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:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002395
Centre county:	Dublin 12
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Declan Ryan
Lead inspector:	Deirdre Byrne
Support inspector(s):	Anna Doyle;
Type of inspection	Announced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 September 2015 09:30	22 September 2015 18:30
23 September 2015 09:30	23 September 2015 15:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration monitoring inspection was announced and took place over two days. It was the centre's first inspection by the Health Information and Quality Authority (the Authority). The centre is ran by the St. Michael's House. The purpose of the inspection was to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

During this inspection, inspectors met with residents and staff members, observed

practices and reviewed documentation. Questionnaires from relatives and residents submitted as part of the inspection were also read. These were discussed are referenced in the report.

The designated centre comprises of three individual homes (called units in the report) where residents lived. The units are all located within the same grounds in an urban residential area. The person in charge was present throughout the inspection, and accompanied inspectors to all three units. There was a management team that includes the provider nominee, service manager and person in charge. The service manager, person in charge and supporting staff attended the feedback meeting at the end of the inspection. As part of the application for registration, the provider was requested to submit relevant documentation to the Authority. All documents submitted by the provider for the purposes of application to register were found to be satisfactory.

There was evidence of good practice found across all outcomes with residents supported by staff who were knowledge of their social and health care needs. There were good managements systems in place with clear lines of authority and accountability. The residents had interesting things to do and during the day went about their day to their respective employments, day services, further education, and voluntary work. The residents were supported to maintain family and personal relationships and receive visitors in their home.

The ethos of the centre was primarily to enable the residents to continue leading independent lives to the best of their ability, with structured staff supports in place. While inspectors found residents were fully supported by the staff support during the day, it was apparent that the residents social, health and mental care needs were changing and additional supports were required at other times of the day. The person in charge had reviewed staffing levels in the centre, and extra staff were rostered at certain times of the week. However, inspectors found that staffing levels were not adequate in the morning.

Other areas of non compliance identified included the use of resources in relation to the staff roster/shift patterns and the deployment of staff, the documentation of residents social care needs, the systems in place to consult with residents and the implementation of the risk management policy to identify and monitor risks.

The action plans at the end of this report identifies the outcomes under which improvements are required.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found the provider ensured the residents privacy and dignity was maintained. While systems were in place to consult with the residents and to manage complaints, improvements were required in both of these areas.

There were systems in place to consult with residents, and house meetings took place in the centre. The minutes of recent meetings read outlined issues raised by residents that included the need for more staff support at times of the day. However, there was no evidence of the action taken to address their concerns, or feedback to the residents in between or at the meetings. The meetings took place every two months. While residents told inspectors they really enjoyed the meetings, they also reported they would like to have more of them.

There were arrangements in place to manage complaints. A complaints policy and procedure was seen by inspectors that met with the Regulation. A log of complaints was maintained by the person in charge. The residents were very familiar with the complaints process and an accessible version of the procedures was displayed in each unit of the centre. However, the procedures were not fully implemented in practice. For example,
• inspectors read where complaints raised had not been formally recorded, and it was not clear they had been investigated or actioned
• where complaints were formally recorded there lack of documented evidence of the action taken to address complaints
• there was no evidence of feedback to the persons making the complaint and their satisfaction.

Inspectors were informed there was an advocacy service available and gave examples of how this was being accessed for some residents. While this information was available if requested by residents, the contact details for the independent advocacy service was not displayed in the residents homes.

Overall, the residents privacy and dignity was respected by staff. The staff enabled residents to live as independently as possible and their homes not entered unless the residents gave permission. This was confirmed by the residents and families in the questionnaires submitted as part of the inspection.

There were many kind and respectful interactions observed by inspectors. For example, residents were observed to be gently reminded by staff about managing their personal finances and when taking medication. The staff were observed to patiently wait for the residents to explain what they needed. All of the bedrooms in the three units were provided with locks along with the bathroom and shower rooms, and blinds and curtains on all bedroom windows. However, the staff office was shared with staff in a day centre, and some interactions and discussions between staff and residents observed by inspectors in the office may compromise the residents privacy. This was discussed with the person in charge who acknowledged improvements were required and she described the proposed plans in place to build a new office in the centre.

The residents civil and political rights were respected. Staff confirmed that residents polling cards were provided before each election. The person in charge informed inspectors polling cards were delivered to the centre before each election.

There was a policy and procedure for the management of residents monies by staff and a procedure on personal possessions. All of the residents had their own bank account and post office account and the majority of the residents were fully responsible for managing their own monies. Inspectors were told that one resident needed some staff support on a day to day basis. This was reviewed, it was evident there were clear, concise records and receipts in place to reflect the individuals outgoing and incoming cash. It was noted there was only one signature provided. The staff said the resident witnesses each transaction but rarely signs themselves. This had been observed earlier also by inspectors. Safe and secure storage was available.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found the person in charge ensured the communication support needs of residents were met.

