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:	Seanna Cill
Centre ID:	OSV-0002356
Centre county:	Dublin 5
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Michael Farrell
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:
30 May 2017 10:30	30 May 2017 20:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of 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 four residents and spoke with two residents, three staff members and the person in charge. 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. One resident informed the inspector "I like living here, I can come and go as I want" and another resident informed the inspector "I am happy here."

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 05. 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 disabilities. The level of support required was a low to a high level of support, as outlined in the statement of purpose. The centre consisted of a seven bedroom house, six bedrooms were used by residents and one was used by sleep over staff members.

Overall judgments of our findings:
Eight outcomes were inspected against, three outcomes were found to be in full compliance and two outcomes were found to be substantially compliant. Three outcomes were found to be moderately non-compliant. Areas of improvement included, fire management, healthcare management and safeguarding and safety.

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 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):
No actions were required from the previous inspection.

Findings:
The inspector found residents' social care needs were maintained within this designated centre.

The inspector viewed three resident's wellbeing assessments, these incorporated both social and health assessments in eight areas. This included communication, social support, emotional wellbeing, general health, physical and intimate care support, safety, environment and rights. From these assessments an action plan was generated this was discussed at a wellbeing meeting with the resident. This resulted in the development of various support plans.

All about me documents were also completed, these had a focus on person-centred social goals, which were currently under development. The inspector viewed elements of these documents, areas included fun things I like and thing I do not like. Staff members listed items within these sections to assist in the provision of individualised person-centre social care provision. Areas included spending one-to-one time with a staff member, going shopping, attending concerts and holidays. One resident wanted to communicate with family members abroad using a visual communication system. This had been facilitated within the centre and staff members were assisting family members to use the system to enable the resident communicate with family members abroad.

Some residents also had picture based social goals, the person in charge identified this would be completed for all residents. Staff members were currently gathering photographs when residents attended football matches and music events for this project. The inspector also viewed documentation in relation to why these goals were

chosen, steps needed to achieve these goals and the progress in relation to the goals highlighted. Some residents identified this information to the inspector and for the other residents the inspector viewed the progress of goals through photographs contained within the resident's file.

The inspector found residents had opportunities to participate in meaningful activities appropriate to their interests and preferences. Two residents discussed these activities with the inspector.

Four residents attended a day service outside of the centre and one resident received their day service within the centre. The inspector was informed this was for a specific period of time as the day service was relocating. To reduce the negative effects of changing locations on two occasions the resident received this service from their home. Another resident informed the inspector that day services were not their "cup of tea". The resident explained to the inspector why they would not like to attend such a service. Instead alternative community based classes were of interest and staff were assisting the resident to source these.

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):
No actions were required from the previous inspection.

Findings:
The centre was suitable for the number and needs of residents. Improvements were required in relation to the fire and sharp management.

Certificates and documents were present to show the fire alarm, emergency lighting and fire equipment were serviced by an external company this was dated February 2017. However, four lights were recorded as failed since February 2016. It was unclear if there was sufficient fire containment in the house, as smoke seals were not evident within internal doors.

The inspector viewed resident's had PEEP's (personal emergency evacuation plans) in place to assist staff to safely evacuate all residents. Fire drills were completed, however, it was unclear if all residents had participated in a fire drill to demonstrate safe and successful evacuations, as the names of residents were not recorded. The person in charge was unable to identify if all residents had or could evacuate the centre, from the documents present. The inspector viewed training records for eleven members of staff

and found one staff member had not received training in the area of fire.

The inspector viewed a sharps container within the centre and this was unlabelled with no tagging system in place for identification.

The centre had an organisational risk management policy in place, which included the specific risks identified in regulation 26. The centre had a risk register, which recorded a number of risks within the house and the controls in place to address these. These included areas such as, aggression and violence, self-harm and food safety.

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

The centre had a health and safety statement dated 2014. The responsibilities of the various staff members within the organisation were outlined. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The centre had an emergency evacuation plan in place in the event of a fire, flood and other emergencies.

The designated centre's vehicle or the paperwork associated with it 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. However, some improvements were required in relation to the management of restrictive practice and behaviour support plans.

The inspector viewed residents' behavioural support plans. The inspector found the documents identified both proactive and reactive strategies. Other support plans were

also developed to assist staff in the management of residents' emotional well being. The inspector found four staff members required training in the management to displays of behaviours that challenge including de-escalation and intervention techniques.

