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A designated centre for people with disabilities operated by St Michael's House, Dublin 9

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Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002386
Centre county:	Dublin 9
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Sheila McKevitt
Support inspector(s):	Jim Kee;
Type of inspection	Announced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
25 May 2015 10:00	25 May 2015 18:30
26 May 2015 09:30	26 May 2015 17:00

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

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

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents and staff of the centre were also sought. The nominated person on behalf of the provider, the service manager and the person in charge were in attendance. They all had many years of experience and knowledge of working with residents with disabilities.

Inspectors found some evidence of good practice across all outcomes; management

had addressed two non-compliances and partially addressed one non-compliance from the last inspection in August 2014. On this inspection the centre was in compliance with 7 out of 18 Outcomes inspected against. Inspectors had concerns that residents were not being adequately protected against all forms of potential abuse. Therefore, the provider was issued with an immediate action plan to which an adequate response was received and accepted by the Authority. Inspectors also had concerns that residents privacy and dignity was not being maintained at all times, however, immediate measures were taken to address this issue on day one of the inspection. Complaints management required review as they were not managed in line with policy. Communication aids for non verbal residents required further development as did the implementation of residents personal plans.

The premises required review to ensure communal spaces were developed to meet the needs of the residents living in the house and the garden needed to be made accessible to all eight residents. A system of auditing care practices needed to be developed and implemented and an annual review completed to ensure the management team had a clear view of the quality of care being delivered in the centre and to ensure improvements were made to care practices.

Some staff had not got up-to-date food safety training in place. Staff supervisory meetings required review. Residents' assessments and care plans had been developed. Restraint assessment did not have a corresponding care plan. The statement of purpose had been amended and now reflected the legislative requirements and a copy had been provided to residents representatives. Behaviours that challenged displayed by one residents required a systematic continuous review.

Medication management practices were safe. Records, specifically one policy outlined in schedule 5 was not available in final draft and therefore had not been implemented.

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

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Residents' were consulted with and participated in decisions about their day to day care as much as they could. They were provided with information about their rights. However, each residents privacy and dignity was not respected. The complaints policy was not being adhered too.

Residents had a weekly meeting where they discussed the week ahead with staff. Here they planned their evening meals, activities, appointments and visits to and from family.. Minutes of these meetings were available for review.

Resident's privacy and dignity was not respected. Inspectors saw that each residents' bedrooms door had an internal lock together with a key on the outside of the door. There were recorded incidences on a frequent basis where a resident with behaviour that challenged entered other residents' bedrooms, invading their privacy. However, keys remained outside bedroom doors. Also, a number of bedroom doors had latches on the upper part of the outer door, these had not been removed despite the person in charge stating they were no longer in use. The communal bathroom/shower room and toilet doors had privacy locks in place they too had keys on the outer side of the door. Inspectors saw that residents could ensure their privacy from the inside, however, anyone, could come along and invade their privacy by turning the key in the outer door and entering their bedroom. There had been two reported incidences where male residents had entered the bathroom when female residents were receiving intimate care. However, no actions were taken to remove keys from outside bathroom and toilet doors. Inspectors brought these concerns to the attention of the person in charge on the first day of inspection, the keys had been removed from outside of all internal doors on day two of this inspection.

Inspectors saw evidence that residents had some choices and retained some autonomy over their own life. However this was restricted due to a lack of resources. They attended house meetings once per week where they chose their food menu and planned activities for the coming week. However, their choices being met were restricted somewhat as they depended on who was on duty on any given day. For example, some residents required two members of staff to go out with them and others required a male staff member to be on duty to tale them swimming. Residents who choose to attend religious services were facilitated to do so. Inspectors were told that none of the eight residents' were registered to vote, as none had the capacity to do so.

There was a copy of the charter of rights published by the National Advocacy Committee which was on display in the front hallway. A representative explained their role in the main offices of St Michaels House, three residents had attended this talk. Inspectors were informed that a representative from the National Advocacy Committee was coming in to the centre to speak with residents in the near future. The relatives of six residents provided feedback to the Authority which was overall positive.

There was a complaints policy in place which met the legislative requirements but a copy was not on display in the centre. A copy was however included in the residents guide, available in the front hallway. The management of complaints was inconsistent. Inspectors reviewed the complaints folder and although all were dealt, they were not dealt with promptly, in line with the centres complaints policy. For example, records of the one complaint made in February 2015 did not state the outcome of the complaint or whether the complainant was satisfied or not.