The residents in the centre were all able to communicate verbally, and did not require assistive technologies or communication aids to promote their full capabilities. Staff were aware of the communication needs of residents. While inspectors were informed there were individual communication passports for the residents, these were not located in their personal plans. Inspectors were informed at the end of the inspection they were located in another file. Therefore the information was not fully accessible if require.

The centre was part of the local community, and residents had access to radio, television, internet, and information on local events. The residents participated in local services, going to the local public houses, undertaking courses in local colleges, pursuing interests in courses in the areas, voluntary work in the local church and purchasing groceries. There were links with the neighborhood, and all of the residents were independent to use public transport to get to work, the shops, restaurants, and visit family or friends in the area.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors were satisfied that residents were supported to develop and maintain personal relationships and links with the wider community, and families were fully encouraged to be involved in the lives of residents.

Inspectors spoke to residents who told them that their family members were free to visit them any time. Inspectors spent time in each of the three units of the centre. There was access to private areas in each apartment for visits. Residents went home regularly and also went on holidays with their loved ones. For example, one resident interviewed travels to Spain to visit a family member up to four times a year, another resident went home every Friday and Sunday. The staff kept a record of contact made with the

residents family members in the care plans.

Additionally inspectors were informed by the residents that they were involved in the community and were supported by staff to be very independent in all aspects of their lives. All residents did their own weekly food shopping, collected their own medications from the pharmacy and withdrew their own monies from their local bank or post office. Residents took part in a wide range of activities in the community including art classes, voluntary and advocacy groups, and day services. One resident showed the inspector pictures of a recent art exhibition that she has organised to sell some of her paintings. During the inspection residents were observed cooking their own evening meal and spoke to inspectors about the many activities they were involved with in the community.

Judgment:
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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found each resident had an agreed, written contract of the service they were provided with, and there was an admissions policy, however, improvements were required in these areas.

Each resident had a written agreement of the provision of services. A sample of contracts of care reviewed were signed by the residents and the manager of the service. While the contract outlined the services to be provided and the fees to be charged, it did not outline items or services that would incur an additional cost to the resident, for example, assistive equipment or technologies.

There were policies in place for admitting and the discharge of residents. Inspectors were told there been no admissions or discharges of residents in a number of years. However, the policy did not reflect the service provided or provide sufficient guidance for staff. For example, the service had no staff support from 8pm till 10am most days, yet the policy did not outline the type of resident who filled the criteria for this type of service and the type of assessment to be carried out. The Statement of Purpose also did not clearly describe the admissions criteria, as outlined in Outcome 13.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found the resident's wellbeing was maintained by a good standard of care and support. However, the development of personal plans for each resident required improvement, along with the review of the plans in consultation with the residents.

Inspectors found the residents' welfare and wellbeing was maintained by a good standard of care and support by staff who were familiar with their social and health care needs. The residents had a mild disability. While the residents required minimal staff input, due to the changing needs of some of the residents it was apparent additional staff support and assistance was required at certain times of the day.

Inspectors read three residents' personal plans. A comprehensive assessment of residents health, emotional, safety and support needs was carried out annually. It was called a "personal wellbeing supports assessment tool" and informed the personal care plans for each that resident. There was a key worker allocated to each resident who supported them and created their personal plans.

The personal plans developed for each resident included their social, health and mental health goals. However, the plans for residents social care needs did not reflect the many interesting things the residents did in their lives (see outcomes 3 and 10 in the report). For example, the plans were not comprehensive, holistic and did not provide for positive outcomes in their lives. One residents goals were a list of tasks to be carried out such as attending the optician, buying a new mattress and intimate care. Apart from completing these tasks, it was not evident how these were having a positive outcome of their lives. The reviews did not include a meaningful assessment to assess how the goals were impacting positively on the residents lives.

While residents told inspectors about their lives and they were aware of files kept for them, there was inconsistent evidence that the residents were involved in or consulted

with in the creation of the personal plans. An annual meeting took place with the resident's which their family or representative were invited to attend however, it was not clear how the residents feedback was considered as part of the review. From discussions with staff on the personal plans it appears they had not been provided with training to develop the goals on the social aspect of residents lives. The plans were not in an accessible format for the residents.

Inspectors read the care plans developed where a health care need was identified. However, the care plans would not fully direct staff on how to care for the resident. For example, the management of epilepsy, crohns disease, behaviours that challenge and certain mental health issues. Furthermore some pertinent information of residents health care needs was not stored in their file and was therefore inaccessible to staff.

The provider and person in charge supported the residents to do interesting things to do during the day that was reflective of their assessed needs. All of the residents had their own itinerary and chose how they spent their day. Inspectors spoke to some of the residents who described their daily activities. For example, residents went to work, attended day service, undertook courses in local colleges, did voluntary work. Many of the residents had interests they pursued, and one residents told inspectors about her art classes, and an exhibition she had taken part in. However, due to residents changing needs improvements were required to support residents who preferred to stay at home during the day. For example, some residents required regular routines and staff interactions to manage and support their mental health issues. This is discussed in more detail in Outcome 17.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found the design and layout the designated centre met the residents needs and the requirements of the Regulations. An area of improvement regarding accessibility to one unit was identified. The centre consists of three units, which are on the same grounds and have a shared gated entrance. The three units are located in an urban residential area close to the city centre. There are good public transport links with a bus

stop close to the centre.

