurrences.

The designated centre’s vehicle paper work was not viewed during this inspection.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided

with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
There were appropriate measures in place to protect residents from being harmed and to keep people safe. Although, some improvements were required in relation to behaviour support plans and restrictive practice.

There were policies and procedures in place in relation to the prevention, detection and response to abuse, the use of restrictive procedures and physical, chemical and environmental restraint.

The inspector viewed one resident's behavioural support plan and other documents such as, emotional wellbeing plans. These documents identified both proactive and reactive strategies. However, another resident was awaiting a behavioural support plan, this was identified within the assessment dated 20 August 2016. This inspector found this time frame of 13 months excessive for the development of such as plan.

The inspector found intimate care support plans were in place for various aspects of intimate care provision for residents requiring them. For the most part residents required support in this aspect of care provision from staff members.

Staff members spoken with were clear in relation to the reporting structure in place should an allegation of abuse arise. Residents spoken with were also clear on what to do should they observe or experience poor aspects of service delivery.

The inspector viewed training records for twelve staff members of staff and found all staff members had received training in the area of adult protection and safeguarding training.

Judgment:
Substantially Compliant

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:
Resident's had opportunities for new experiences, social participation, education and training, these aspects of resident's lives were facilitated within the centre.

During the course of the inspection, some residents attended day services, other residents remained within the centre for various reasons including healthcare and personal preferences. Staff members within the centre supported residents to remain in the centre if that was their choice.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Each resident was supported to achieve the best possible health within the centre. However, improvements were required within the information contained in resident's healthcare plans and the review process.

Overall, the inspector found the healthcare plans were not updated to reflect the current needs of residents. The reviews conducted did not assess the effectiveness of the interventions contained within the plan.

The inspector viewed four residents' assessments of need, these included eight assessments in both social and healthcare. Areas included communication, social support, emotional wellbeing, general health, physical and intimate care support, safety, environment and rights. From these assessments an action plan was generated. This resulted in various support plans, yet, some of these were not related to the assessment. Other assessments identified there was no support plan required, yet, a support plan was developed, for example, respiratory issues. In addition some aspects of assessments were blank such as, the date of referral for a cognitive assessment. This information was not available within the designated centre. Therefore, the inspector was unable to determine how long the resident was waiting this assessment.

The details contained within some healthcare plans were not sufficient to guide staff members, for example, one plan contained several plans in relation to nutritional intake. These documents did not effectively guide practice, as different information was contained in relation to food and fluid consistency and fluid restrictions. For example, some documents identified fluid intake and output. The interventions specified within the plan did not guide practice, for example, from viewing the monitoring charts there were nine days that the resident did not receive the recommended fluid intake, however, no action was specified. This was discussed with staff members on the day of inspection. Other nutritional plans for the resident identified a trial plan was required for two weeks, this was dated 19 May 2017, the resident remained on this plan and no follow up or review was evident within the plan.

Another plan viewed identified a resident was awaiting a bone density scan, this was dated 07 December 2016. The inspector requested evidence of this referral, however, staff identified the resident had received this procedure in June 2017. Therefore, the resident's plan was not updated to reflect this information. Other plans were not reviewed annually at a minimum, for example, to prevent the risk of deep vein thrombosis. This was reviewed on 16 September 2015 no further review was evident, nor did the review identify the effectiveness of the plan.

The inspector viewed an epilepsy plan in place, this was dated 30 December 2016. This plan did not identify that a second dose of rescue medication could be administered after five minutes. The inspector also viewed a second plan in place for the same resident in relation to epilepsy, this was dated 25 May 2015. However, this was also not reflective of the resident's prescribed medication. The inspector found these documents were not guiding staff members' in relation to this healthcare need.

Residents had access to a G.P. (general practitioner), speech and language therapist, physiotherapy and other healthcare professionals depending on the needs of residents.