The inspector viewed evidence where environmental restrictions were applied following an incident. There was no evidence that all alternative measures were considered before a restrictive practice was put in place. The inspector also found there was no recording log in place for other environmental restrictions, such as, the locking of the kitchen door and laundry door within the centre when asked to view these documents.

The inspector identified the management of unexplained bruising sustained by residents required clarity within the centre. No guidance was available for staff members to follow should such an incident arise. The inspector viewed two recorded incidences of this within the centre, during feedback the providers representative identified unexplained bruising was to be notified to HIQA (health information and quality authority) after screening if no cause was determined. However, the inspector found one incidence where this did not occur for example, on the 09 March bruising was identified and the outcome of the screening was communicated to the person in charge on the 15 March. Due to the timeframe, this did not facilitate the person in charge to notify HIQA within the required timeframes. The inspector found this inconsistent approach and lack of guidance available within the designated centre to guide staff members could lead to inconsistent approaches being adopted by staff members in relation to this matter.

The inspector found intimate care support plans were in place for various aspects of intimate care provision for residents requiring them.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

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

The inspector viewed three residents' assessments these incorporated both social and health assessments in eight areas. 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 developed.

The inspector found, some healthcare conditions were not identified within the assessment, despite a support plan in place for the condition. The inspector also identified some conditions were identified within the assessment, however, no support plan was present in relation to the specific healthcare need. For example, a support plan was in place in relation to sleep hygiene, however, the person in charge identified this was not an area that the resident required support in. The inspector also spoke with the resident who stated they had no difficulty in sleeping. The inspector viewed a pain management support plan this outlined various approaches staff were to undertake to establish care provision. However, the resident could articulate to members of staff the type and location of pain they were experiencing. This was identified and discussed with the person in charge on the day of inspection.

The inspector found the review process in place for areas identified required improvement to identify the effectiveness of the interventions implemented. The inspector did acknowledge the revised planning system had commenced and was at the initial stages of completion.

The inspector viewed some epilepsy plans in place and improvements were required in relation the process staff members were to follow. Various documents within the same file contained conflicting information for when staff members were to call an ambulance.

Residents had access to a G.P. (general practitioner), including phlebotomy tests as required for some residents due to medication prescribed, chiropodists and neurologists.

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. Residents participated in cooking in accordance with their own preferences. Some residents informed the inspector how they assist staff members cooking and what snacks they prepare for themselves with the assistance of staff members when required.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The medication management system within the designated centre protected residents through policies, procedures and medication practices within the centre.

The inspector found the label on one PRN medicine (a medicine only taken as the need arises) did not match the information on the resident's administration record in relation to dosage.

The inspector viewed a PRN medicine plan was in place in relation to one medication. However, this medicine was not a PRN medicine as this medicine was prescribed on a regular basis.

The inspector observed all PRN medicine prescribed was present within the designated centre. Stock records were maintained and samples of medicines were crossed checked and these were accurate on the day of inspection.

The inspector viewed administration sheets and found these contained the required information.

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

Medicine was supplied to the designated centre by a local pharmacist and medicine was recorded when received.

There was a system in place for recording, reporting errors and reviewing medicine within the system these were discussed at team meeting to ensure learning from these incidents to mitigate the risk of future reoccurrences.

One resident clearly outlined the rationale for taking the medicine they were prescribed.

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:
Overall, the inspector found there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the quality of the service delivered.

There was an annual review of the quality and care completed in this designated centre dated December 2016.

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 one completed on the 21 November 2016 and another one was completed on the 25 May 2017. Both documents contained an action plan to address areas requiring improvement.

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. Each staff 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 relating to the designated centre health and safety issues, outcomes of audits and other information relevant to the designated centre including medication errors.

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

The person in charge also attended cluster meetings, these involved other centres within the same governance area of the service manager. The inspector viewed records of these meetings were areas discussed included organisational aspects of service provision and various reviews were discussed.

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

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
There was appropriate staff numbers and skill mix to meet the assessed needs of residents.

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

The inspector viewed a sample of three staff members supervision records on the day of inspection. This facilitated staff members to raise concerns about the quality and safety of the care and support provided to residents. Supervision records also identified staff members professional and personal responsibility to the quality and safety of care delivered.

Judgment:
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:
The inspector found the policies set out Schedule 5 were available. However, different versions of the same policy may have been present in the centre, for example, the missing persons document viewed by the inspector was dated 2011. Following the inspection the person in charge sent in a revised version dated 2017.