Unit 1:

The unit is a first floor two bedroom apartment. It has an occupancy for two residents. The entrance opens into a wide stair well. There are two bedrooms at the top of the stairs. The two residents who lived in the unit invited the inspectors to visit their bedroom. Both of the bedrooms were provided with double beds, and there was adequate space and storage for clothing/personal possessions. There is an ensuite shower room with toilet and wash hand basin in both bedrooms. A large open plan kitchen-dining-living room with large windows provided lots of natural light. Storage for equipment is provided. The unit is homely and tastefully finished, with many personal possessions and photos of the residents on display. There is a separate staircase to a paved garden area on the ground floor. There is no lift provided. The residents reported to inspectors they are finding it more difficult getting up and down the stairs and would like to move to accommodation on the ground floor. The person in charge outlined long term plans to inspectors about future planned changes to the layout of the centre which would provide for ground floor accommodation for the two residents. However, in the meantime the staircase had not been risk assessed for potential hazards and residents had yet to be a professionally assessed in the the use the staircase (see outcome 7 for more details).

Unit 2:

The unit is a one story three bedroom house, with an occupancy for three residents. There is a large entrance area provided, with store rooms and a ground floor toilet. There are three bedrooms located off the entrance area. The bedrooms are provided with an en-suite shower, toilet and wash hand basin. Two residents in the house gave inspectors permission to visit their bedrooms There is adequate space and storage for clothing and personal possessions. There is a large kitchen-dining with direct access to a paved shared garden area. A large sitting room is located off the kitchen. There are large patio doors providing natural light. The unit is very tastefully finished, with tiled and carpeted flooring.

Unit 3:

This is a ground floor one bedroom apartment, with an occupancy for one person. There is a small entrance area into the apartment. There is a double bedroom off the entrance hall. Off the hallway is a compact open plan kitchen-dining-living area, with windows providing natural light. A shower room with toilet and wash hand basin provided. There is storage for equipment and personal possessions is provided. The unit is nicely decorated. Inspectors met the resident who lives in the apartment. He showed them some furniture they had purchased for the sitting room. There were many personal possessions and photos belonging to the resident in the room. A small paved garden was located directly off the apartment. It was maintained to a good standard of repair.

The centre was maintained to a good standard cleanliness and hygiene. Inspectors were informed both staff and the residents carry out the cleaning procedures. There was suitable cleaning equipment provided. The resident in the three units had also chosen to

have a cleaner visit the house every two weeks to do general cleaning.

Judgment:
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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found the provider had put measures in place to ensure the health and safety of residents, staff and visitors to the designated centre was promoted and protected. However, improvements were required in relation to aspects of fire safety and the identification and assessment of risk in the centre.

Inspectors reviewed the systems in place for the management of fire safety, and in particular the procedures at night time. As previously reported, there were no staff rostered to work in the centre after 8pm at night time. The residents had been identified as independent and required no support in the night-time. Inspectors spoke to staff who were knowledgeable of the fire prevention and evacuation procedures in place. All staff had received training in fire prevention and the use of extinguishers. The residents were also familiar with the fire evacuation procedures at night time. They told inspectors they would leave the house if the alarm went off and they had participated in fire drills.

Each resident had a pendant alarm that connected to a security company. Once activated the company would start contacting each named designated person. These persons would be contacted by the security company to alert them. There was an on call nurse who would also be contacted in the event of an emergency. There were risk assessments on fire evacuation procedures for each resident. They had been reviewed in March 2015 for each resident. However, the specific fire safety procedures in place at night time were not clearly described.

The person in charge completed regular fire drills in the centre. There have been four drills completed so far in 2015, including a night time drill that staff returned after hours to complete. Inspectors read the drill records that listed the residents and staff present and the length of time of the drill. However, the outcome or problems encountered during the drill were not reported. The staff completed daily, weekly, monthly and quarterly checks of safety equipment and alarms and exits.

Records read confirmed that extinguishers were serviced annually. However, the fire alarm and emergency lighting were not regularly serviced every three months. For

example, the records indicated the equipment was serviced once a year. This was discussed with the person in charge and the service manager who undertook to address the matter.

There were suitable containment systems in place, with fire doors provided on all doors of the three units. Fire orders were displayed prominently throughout the centre. An emergency bag was also provided for the residents that included a torch.

A risk management policy was reviewed by inspectors. However, it did not fully meet the requirements of the Regulations. For example, risks specified in the Regulations were not referred to in the policy such as the risk of self harm, abuse, accidental injury. Inspectors reviewed a risk register for the centre, that included individual risk assessments of residents and environmental risk assessment. However, inspectors found areas of risk that had not been identified or assessed. For example, the staircase in the first floor apartment and residents at risk of falls in this unit (see outcome 6). In addition, the risk assessment of residents self medicated was not comprehensively reviewed on a regular basis and individual controls were not in place for each resident. This is discussed in outcome 12.

