

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Royal Oak
Centre ID:	OSV-0002361
Centre county:	Dublin 9
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:	3
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: 28 February 2017 09:30 To: 28 February 2017 20:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the 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 designated centre, met with three residents and spoke with the person in charge and three staff members. The inspector viewed documentation such as, support plans, recording logs and policies and procedures. Over the course of this inspection, residents communicated in their own preferred manner with the inspector. Residents allowed the inspector to observe their daily life in the designated centre. This included meal times and activities. The inspector spoke with three residents, one resident stated "it's the best house in the whole wide world to be in". Another resident spoke at length with the inspector in relation to current issues they were experiencing within the house and the resident

stated "I'm not happy living here I want to move out". The inspector spoke with staff members in relation to this and viewed minutes of meeting taking place in relation to sourcing alternative accommodation for this resident.

Description of the service:

This designated centre was 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 designated centre is based in Dublin 9. Three residents resided in the designated 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 adults over the age of 18 with intellectual disabilities as outlined in the statement of purpose. The designated centre consisted of two attached houses with an internal door for access, the designated centre contained five bedrooms three of these were used by residents and one was used by sleep over staff members.

Overall judgments of our findings:

Twelve outcomes were inspected against and one outcome was found to be in major non-compliance with the regulations in relation to medication management. Seven outcomes were found to be moderately non-compliant. One outcome were found to be substantially compliant with three outcomes fully compliant. Areas of improvement included, information contained within residents' files and risk management.

The person in charge facilitated the inspection for a brief period in the morning with the service manager facilitating the majority of the inspection.

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

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

The inspector viewed this outcome in relation to the non-compliances identified on the previous inspection and found the four actions had been addressed in relation to complaints and advocacy.

The inspector viewed a sample number of complaints, however, the follow through of these complaints were not available within the designated centre. The service manager provided the inspector with the outcome of these complaints on the day of inspection.

During the course of the inspection, the inspector identified some staff members spoken with were not familiar with the process of making a complaint on behalf of residents.

The inspector viewed the complaints policy and procedure in place, however, the complaints procedure did not specify a nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure all complaints were appropriately responded to and a record of all complaints maintained. The inspector was informed an individual was nominated within the organisation, however, this person also may be involved in the investigation process of some complaints.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

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

Findings:

The inspector found improvements were required in relation to residents' social plans to ensure plans reflected practice.

The inspector viewed three residents' wellbeing assessments, these included both social and healthcare assessments in eight areas. These 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. The inspector found the assessment was completed and support plans were generated. However, the wellbeing meetings had not taken place for residents in accordance with the assessment in place. The inspector viewed documents which identified wellbeing meetings dated 2014, the inspector requested the service manager to provide more recent meetings however, these were not available.

The inspector found the number of support plans generated was excessive, for example, residents had 37, 32 and 20 support plans developed. Each support plan had a goal for the resident to achieve. It was evident that many of the goals and interventions were not developmental goals and were more aimed to guide staff in addressing support requirements. For example, the goal of 'keeping money safe'. There was no information available to identify that this was a chosen area of priority and the plans identified a reliance upon staff support in this area to manage residents' monies. In addition the inspector found the majority of goals were not tracked to monitor progress and how these were impacting upon residents.

From speaking with residents the inspector acknowledged residents were assisted to participate in social activities and on the day of inspection one resident went on a day trip to an area of their choice. The resident showed the inspector where they were going via their computer prior to leaving the designated centre and discussed with the inspector why they wanted to visit the area.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspector found the designated centre was suitable for the number and needs of residents. Improvements were required in relation to the risk management system, sharps management and fire management.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company this was dated December 2016.

It was unclear if there was sufficient fire containment in each house, additionally it was noted that within the second house the cold smoke seal was no longer attached to the frame of the door. The inspector viewed a fire drills dated 20 November 2016 this demonstrated all residents safely evacuated the designated centre. Residents had PEEP's (personal emergency evacuation plans) in place to assist staff to safely evacuate all residents. However, some residents had multiple PEEP's in place with different dates. This had the potential to miss guide some staff members in the event of an emergency. The inspector viewed training records for 5 members of staff and found staff members had received training in the area of fire.