Regarding food and nutrition, the inspector found residents participating in mealtimes within the designated centre in accordance with residents' preferences in relation to food choices. Refreshments and snacks were available for residents outside meal times within the designated centre.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Residents were protected by the centres' procedures on medication management. Improvements were required to in relation to some PRN (a medicine only taken as the need arises) medicine guidance and the identification of the expiry date for some medications.

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, medications prescribed for the same purpose.

The inspector identified the expiry date was not present within one medication within the centre. Staff members spoken with on the day were unable to provide assurance that this medication was within the expiry date. Following inspection the inspector received a document outlining an agreement in place with the pharmacy, however, this information was not available on the day of inspection.

The inspector viewed the medication records for four residents. Prescription and administration records were complete, for example, the name, dose and route of medications were documented. Residents' details were also specified and the general practitioner name was recorded. PRN (a medicine only taken as the need arises) medications had the maximum dosage stated to be administered within a 24 hour period.

Medications were administered by all staff within this designated centre once training was completed.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines.

Medication was supplied to the designated centre from a community pharmacy, 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 and found preventative measure were put in place to mitigate the risk of future reoccurrences. For example, two staff administered medication within the centre as a measure to prevent errors.

The inspector viewed an audit of stock balances of medication within the centre balances were cross checked and these were found to be accurate.

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

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:
There was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the quality of the service delivered within the centre. Improvements were required in relation to the completion of an annual review and audits to improve practice.

The inspector found there were a limited number of audits completed within the centre. This impacted on the quality of care delivered to residents as care plans or interventions within plans were not audited effectively. Where audits were completed follow up to theses were not evident. For example, the inspector was unable to see what progress had occurred or actions completed as a result of an audit dated 09 November 2016 in relation to residents' plans. Therefore, the system of auditing within in the centre required improvement to ensure audits were having a positive outcome on resident's quality of life.

The centre had completed an annual review dated May 2015 to 2016 on the quality and care of the designated centre. However, there was no annual review completed for May 2016 to May 2017.

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 designated centre. The inspector viewed the report for a visit completed in November 2016 and another one was completed in June 2017. Both documents contained an action plan to address areas requiring improvement some of these were implemented and others were in progress.

The inspector requested to view a sample of staff member's supervision records. These required improvement, from the records viewed, there was no evidence that one staff member received supervision and for another staff member their last supervision was dated December 2012. The inspector identified this was not ensuring effective arrangements to support, develop and performance manage all members of the workforce. This lack of supervision did not facilitate staff members to discuss their role

on an individual basis with the person in charge within the centre. The person in charge identified this was an area they themselves had acknowledged required improvement to ensure staff were supported and provided with an opportunity to discuss their individual performance in relation to their care delivery.

The person in charge facilitated this inspection. From speaking with the person in charge at length over the course of the inspection it was evident they had knowledge of the individual needs and support requirements of each resident. Family members spoken with was complementary of the support provided to them from the person in charge. The person in charge was supported in their role by a service manager. The person in charge was aware of their statutory obligations and responsibilities with regard to the role of person in charge, the management of the designated centre and the remit of the Health Act (2007) and Regulations. Throughout the course of the inspection, the inspector observed residents knew the person in charge and were very comfortable in their communication with this member of staff. The person in charge worked on a full-time basis within this designated centre.

The inspector viewed minutes of team meetings within the centre dated in 2017. Areas discussed included policies related to the designated centre, health and safety issues, complaints and budgets.

The person in charge met with the service manager to discuss areas related to the centre. The inspector viewed minutes of these meetings.

The inspector also viewed minutes of the service manager meeting with the director of services to disuses areas related to the designated centre including resident's needs and staffing arrangements.

Judgment:
Non Compliant - Moderate

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
There was evidence that sufficient resources were available in the centre to meet residents' needs from a staffing perspective, however, the availability of drivers to provide a transport system required improvement.