The directory of residents did not contain all the required information for each resident living in the centre.

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

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-0002356
Date of Inspection:	30 May 2017
Date of response:	05 August 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 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:
A sharps container within the centre this was unlabelled with no tagging system in place for identification.

1. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a

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

healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
The sharps container within the designated centre is now labelled with a tagging system in place.

Proposed Timescale: 14/07/2017

Theme: Effective Services

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

2. 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:
1 The centre has 30 minute fire doors in situ which will provide sufficient fire containment for occupants. In addition the corridor has been subcompartmented with FD30 to further ensure the protection of the means of escape for occupants.

2 The registered provider has identified improvements to be made to the doors and these have been included on an organisational fire risk register which the registered provider uses to manage actions required in a risk based manner.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of fire drills viewed did not identify if all residents had participated in a fire drill, nor could the person in charge identify this.

3. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
The PIC has created a fire drill register for the centre, that clearly identifies the residents who participate in the drills and individual response time is takes to evacuate the centre.

Proposed Timescale: 14/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One member of staff required training in the area of fire management.

4. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
The identified staff member is scheduled to attend fire management training in September 2017

Proposed Timescale: 30/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Four lights had failed each time emergency lights were tested since February 2016.

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

Please state the actions you have taken or are planning to take:
Emergency lighting has been identified for replacement for the centre and is on a replacement programme by SMH Technical Services Department

Proposed Timescale: 31/12/2017

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:
Four staff members required training in the management of displays of behaviours that challenge including de-escalation and intervention techniques.

6. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
The PIC has scheduled for the identified staff members' to commence training in Positive Behaviour Supports in September and October respectively.

Proposed Timescale: 31/10/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence to identify all alternative measures were considered before the use of a restrictive procedure was not present, to demonstrated that the the least restrictive procedure, for the shortest duration necessary, was used in relation to an environmental restriction.

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

Please state the actions you have taken or are planning to take:
The PIC will review all restrictive practices within the centre with Senior Psychologist with the aim of identify alternative measure before any restrictive procedure is used and for the shortest duration necessary.

Proposed Timescale: 30/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff members were not guided in relation to the management of unexplained bruising and time taken to complete screening did not facilitate the person in charge to notify HIQA within the specified time frame.

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

Please state the actions you have taken or are planning to take:
The organisation is currently drafting guidelines in relation to unexplained bruising in

order to guide staff as to when these unexplained bruises should be notified to the Designated Officer. It is envisaged that these guidelines will be available to all staff by the end of August 2017.

Proposed Timescale: 31/08/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some healthcare conditions were not identified within the assessment despite a support plan in place for the condition.

Other conditions were identified within the assessment, however, no support plan was present in relation to the specific healthcare need.

The review process in place for areas identified did not outline the effectiveness of the interventions implemented.

Some epilepsy plans required improvements to ensure staff members were guided consistently and effectively in care provision.

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

Please state the actions you have taken or are planning to take:
1. Support plans will be reviewed and updated reflecting the identified medical conditions of each resident based on their annual health check.

2. PIC together with individual keyworkers will complete quarterly audits of personal plans in order to assess the effectiveness of each plan and take into account any changes in circumstances and or new developments.

3. In consultation with the resident, Allied healthcare professionals and the residents representatives, a comprehensive care plan for the management of Epilepsy will been completed

Proposed Timescale: 30/09/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
The label on one PRN medicine did not match the information on the resident's administration record in relation to dosage.

A PRN medicine plan was in place in relation to one medication, however, this medication was prescribed on a regular basis not as a PRN medicine.

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

Please state the actions you have taken or are planning to take:
1. All staff have access to St Michaels Policy on safe administration of medication.

2. The PIC will ensure that the systems for monitoring the ordering, prescribing, storing, receipt, disposal and administration of medicine are in place

3. At the time of inspection, the PIC contacted the pharmacist to rectify the error. All PRN medication label matches the information on the resident's administration record sheet.

4. PRN medication support plan which was in place has now been removed as the medication is a regular medication.

Proposed Timescale: 14/07/2017

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 inspector viewed a missing persons guideline dated 2011 within the centre.

11. 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 PIC has sent on the updated missing persons protocol dated 09/01/2017 to the authority.

Proposed Timescale: 31/07/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents was not maintained up-to-date.

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

Please state the actions you have taken or are planning to take:
The PIC will update the centres directory of residents in accordance with Regulation 19 (1)

Proposed Timescale: 01/09/2017