There were improvements identified in the overall learning from incidents and accidents. Inspectors reviewed the electronic incident report documents that had been printed off. Incidents that occurred in the centre were mainly falls resulting in minor or no injuries and behaviours that challenge. However, there was no evidence of action taken to minimize the risk of re-occurrence. For example, one resident had fallen recently, and their care plan had not been updated to include any additional measures in place to prevent future falls or any further action required to be carried out by the staff. There was no system of escalating risks for further review. Also, the improvement and learning from medication errors was not documented.

There were health and safety policies in place, and a safety statement dated June 2014 was seen by inspectors. An emergency evacuation plan in place. Staff were familiar with it and the alternative accommodation an evacuation was required. There were infection control procedures in place, and guidelines for the staff.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found systems were in place to protect residents from being harmed or suffering abuse and the management of responsive behaviours. Overall this outcome was compliant, with an area of improvement in the management of responsive behaviours being action in Outcome 5.

There had been no allegations of abuse reported in the centre. While the person in charge and senior staff were clear of what constituted abuse, they gave differing accounts how they would respond to an allegations of abuse. For example, the reporting procedures regarding the designated person. This was discussed with the service manager, who said this would be addressed. Inspectors were later shown a five point summary of the reporting procedures already in place and these would be displayed and discussed with all staff.

The person in charge was supported by the service manager in the event of an allegation of abuse being made. The service manager was familiar with the procedures to follow if an investigation into an allegation of abuse was required. As reported above there was a designated person in the organisation to oversee investigations into an allegations of abuse.

Records read confirmed all staff had received training in the protection of vulnerable adults, with regular training taking place. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place, although as outlined above improvement was required. Inspectors spoke to residents who told them they felt safe in the centre and could talk to the staff if they had any worries.

Each resident had an intimate care plan that was incorporated into their personal plans. The plans provided clear guidance and reflected the residents' wishes.

There were systems in place to support residents responsive behaviours. Inspectors were informed there were very few residents with responsive behaviours in the centre. There was a policy relating to positive behaviour supports. However, the behaviour support plans for two residents required improvement. For example, one plan did not provide sufficient direction for staff, the action to take if there were no improvements in the residents behaviours and if the current arrangements were ineffective. The residents mental health needs were not reflected in the support plan. The support plan for another resident was reviewed. However, it was not implemented in practice by staff. For example, the residents low mood needed to be monitored and a mood chart was to be maintained however, none was completed by staff. This is actioned in outcome 5.

As reported earlier, there was very good access to an internal psychology and psychiatry services, with letters and minutes on residents files of the regular input from these departments.The plans were developed by an internal psychology team, whom residents were referred to after incidents of responsive behaviours.

There were no restrictive practices carried out in the centre. The person in charge and service manager were aware of the National Policy "Towards a Restraint Free Environment". There was an organisation policy that provided guidance to staff.

Judgment:
Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that the person in charge and staff had maintained records of all accidents and incidents that had occurred in the centre.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date and to the knowledge of inspectors, all relevant incidents had been notified to the Chief Inspector by the person in charge.

Judgment:
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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors were satisfied that each resident had opportunities for new experiences, social participation, and employment was facilitated and supported.

There was a policy on access to education and training. This committed to all residents being supported to engage in learning opportunities.

Records reviewed, and discussions held with residents and staff, confirmed residents had a variety of opportunities to engage. Each resident was involved in a range of activities. Inspectors read information, which was confirmed by residents and the staff, that residents had access to a range of different day services, attending groups, classes, and attending day service.

Inspectors spoke with the some residents about these activities and all reported they enjoyed their options and routines. For example, some residents were employed in local businesses. One resident told the inspector about his job that he went to every day. Another resident was working a few days a week and doing a course in a local college on other days. For other residents they were in the process of considering more longer term opportunities. For example, retirement and cutting back on the number of days per week in day service. One resident told inspectors she had worked but was enjoying going to college now. She also pursue voluntary wok in two centres during the week.

Staff informed inspectors that some residents visited family, had visitors in their homes, had parties, and attend shows and events in local entertainment venues. This was confirmed by the residents who told inspectors they regular saw their family. The comments in the questionnaires submitted by the families also reiterated that the residents met them regularly.

The residents were central to how their day went and what new directions they chose to take. Each resident had a key workers who supported the residents to identify and the goals they wanted to achieve and how they were going to organise completing them.

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:
Inspectors found residents were supported to achieve and enjoy the best possible health. While this outcome was compliant, an the completion of care plans for the residents health care needs required improvement.

Inspectors reviewed resident files and found residents had access to medical and allied health care professionals. These included, but were not limited to, a general practitioner (GP) of their choice. The residents decided along with staff support when they needed to attend the GP. There was also a full time medical officer available within the organisation.

There was access to a range of allied health professionals that included, optician dentist, occupational therapist, dietitian, dentist, psychiatrist and physiotherapist. The files indicated that access to these services was timely, and residents were facilitated by staff to receive any recommended treatments.