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

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

The inspector also viewed individual resident's risk assessments in place, however, these required review as some assessments viewed were dated 25 May 2014 to be reviewed in September 2014. No evidence of review was evident nor was the information contained within the assessment reflective of practice for example, locked internal doors was specified. Other individual risk assessments were dated 2015, with no evidence of review. Other areas such as, staying within the designated centre without staff was risk assessed, however, there was no identification of the duration of time the resident was safe to stay by themselves. The inspector spoke with the resident and discussed what the process would be should an emergency occur within the designated centre. The

outcome of this was discussed with the service manager and improvements were required to ensure the resident was aware of the exact process to follow should the need arise.

The designated centre had a health and safety statement. The responsibilities of the various staff members within the organisation were outlined. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as, fire, adverse weather conditions, flooding and power failure.

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:

The inspector found there were appropriate measures in place to protect residents from being harmed and to keep people safe. However, some improvements were required in relation to the management of behaviour support.

The inspector viewed residents' behavioural support plans. The inspector found the documents identified both proactive and reactive strategies, some of these plans were dated 2014. The inspector was informed these were currently under review. Other support plans were also developed to assist staff in the management of residents' emotional well being.

The inspector found the interventions contained within these documents require clarity for example, specific training was identified as a requirement for staff members and residents in June 2016, no progress had been developed since then. Other interventions identified in 2014, were not reviewed to assess if these were effective in the

management of behaviour.

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. Residents spoken with were also clear should they observe or experience aspects of service delivery in an inappropriate manner that they would report this.

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

Judgment:

Substantially Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

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

Findings:

The inspectors reviewed this outcome in relation to the non-compliances identified on the previous inspection and found the actions had been achieved.

The inspector spoke with residents and also viewed evidence within resident's files in relation to opportunities for education training development or employment in accordance with resident's preference. For example, one resident was employed on a part time basis each Saturday within the local community.

The inspector also viewed evidence of communication between resident's daycentre and the designated centre.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible

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 resident's assessments these included social and health assessments in eight areas including communication, social support, emotional wellbeing, general health, physical and interment care support, safety, environment and rights. From these assessments an action plan was developed.

The inspector also viewed other assessments dated 2014, however, the inspector was informed these were no longer current documents.

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. This was identified and discussed with the service manager on the day of inspection.

The details contained within some healthcare plans were not sufficient to guide staff members these were identified to the service manager on the day of inspection. For example, it was unclear as to the need for some support plans relating to general rights for residents such as, a support plan to allow a resident to have a nap as they wish.

The inspector also viewed guidelines in relation to orthotics use, however, the resident no longer required these interventions to be implemented. Overall the inspector found the system of healthcare plans required review to ensure staff members were guided consistently and effectively in healthcare delivery.

The inspector found the review process in place for healthcare areas required improvement to identify the effectiveness of the interventions implemented.

The inspector viewed an epilepsy plan in place this did not guide staff members in effective delivery of care in relation to seizure management as multiple versions on the plan was present with different information.

Residents had access to a G.P. (general practitioner), however, recommendations were not evident in regards to phlebotomy tests. The inspector requested staff members to identify when these were obtained, however, no record of this was maintained within the designated centre for one resident.

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.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

The inspector found the medication management system within the designated centre required significant improvement in relation to the management and administration of medication, this was also identified within the previous inspection.

Some administration sheets did not contain a photo of the resident.

Medication was present without the resident's name for whom the medication was prescribed.

Topical medication was present without an opening date.

No guidance was available for staff members in relation to the administration of PRN medicine (a medicine only taken as the need arises) for the same indications.

The inspector also viewed guidelines in relation to supporting a resident to become independent in relation to taking their own medication, this was dated 14 January 2016. However, the information contained within this guideline for staff members was not reflective of practice within the designated centre on the day of inspection.

The inspector viewed guidelines in relation to the administration of rescue medication, this was present in two different versions outlining different administration process. The inspector was informed one was outdated and the other one was the more recent version.

On the day of inspection the inspector found PRN medicine without an expiry date for

one resident.

Other PRN medication containers were empty, and for one resident no PRN medication was available. Staff members identified should the resident required such medication the resident would be administered medication from another resident's supply until the stock was replenished. Another staff member identified the PRN medication for the resident was only prescribed for a specific duration and when the stock was consumed the resident's did not require any more until the resident was reviewed by the doctor. However, the resident's prescription did not identify medication was prescribed for a specific duration, these medications were identified as a medicine only taken as the need arises, for example, when experiencing pain. The inspector met with the resident and discussed what they would do when experiencing pain and the resident identified they had their own stock of medication in their room. The inspector viewed this medication which contained two of the three medications prescribed to the resident as a PRN medication. These medications had been dispensed from the pharmacy on the 26 January 2017. Staff members did not know the resident had their own stock of medication within their room. The inspector found this system of medication management unsafe, as staff members were not aware of medication within the designated centre. The resident outlined when they would take this medication however, no assessment was evident in relation to self administration of medication.