Due to an imminent reduction in staff members, the inspector identified that there were not sufficient number of drivers. As only two drivers would be present within the centre from the following day. In addition, the proposed rota identified there was no staff member available to drive the vehicle on some days. Therefore, improvements were required in this area to ensure residents had access to transport should they choose to leave the centre and go into the community.

Also, within some of the previous rotas viewed the clinical nurse manager two was required to complete the bus run in the morning times. This reduced the nursing recourse available within the centre during those times as some residents remained in the centre. The service manager outlined this would be reviewed to ensure that resources within the centre would be appropriately allocated to ensure residents needs were effectively met.

The inspector acknowledged the improvements in the rota since the previous inspection.

Judgment:
Substantially Compliant

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

Theme:
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 there were sufficient staff numbers deployed to meet the needs of the residents, although resources in terms of transport as outlined previously required review. From viewing the rota in place improvements were required to ensure staff members on duty within the centre were identified.

The inspector viewed twelve staff members training records, refresher training was required for some staff members in relation to safeguarding and protection and behavioural support.

The inspector viewed a review of the staffing levels within the centre, this was dated 15 September 2017. This recommended 6.5 whole time equivalent nurses to be included

within the 11 whole time equivalent. The recommendations from the review had yet to be implemented.

The inspector viewed the actual and planned rota, it did not outline the full name of staff members or their role within the designated centre. Vacancies were being filled with both agency and relief staff members, the person in charge outlined a recruitment process in place to fill the vacancies.

There were no volunteers within the centre.

Judgment:
Substantially Compliant

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

Theme:
Use of Information

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

Findings:
Over the course of the inspection, the inspector found the retrieval of some Schedule 3 documentation difficult. Information contained within some residents' files, was outdated or present in duplicated versions. Some personal plans contained no dates.

The inspector also requested to view evidence why an alarm system was in place and who had prescribed this device. The inspector was informed this was not reviewed by the internal rights committee. The inspector requested to view evidence in relation to the rationale for the use of this device, however, this was not available within the designated centre. Following inspection written confirmation in relation to the rationale of this devise from an assessed healthcare perspective was provided to the inspector.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002378
Date of Inspection:	15 September 2017
Date of response:	01 December 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The practice of staff entering some resident's rooms during the night to complete regular checks was not promoting the privacy and dignity of residents. The need for this practice was not evidenced based on the needs for residents.

1. Action Required:

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The PIC will review and update support plans relating to the need for nightly checks. These support plans will be discussed with all staff at the staff meeting on 26/01/2018. Minutes of the staff meeting and residents support plans will be available for inspection. Nightly checklists will be reviewed and updated by the PIC to reflect the change in the nightly checks as per the service users needs.

Proposed Timescale: 30/01/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of the consultation process among all residents in the centre in relation to the admissions procedure was not evident for one transition.

2. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The PIC will review the recent admission and ensure that the consultation with residents is documented. All further admissions will be discussed at a residents meeting and minutes will be kept

Proposed Timescale: 30/01/2018

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some personal plan reviews did not take into account changes in circumstances and new developments for residents.

3. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in

circumstances and new developments.

Please state the actions you have taken or are planning to take:
The PIC organised staff training to support a person centred approach in this centre. This took place on the 17/11/2017 at the staff meeting. Minutes of the staff meeting are available for inspection

PIC will support key workers to review and update personal plans to reflect changes in circumstances and residents needs. Updated support plans will be available for review.

Proposed Timescale: 24/02/2018

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 system in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review in relation to risk assessments and emergency procedures.

4. 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 PIC has reviewed and updated emergency plans to reflect overnight accommodation in the event of an emergency. Plans available for inspection

PIC will review and update individual risk assessments to reflect current practice.

Proposed Timescale: 30/01/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire containments measures required improvements.