The residents required a minimal to moderate level of clinical input. Some residents had a range of identified health care needs that required nursing input in the administration of medications, and completion of health care plans. While the staff were observant and responsive to any changes in the health care status of the residents, there was a need for a more permanent level of supervision of clinical care. For example, one resident needed support with specific medications that may only be administered by a nurse. There was a nurse vacancy in the centre, with support coming from a nurse based in a day service on the grounds the centre during the week, and a public health nurse on bank holidays and weekends. There was clinical nurse manager on call in the evening times also.This was discussed with the person in charge, who was acknowledged there was a deficit and a clinical need and was actively recruiting a new nurse. This is discussed under Outcome 18.

There were practices in the identification and assessment of the residents health care needs, and care plans were developed where a need was identified. However, the care plans did not consistently guide staff practice. For example, the epilepsy care plan for one resident did not outline the procedures to follow in the event of a seizure at night time; and a care plan for a resident with deep vein thrombosis was not comprehensive to guide staff practice. This is discussed in Outcome 5.

Where residents were currently undergoing medical treatments or tests these were noted in the residents files for follow up and staff were aware of any particular current needs. Residents were seen to be actively encouraged to make healthy living choices during the inspection and to take responsibility for their own health and medical needs.

All of the residents in the centre were skilled to prepare their own meals. One resident told inspectors about the meals she made and how much she enjoyed cooking. There were good practices in place to support residents to make healthy living choices around food. The residents all chose what foodstuffs they wished to purchase each week and with staff support would go to the shops for groceries. The residents were encouraged to choose food that were nutritious and wholesome. One resident told inspectors about a nutrition course he was attending.

The staff supported some residents during preparation. Inspectors spoke to residents who told them about the types of meals they made. During the inspection inspectors were also offered cups of coffee by residents. In one house residents prepared dinner while talking to the residents. In each unit, the kitchen presses and fridges were well

stocked with plenty of fresh food.

Judgment:
Compliant

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found there were medication management policies and procedures in place protect residents However, the procedures for the assessment of residents who self administer medications required improvement.

All of the residents in the centre self administered their own medications, and one resident received staff support. Inspectors reviewed the procedures in place for the self administration of medications, however, they were not implemented in practice. For example, risk assessments were not completed every three months and individual guidelines were not developed for each of the residents. The risk assessment tool used to assess residents was not meaningful or comprehensive. For example, it did not guide staff practice to identify any possible risks associated with self administration. Inspectors were also informed one resident had told staff he did not want to administer his own medications, yet his fears and existing controls in place were not regularly assessed to ensure he was safe. Furthermore there had been no assessment of each residents capacity to self administer medications, as required by the regulations. This was discussed with staff and the person in charge during the inspection.

The staff supporting the resident to manage their own medications completed his administration and prescription sheets each day. The staff would also complete these for the other residents when they confirmed with staff them that they had taken their medications. There was evidence that residents prescriptions were reviewed every three months by their GP.

The staff completed weekly audits of the residents practices. However, there was no review or analysis of the procedures in place for the residents who self administered medications in the centre. The staff had also completed training in the safe administration of medications.

There was evidence of recording of medication errors. However, as outlined under Outcome 7 (Health and Safety), there was no evidence of an investigation carried out to

ascertain the cause of the error, and what learning or improvement had been brought about.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that the Statement of Purpose did not fully meet the requirements of the regulations. For example, it did not fully describe all of the units in the designated centre, the layout of each unit and the room sizes were not included.

The information in the Statement of Purpose did not fully reflect the service carried out for example, admissions criteria, the organisation chart and consultation with the residents.

Feedback was provided to the management team on the deficits in this document.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:
The designated centre is part of a larger organisation with a clearly defined management structure which identifies the lines of authority and accountability in the centre. Overall, inspectors found that governance arrangements were satisfactory with some improvements required.

The person in charge of the designated centre was suitably experienced and qualified. The staff rosters reviewed indicated the days the person in charge was present in the centre. The person in charge also oversaw the management of another service within the organisation. It meant she was not fully available to the centre. However, she explained to inspectors that she based herself in the centre every second week and was available over the phone and may visit the centre at any time if required. This was confirmed by staff who felt supported by her.

While inspectors noted that residents were familiar with the person in charge and they had an easy rapport with each other, as the person in charge was covering two different services this may impact on the staff's ability to be manage issues around the residents health and social care needs, as evidenced in outcomes 1 (residents rights), 5 (social care needs), 11 (health care needs) and 12 (medication management). The governance arrangements in the centre in absence of the person in charge and the senior care staff were not clear. This was discussed with the person in charge who also acknowledged she was relatively new to the role of person in charge and covering another service which may impact on this.