The inspector was informed weekly stock balances were maintained, the inspector crossed checked a sample of these and found one medication contained a stock balance check dated 2015, no other more recent stock was evident within the designated centre.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. However, the inspector found this policy was not adhered to within the designated centre. Nor was the most current document available to staff members, for example, the policy displayed within the medication press was completed in 2009 and reviewed in 2014.

Medication was supplied to the designated centre by a local pharmacist.

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

Judgment:

Non Compliant - Major

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The statement of purpose did not meet the requirement of the regulations as outlined in Schedule 1.

The document did not outline the information set out in the certificate of registration.

The number and size of rooms in the house was not accurately reflected in the document.

The arrangements for residents to access education, training and employment were not included within the document.

The information in relation to the organizations policies was not accurately reflected within the 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):

No actions were required from the previous inspection.

Findings:

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

The inspector found limited auditing of areas within the designated centre combined with the level of non-compliances found during this inspection. The inspector found more effective oversight was required to ensure efficient governance and management was facilitated within this designated centre. For example, the management of

medication, risk management and complaints.

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 15 December 2016 and another one was completed on the 10 June 2016.

The person in charge was on a sleep over shift the previous night and met with the inspector briefly. The service manager and frontline staff facilitated this inspection. The person in charge was supported in their role by a service manager. The person in charge worked on a full time basis within this designated centre.

The inspector viewed minutes of team meetings within the designated centre dated for 2016 and 2017. Areas discussed included policies relating to the designated centre Health and safety and training in relation to epilepsy .

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

The person in charge also attended cluster meetings, this involved other designated centres within the same governance area of the service manager. The inspector viewed 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 discuss areas relating to the designated centre including resident's needs and staffing arrangements.

Judgment:

Non Compliant - Moderate

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

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

Findings:

The designated centre was resourced to ensure the effective delivery of care and

support in accordance with the designated centre's statement of purpose.

Since the previous inspection staff members were no longer required to provide support to other residents in another location.

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):

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

Findings:

The inspector found there was appropriate staff numbers and skill mix to meet the assessed needs of residents.

The inspector found the actions from the previous inspection had been achieved.

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

The inspector was unable to view staff supervision records on the day of inspection, this was forwarded into the inspector following inspection for three member of staff.

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)

Theme:

Use of Information

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

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

Findings:

The inspector reviewed this outcome in relation to the non-compliances identified on the previous inspection and found some of the action remained outstanding.

The inspector found some Schedule 5 policies were present in the designated centre were not the current policies used by the organisation.

- medication storage, audit and disposal of medication was dated March 2009 and signed 2014

- provision of intimate care January 2004 for review in 2005.

Over the course of the inspection the inspector viewed the directory of residents and found this document did not contain all the information as specified in Schedule 3 for example, the date of admission and the name and address of any authority, organization or other body which arranged the resident's admission to the designated centre.

During the inspection, the inspector found the retrieval of some Schedule 3 documentation difficult as information contained within some resident files, was outdated and staff identified more up to date documents were completed. However, these were not available within the designated centre.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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 report¹

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002361
Date of Inspection:	28 February 2017
Date of response:	03 May 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Evidence of complainants being informed promptly of the outcome of their complaints was not available within the residents file or the designated centre, this was provided by the service manager.

1. Action Required:

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

Under Regulation 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 has completed the training in "Managing Complaints 2017" in April 2017. The PPIM is scheduled to attend the training in May 2017.

All staff have read and signed St. Michael's House complaints and compliments policy.

The PIC has developed a new complaints register and he will monitor all complaints to ensure staff adhere to St. Michael's House Complaints and Compliments policy.

In line with St. Michael's House Complaints and Compliments policy, all complaints will be investigated promptly.

In line with St. Michael's House Complaints and Compliments policy all complainants will be informed of the outcome of their complaint and details of the appeals process if required.