5. 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:
A FD3OS was installed to the bedroom corridor in order to sub compartment the means

of an escape to support evacuation based on complexity needs in the house- installed 8/11/2017

A review of the St Michaels House fire risk register is scheduled by the fire prevention officer and the building & property development manager in December 2017 in order to prioritise work for 2018, which will include fire seals on doors.

Proposed Timescale: 24/02/2018

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:
Staff did not 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 as one resident was awaiting a plan since 20 August 2016.

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:
The PIC will work with the centre Psychologist to ensure Positive Behaviour Support Plans are in place for residents that require them.

PIC will review residents individual risk assessments to reflect behaviours that are challenging and to support residents to manage their behaviour.

The PIC will review the PBS policy with all staff at a staff meeting on the 26/01/2018 to remind staff of the key element of Positive Behaviour Support. Minutes of staff meeting will be available for review.

Proposed Timescale: 30/01/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Within some plans where an assessed healthcare need was identified no plan of care was completed.

Within some other plans where the assessment determined no healthcare need was

evident plans of care were developed.

The details contained within some healthcare plans were not sufficient to guide staff members.

Reviews did not assess the effectiveness of each plan and take into account changes in circumstances and new developments in relation to healthcare needs.

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

Please state the actions you have taken or are planning to take:
The PIC with individual key workers will review all Assessment of Needs and related support plans to ensure:
- The Assessment of Need identifies all support needs
- Support Plans are completed to demonstrate how assessed needs are met
- Support Plans are reviewed to take account of new/changing needs.
- Support plans are evaluated to assess effectiveness

The PIC will support Key workers to review Epilepsy support plans to reflect current practice and PRN medications.

Proposed Timescale: 24/02/2018

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

The expiry date was not present within one medication within the centre. Staff members spoken with on the day were unable to provide assurance that this medication was within the expiry date.

8. 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:
PRN guidelines to be reviewed to ensure there are guidelines for all PRN medications- PIC and key workers to complete guidelines

The updated PRN guidelines will be available for review in the centre.

Proposed Timescale: 30/01/2018

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:
There was no annual review conducted in the previous 12 months within the centre.

9. 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 PIC and Service Manager will complete an Annual Review for 2017

This will be available for review in the centre.

Proposed Timescale: 28/02/2018

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
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 they are delivered was not evident.

10. 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:
The PIC will re-introduce a system for support meetings. This will be based on the St Michael's House supervision and support policy. Records of support meetings will be maintained and available for inspection.

Proposed Timescale: 30/01/2018

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a limited number of audits completed within the centre, within audits were completed follow up to theses were not evident. For example, the inspector was unable to see what progress had occurred or actions completed as a result of an audit dated 09 November 2016 in relation to residents' plans.

11. 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 PIC has established an audit system which involves key workers completing a review and this is checked by the PIC monthly. An action plan will be developed and as actions are completed the action plan will be updated

Proposed Timescale: 24/02/2018

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre was not resourced sufficiently in relation to the provision of drivers or in the absence of drivers with a transport service for residents.

12. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
PIC will co-ordinate a transport review meeting with the service manager and administration manager to identify how to improve transport services in the centre. A record of the meeting and actions will be available for review in the centre.

Proposed Timescale: 30/01/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The actual and planned rota, required improvements to ensure the full name of staff

members were recorded along with their role within the designated centre.

13. 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:
PIC will ensure that all staff members' names and roles are included on the staff rota. The Rota will reflect staff numbers during the day and night

Proposed Timescale: 30/01/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff members required refresher training in relation to safeguarding and protection and behavioural support.

14. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
The PIC has requested refresher Safe Guarding and Protection training from the training department. A copy of the request is available for inspection

Proposed Timescale: 30/01/2018

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The maintenance of schedule 3 documents required improvements.

15. 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:
The review of resident's assessments and support plans as outlined under outcome 11 will be undertaken by the PIC. This review will ensure documents outlined in schedule 3 will be easily retrievable and out of date plans will be archived.

Proposed Timescale: 24/02/2018