There was a senior management team that oversee the designated centre, with clear lines of authority. It consists of the provider nominee, service manager and the person in charge. The provider nominee is engaged full-time as the eastern regional manager in the organisation. He was not met at this time, however, he had been interviewed at inspections of other designated centres in the organisation. Inspectors did meet the service manager who was suitably qualified, experienced and knowledgeable of the residents social and health care needs. The residents in turn were familiar with her. She was seen to be very involved in the direction of care practices. She regularly met the person in charge at centre meetings, along with meetings of managers of other designated centres that she oversaw.

A number of processes were used to monitor and oversee the safety and quality of care. These included the undertaking unannounced audits in the designated centre from which actions were identified and monitored for compliance. These were carried out by the service manager for a range of areas such as health and safety, medication management, resident's records and the environment. Two audits had been carried out in February and September 2015. A health and safety audit had also been carried out, and issues identified were followed up and actioned.

Inspectors reviewed a comprehensive annual report. It had been completed in conjunction with feedback from staff, residents and their families. Overall, it was clear the residents and their families were clear on the management structure, reporting systems and areas of responsibility. As outlined in outcome 1, where issues had been

raised in in the annual report it was not evident what follow up action had been taken. The service manager assured inspectors that this had been followed up but would ensure documentation would reflect this in the future.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
This outcome was compliant in so far as the provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The provider nominee had appropriate contingency plans in place to manage any such absence through the availability of a senior health care worker. However, as reported in Outcome 14, the day to day cover in the absence of the person in charge was not clear and required clarification.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found there were sufficient resources available to meet the needs of

residents however, they were not deployed effectively throughout the centre to ensure there was sufficient support for the residents within the units.

Inspectors found the resources for the centre were not effectively deployed to support residents individual needs, particularly in the morning times. For example, staff worked a shift pattern that started at 10am (Monday to Friday) and 8 am (Saturday and Sunday) and ended at 8pm in the evening. Inspectors spoke to residents who reported they needed support with exercises and specialist footwear every morning. As there was not staff available till 10am each day they had to wait until they started work, and then they may be busy with other residents. This had been raised by residents in reports and complaints read but had not been suitably addressed.

In residents care plans it was reported that some residents with mental health and behavioural issues required additional staff support in order to implement their personal plans. For example, one resident needs staff supports as they will spend time alone and need support to engage in activities. In another care plan, it was reported that a resident enjoyed frequent staff contact as it elevated his mood.

Overall, comments read in questionnaires submitted as part of the inspection were generally positive and very complementary of the service provided. However, some comments read included "residents needs were increasing and there is a greater call on staff to provide essential input" and " it would be great benefit if a little more one to one support could be given". This was discussed with the person in charge and the service manager during feedback at the end of the inspection.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found there were experienced staff to meet the assessed needs of the residents at the time of the inspection. However, improvements were required in relation to staffing levels and skill mix at times of the day in the centre.

The staff in the centre were appropriately qualified and there was a suitable skill level to meet the needs of the residents. Staff were knowledgeable of the residents and their needs, were friendly and patient with the residents and had a good relationship with them and their families. Inspectors found staff endeavoured they were knowledgeable of policies and procedure, which were available to them in the centre. Although additional support was needed as outlined in outcome 18.

As reported in outcome 16, staff were not rostered between 8pm and 10am Monday to Friday (8pm to 8am Saturday and Sunday). While the person in charge said there was cover available, it was only provided in the morning time, from staff of the day service located on the grounds. There was a vacancy for a nurse for the centre. It was apparent residents needs were changing and the support of nursing staff was required. The service manager stated they were actively recruiting a nurse for the vacant role.

Inspectors were satisfied a recruitment policy was in place and it was being followed in practice. Personnel files reviewed at this inspection met the requirements of Schedule 2 of the Regulations. There was a service level agreement giving assurance of the qualification and vetting of agency staff.

The centre did use volunteers, and An Garda Síochana vetting and references as required by the Regulations were in place. It was noted that external service providers who provided additional support had no such confirmation of vetting or references. The service manager assured inspectors that this would be addressed.

There was a policy on staff supervision and formal arrangements for one-on-one supervision meetings were in place. These were read by inspectors during the inspection.

Inspectors reviewed a sample of training records for the centre. The person in charge ensured all staff in the centre were provide with access to mandatory training including fire and protection of vulnerable adults. The staff had completed training in other areas such as manual handling, first aid, and the safe administration of medication. However, training in the completion of social care plans had not been provided, as outlined in outcome 5.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that records were accurate, up-to-date, maintained securely and easily retrievable. An area of improvement regarding the review and implementation of policies was identified.

The provider had ensured the designated centre had most of the written operational policies as required by Schedule 5 of the Regulations. However, the policy on the prevention of abuse did not reflect the Safeguarding Vulnerable Persons at Risk of Abuse HSE National policy and procedures, December 2014. Inspectors also found some policies were not being implemented fully in practice. For example, the medication management policy (as discussed in outcome 12). The policy on the management of complaints was not implemented in practice as outlined in outcome 1. While staff were aware of these policies, they were not consistently reflected in practice.

Inspectors reviewed the records listed in Schedules 2, 3 and 4 of the Regulations which were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

Inspector read the residents' guide and found it described the terms and conditions in respect of the accommodation provided and included a summary of the complaints procedure. There was directory of residents was up-to-date for each resident that contained the information to be maintained as required by Regulations.