The unresolved complaint during the recent HIQA inspection is now closed. The complainants have been informed of actions taken and they are satisfied with the outcome.

Proposed Timescale: 31/05/2017

Theme: Individualised Supports and Care

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

Some complaints may not be investigated promptly as some staff members were not familiar with the process of assisting residents to make a complaint.

2. 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 has completed the training in "Managing Complaints 2017" in April 2017. The PPIM is scheduled to attend the training in May 2017.

All staff have read and signed St. Michael's House complaints and compliments policy.

The PIC has developed a new complaints register and he will monitor all complaints to ensure staff adhere to St. Michael's House Complaints and Compliments policy.

In line with St. Michael's House Complaints and Compliments policy, all complaints will be investigated promptly.

Proposed Timescale: 31/05/2017

Theme: Individualised Supports and Care

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

The complaints policy did not nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

3. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

1. The Registered Provider has reviewed the Complaints Policy and will ensure that when the policy is updated a person, other than the person nominated in Regulation 34(2)(a), will be identified in the Policy, to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

2. In the interim the Registered Provider has nominated the Service Manager to be available to residents and family to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Proposed Timescale:

1. 31/12/17

2. 15/5/17

Proposed Timescale: 31/12/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

Arrangements to meet the assessed needs of each resident through implementing the interventions in place for each set was not evident as residents had over twenty goals in place.

4. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the

assessed needs of each resident.

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

All staff have received further training in assessment of need on 26/4/17

All residents' assessment of needs are currently being updated by their keyworkers and personal plans will be reviewed by the PIC quarterly or as required.

Goals will be developed in an appropriate manner to capture the specific goal, how they will be measured, how they are going to be attained, that they are realistic, timeframes established, that they are ethical and the manner in which each stage of the process is going to be recorded, (SMARTER).

Proposed Timescale: 03/07/2017

Theme: Effective Services

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

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

5. 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:

All residents' assessment of needs and support plans are currently being updated by their keyworkers.

Consultation will occur with the resident, their representatives and allied health professionals as required.

Service Manager has developed a monitoring sheet that will be placed in each residents identified support care plan which will capture the implementation of supports.

PIC 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.

The PIC will develop a schedule for residents Wellbeing reviews.

Proposed Timescale: 03/07/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The systems in place within the designated centre were not effective in relation to the assessment, management and ongoing review of risk for some areas within residents' lives.

Some individual risk assessments were not reflective of current practice within the designated centre.

6. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

PIC is currently reviewing and updating all risk assessments within the centre.

Through updating and review of the assessment of need for each resident, where required a risk assessment will be completed with the identified keyworker. All risk assessments will now reflect current practice within the centre

Risk Register will be reviewed and updated as required capturing identified risks and control measures within the designated centre. This will be discussed at monthly staff meeting.

PIC will complete audits of risk assessments in order to assess the effectiveness of each control measure to minimize risk. This will be completed quarterly thereafter.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

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

7. Action Required:

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

Organisational policy on clinical waste is accessible within the designated centre.

All staff will read and sign the organisational policy

The sharps container within the designated centre is now labelled with a tagging system in place.

Health and safety audits will be completed quarterly by the PIC, which will include best practice in clinical waste.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

Adequate arrangements for containing fires within the designated centre were not evident.

8. 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:

An assessment was conducted by the Organisation Fire Officer and it was deemed that adequate fire containment is in place for the safe evacuation of the current residents living in the designated centre

The cold smoke seal will be replaced to the door identified during the inspection.

Proposed Timescale: 31/05/2017

Theme: Effective Services

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

Some residents had multiple PEEP'S in place with different dates. This had the potential to miss guide some staff members in the event of an emergency.

9. 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:

Two fire evacuation drills have been completed since the inspection. 11/03/17 and 25/04/17. These fire evacuation drills have informed the development of up to date PEEP's for all residents in the centre.

All old PEEPS have been removed.

Proposed Timescale: 10/05/2017

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:

Staff were not guided effectively or constantly to appropriately respond to displays of behaviours that is challenging as inconsistencies were documented between various support plans.

10. Action Required:

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

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

The Senior Clinical Psychologist is currently updating all residents Positive Behavioural Support Plans.

The Senior Clinical Psychologist will schedule a roll out of the positive behaviour support plans with the staff team, giving advice and guidance on their implementation.

Proposed Timescale: 05/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Epilepsy plan did not guide staff members in effective delivery of care in relation to seizure management.