An up-to-date insurance policy was in place for the centre which included cover for resident's personal property and accident and injury to residents in compliance with all the requirements of the Regulations.

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:

Deirdre Byrne
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 report[1]

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002395
Date of Inspection:	22 & 23 September 2015
Date of response:	03 November 2015

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:
There were infrequent house meetings with residents on how their centre was organised.

There was no evidence of feedback to residents on action taken after the meetings.

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

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
The PIC will establish a system for weekly house meetings, and will follow up at each meeting, on all items raised by the residents at the previous meeting.
The minutes of these meetings will be retained and available for inspection.

Proposed Timescale: 30/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no information on advocacy services displayed for the residents.

2. Action Required:
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

Please state the actions you have taken or are planning to take:
The PIC will source information regarding the National Advocacy Service, and will discuss this with residents at the house meetings.

The PIC will ensure that all residents have access to information on advocacy, by displaying this information prominently on the notice-boards of each house \ apartment.

A representative from the National Advocacy Service will meet with staff and residents in the designated Centre on October 22nd 2015.

Proposed Timescale: 22/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no private space for staff and residents to discuss personal matters.

3. Action Required:
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:
(Part 1.)The PIC will establish a system for keyworkers to meet privately with residents,

weekly, to address personal matters commencing on October 30th 2015.

(Part 2.) The PIC and provider nominee will develop an office space in the designated centre so that residents will have a private space to meet staff as the need arises.
An initial meeting was held on October 21st, with the PIC, the service-manager, and the buildings manager, during which the layout of 107b was discussed, and options for developing an office space were considered.

St. Michael's House has engaged the services of an architect, who will submit initial plans to the buildings manager by October 30th 2015.

The plans will be finalised and costed by November 13th.

The plans will be submitted to the Registered Provider by November 16th for consideration.

A consultation process will take place with residents and their Families by November 30th. This will be conducted by the PIC and Service-Manager.

The plans will be available for inspection.

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistent evidence that all complaints were promptly investigated.

4. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
The PIC and Service manager will review all complaints made by residents and family members and will identify complaints which were not managed in line with the policy. The PIC and Service Manager will ensure that these complaints are fully investigated and that records of the investigation and the outcome are recorded using the complaints management form.

Proposed Timescale: 09/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that complainants were informed of the outcome of the

investigation into their complaint.

5. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
The PIC and Service manager will review all complaints made by residents and family members and will identify when complainants were not informed of the outcome of their complaint. The PIC will meet individually with each complainant and inform them on the outcome of their complaint. This will be recorded on the Complaints Management Form and will be available for review in the designated centre.

Proposed Timescale: 09/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where improvements were required following a complaint it was not evident action had been taken.

6. Action Required:
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The PIC and Service Manager will review all complaints and identify what actions have been taken to address complaints and record these on the complaints management form. They will also identify additional actions that are required to be taken and develop an action plan to address these. This will be recorded on the complaints management form.

Proposed Timescale: 09/11/2015

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:
The admissions process for the centre did not provide sufficient information or guide practice.

7. 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 Provider Nominee and PIC will review the admissions policy and process for the designated centre and will update the Admissions Policy as required. The updated admissions policy will include criteria for admission as outlined in the Statement of Purpose and will highlight the staffing arrangements for the centre. The updated policy will be available in the designated centre for review.

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contact of care did not include an outline of assistive equipment or technologies that would incur extra costs on the residents

8. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The PIC will update the contracts of care to ensure that they include all extra costs that might be incurred by service users. The updated contracts of care will be signed and filed in each persons personal file and will be available for review.

Proposed Timescale: 30/11/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were reviewed without the involvement of the resident.

9. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
The PIC and the Service-Manager will devise and commence a system, by November

6th 2015 whereby all aspects of Residents' personal plans are discussed with them before, during and following the completion of the plan. These plans will be reviewed with the residents, at least annually, and will be available for inspection.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of each plan did not assess their effectiveness and how they impacted on the residents life.

10. 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:
Commencing on November 9th 2015 the PIC and Service Manager will devise and implement a plan whereby all personal and social goals are discussed and agreed with individual residents, that the progression and attainment of all goals is documented, and that the resident's experience of this is recorded throughout the process.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not holistic and focused on limited aspects of the residents life.

11. 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:
Commencing on November 9th 2015 the PIC will review all personal plans to ensure that each plan is holistic and takes into account all identified physical, emotional, social, and health care needs. The review will ensure that the supports necessary to maximize the residents personal development are identified.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not in an accessible format for the residents.

12. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
Commencing on November 6th 2015 the PIC will meet with each resident to discuss with them, the format of their personal plans. The PIC will ensure that the format of each plan is accessible to the person to whom it pertains, and where appropriate, their family members.

Proposed Timescale: 30/03/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include all the information required by Regulations 26 (1)

13. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
A copy of the St. Michael's House Risk Management Policy, which includes all the information required by Regulations 26 (1) is in place in the centre and has been forwarded to the inspector. This is a new policy which was implemented in April 2015.

Proposed Timescale: 23/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas of risk in the centre had not been identified or risk assessed (as outlined in the inspection report).

14. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The PIC and Service Manager will undertake a review of all risks in the Centre. Areas of risk not already identified, will be assessed, and appropriate control measures will be put in place.
The updated risk assessments and amended risk register, will be available for inspection.

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of learning and improvement following incidents occurring in the centre.

15. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The current S. Michael's House Risk Management Policy, which includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents is in place in the centre and has been forwarded to the inspector.

In line with the policy the PIC and Service Manager will review the risk register on a quarterly basis and identify any themes emerging. Controls will be put in place to address these. Furthermore they will review all incidents, adverse events and accidents for 2015, and will ensure that risk-assessments and care plans are amended and updated accordingly.

Proposed Timescale: 30/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures to be following the event of a fire at night time in the centre were not outlined in residents individual risk assessments.

16. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
The PIC and the service Manager will review and amend individual fire-risk assessments, to ensure that night-time fire procedures are fully outlined.

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of fire drills required improvement in order to review the effectiveness of fire procedures in the centre.

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

Please state the actions you have taken or are planning to take:
The documenting of fire-drills will be altered by the PIC and the Service-Manager, to ensure that all drill reports contain all relevant information. This process will be reviewed at staff meetings, and during monthly PIC \ Service-Manager support meetings.

The minutes of these meetings will be available for inspection.

Proposed Timescale: 30/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The frequency of servicing the fire alarm system and emergency lighting required review.

18. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
The regularity of fire alarm servicing has been reviewed. Plans are in place to introduce quarterly check as required by the regulations.

Proposed Timescale: 02/01/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The systems in place to risk assess and assess the capacity of residents who self administered medications required review.

19. 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:
The PIC, with support from the Health and Medical Trainer will assess each person's capacity to self administer medication. For the residents assessed as having the capacity to self administer medication, an individualised risk assessment and medication administration plan will be developed and implemented. These will be filled in each person's personal file. The risk assessment and plan will be reviewed every three months.

Proposed Timescale: 20/12/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose did include the information required by Schedule 1.

The information in the Statement of Purpose did not fully reflect the service provided.

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

Please state the actions you have taken or are planning to take:
The Provider Nominee has updated the Statement of Purpose to reflect the service provided and to ensure that it includes all information as required in Schedule 1. A copy of the updated statement of purpose has been submitted to the Authority and is available for review in the designated centre.

Proposed Timescale: 09/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance arrangements for when the person in charge is working in away from the designated centre required review.

21. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
Commencing on November 1st the PIC has ensured that a minimum of 50% of her working hours each week are assigned to the designated centre. The Provider Nominee with support from the PIC and service manager will further review the arrangements for when the person in charge is working away from the designated centre. The purpose of the review is to consider how governance arrangements can be strengthened when the PIC is working away from the centre.

Proposed Timescale: 11/12/2015

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 centre was not adequately resourced at certain times of the day to ensure residents personal plans were implemented.

22. 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:
The PIC and Provider Nominee will review the staff roster arrangements to identify times when additional support is required in the designated centre to ensure residents personal plans are implemented. The roster will be updated to provide supports as identified in the review. Minutes of the review will be available for inspection in the

centre as will the updated roster.

Proposed Timescale: 11/12/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of staff in the centre in the morning time required improvement.

The staff skill mix in the centre required review.

23. 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:
The PIC and Provider Nominee will review the staff roster arrangements to ensure sufficient staff are rostered in the morning time to ensure residents needs are met. The roster will be updated to provide supports as identified in the review. Minutes of the review will be available for inspection in the centre as will the updated roster.

The provider nominee is actively trying to recruit a nurse to fill a part time nursing vacancy in the centre. As soon as a nurse is recruited the PIC and Service-Manager will identify times when a nurse is required, and the staff roster will provide evidence of the effective deployment of these nursing hours.

A risk assessment will be carried out and additional control measures will be implemented while the recruitment process is proceeding.

Proposed Timescale: 11/12/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the policies for the centre were not fully implemented in practice for example, the medication and complaints policy.

24. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care

and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Provider nominee will ensure that all policies are implemented in full in the designated centre. The Provider will provide additional support and coaching for the PIC and staff team on implementing the Medication Administration Policy. This will be scheduled for a staff meeting and minutes of the meeting will be available for review. The PIC will receive one to one mentoring on the implementation of the complaints policy from one of the policy authors. Evidence of this will be recorded in the centre diary and will be available for review.

Proposed Timescale: 04/11/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the prevention of abuse did not reflect the HSE National policy and procedures.

25. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
The Provider Nominee has discussed the Safeguarding Policy with the designated person for the organisation. This policy will be updated to bring it in line with the HSE National Safeguarding Policy. When the policy is updated it will be available for review in the designated centre.

Proposed Timescale: 30/03/2016