11. Action Required:

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

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

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

Proposed Timescale: 03/05/2017

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.

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

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

The review process in place for healthcare areas required improvement to identify the effectiveness of the interventions implemented.

12. Action Required:

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

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

Support plans will be reviewed and updated reflecting the identified medical conditions of each resident based on their annual health check.

All staff have received further training in assessment of need on 26/4/17 in order to provide an appropriate health care plan for each resident

PIC will sign each support plan on its completion

Service Manager has developed a monitoring sheets that will be placed in each residents identified support care plan which will capture the implementation of supports.

Personal plans will be reviewed by the PIC quarterly or as required.

Proposed Timescale: 03/07/2017

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:

Medication was present without the resident's name for whom the medication was prescribed.

Some prescribed medication was not present in the designated centre and the inspector was informed should the resident required such medication the resident would be

administered medication from another's residents supply until the stock was replenished.

Accurate stock balances were not maintained.

Some administration sheets did not contain a photo of the resident.

Tropical medication was present without an opening date.

No guidance was available for staff members in relation to the administration of PRN medicine for the same indications.

13. Action Required:

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

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

All staff have access to St Michaels Policy on safe administration of medication.

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

PRN protocols are being developed in consultation with the residents, their representatives and allied health care professionals

All residents SAM sheets now contain the residents photograph

PIC will ensure that dates are written on topical medication when they are first opened

Proposed Timescale: 15/05/2017

Theme: Health and Development

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

Appropriate and suitable practices relating to storing of medicines to ensure any medicine that is kept in the designated centre is stored securely was not evident, as one resident had their own medication without staff members' knowledge.

14. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

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

The identified resident during the recent inspection has now been assessed for self medicating and supporting guidelines are now in place. This assessment was carried out in consultation with the resident, their representatives and allied health care professionals

Proposed Timescale: 03/05/2017

Theme: Health and Development

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

One resident was self medicating however, no risk assessment and assessment of capacity was present within the designated centre.

15. Action Required:

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

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

The identified resident during the recent inspection has now been assessed for self medicating and supporting guidelines are now in place along with appropriate risk assessment. This assessment was carried out in consultation with the resident, his representatives and allied health care professionals

Proposed Timescale: 03/05/2017

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:

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.

The document did not outline the information set out in the certificate of registration.

The number and size of rooms in the house was not accurately reflected in the document.

The arrangements for residents to access education, training and employment were not

included within the document.

The information in relation to the organizations policies was not accurately reflected within the document.

16. 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:

In line with schedule 1, the PIC is updating the statement of purpose and will submit the centre's Statement of Purpose to HIQA.

Proposed Timescale: 11/05/2017

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 management systems in place in the designated centre required improvement to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. This was evident through the level of non-compliance and the lack of audits completed within the designated centre.

Lack of oversight in relation to risk management.

17. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The registered provider will continue to provide unannounced six monthly visits to the centre.

PIC 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.

PIC will complete quarterly audits of risk assessments in order to assess the effectiveness of each control measure in order to minimize risk.

All risk assessments will now reflect current practice within the centre

PIC will ensure quarterly Health and Safety audits are completed

All complaints will be addressed and complainants informed promptly of the outcome of the complaints

Proposed Timescale: 03/07/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

Some Schedule 5 policies were present in the designated centre were not the current policies used by the organization.

18. Action Required:

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

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

In line with schedule 5 of the health act 2007, PIC will ensure the most up to date written policies and procedures are in place in the centre

All staff in the centre will read and sign all policies and procedures including those identified under schedule 5.

Proposed Timescale: 30/06/2017

Theme: Use of Information

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

The directory of residents did not include all the information as specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

19. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 PIC will review the directory of residents ensuring that all information is available as specified in paragraph (3) of schedule 3 of the Health Act 2007

Proposed Timescale: 08/05/2017

Theme: Use of Information

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

During the inspection the inspector found the retrieval of some schedule 3 documentation difficult as information contained within some resident files for example, was outdated and staff identified more up-to-date documents were completed. However, these were not subsequently available within the designated centre.

20. Action Required:

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

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

The PIC will review the directory of residents ensuring that all information is available as specified in paragraph (3) of schedule 3 of the Health Act 2007

All staff will be familiar of the location of schedule 3 information

Proposed Timescale: 15/05/2017