Judgment:
Non Compliant - Major

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

Theme:
Individualised Supports and Care

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

Findings:
There was a policy on communication with residents, it was in draft format.

Staff were aware of the different communication needs of residents. Each non verbal resident had a detailed communication assessment completed. Some individualised communication systems had been recommended following input from members of the allied health care team and these were reflected in residents' personal plans. However,

they were not fully implemented for all residents. For example, it had been recommended that all residents have a communication passport developed, however, just one resident had this communication aid developed to date.

Other means of communication used throughout the centre included pictorial boards and personal planning boards. Inspectors saw that some communication boards in use contained too much information, making it difficult for residents' to interpret the information on display.

Residents had access to communication appliances of their choose such as radio, television and music systems. Residents were able to communicate at all times. All residents had access to two portable house telephones and the one resident capable of using the internet had portable access to it and was in the process of attaining a skype account to enable greater communication with relatives.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Residents were supported to develop and maintain personal relationships and links with the wider community.

There was a visitors policy in place and it was on display. Residents told the inspector that they had visitors of their choice visit them in their home. Some also visited their family home, staff providing transport when required. There was a family contact sheet in each resident's file where staff recorded all verbal contact with the residents family. Families who completed pre-inspection questionnaires said they were consistently kept up-to-date on their relatives condition.

Residents used facilities in the local community. They told inspectors they regularly visited the local swimming pool and the church on the local college campus. They used local failities including the local shops, garage and post office.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:
Effective Services

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

Findings:
Contracts of care were available for each resident and admission to the centre was in line with the admissions policy. The contracts reviewed were signed and dated by the respective residents' representative and the person in charge. The contracts included details about the supports, care and welfare the resident would be expected to receive, details of the services to be provided and the fees to be charged. They also referred to additional costs that may be charged.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
An assessment of each resident’s health, personal and social care and support needs was carried out as required to reflect changes in the residents' need and circumstances, and at a minimum once a year. The assessments reviewed had multi-disciplinary input. Each identified need was reflected in a care plan which specified the care required to ensure the specific need was met. Residents' had social care plans in place, however,

these were not detailed and did not ensure the resident was enabled to meet their desired goal. Residents representatives stated they were involved their personal plans (on the pre-inspection questionnaires submitted) however evidence of their involvement was not recorded.

The assessments completed comprehensively reflected the care needs of all residents. As mentioned under Outcome 2, a number of residents who could not communicate verbally had comprehensive communication assessments completed.

Residents who required nursing care had comprehensive assessments in place to reflect their nursing care needs. For example, one resident with epilepsy had a care plan in place to reflect care required to prevent and treat any seizures. Care plans were updated when there was a change in residents care.

Seven of the eight residents' had a personal outcome based, social plan in place, all had been written in 2015 and each outlined up to three individual goals set for the year. However, inspectors noted that for most of the seven the goals for 2015 were the same as those set for 2014. Staff told inspectors goals had not been implemented in 2014 due to the house being extremely busy. The personal outcome based goals set for residents for 2015 were too vague. For example, for one, the plan stated wishes to lose weight. Records did not reflect how much weight, by when or how the resident could be facilitated to achieve this goal. Staff stated and representatives in writing stated that the eight resident was not well enough to set annual personal goals for 2015.

Residents' personal plans were not made available in an accessible format to the residents as mentioned under Outcome 2, residents had complex communication needs and personal plans were available in written format only.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The centre was large enough to meet the individual and collective needs of the eight

residents currently living in the centre. However, the design and layout was not suitable to meet the complex needs of the eight residents currently living there. The number of residents in the house had reduced from nine to eight since the last inspection and the provider was applying to care for eight residents in this house with a plan in place to reduce to six residents by end November 2015. The centre was clean and free from clutter and provided a secure environment for residents to live in.

The main communal sitting/living room was situated in the centre of the house. Several doors opened into this room including the dining room, upper hallway and lower hallway; hence it was used as a walkway to access these areas of the house, allowing for little or no privacy. As one side of the room was kept clear for people to walk through there was a minimal amount of actual floor space available for use as a sitting room. However, it was just adequate to accommodate eight residents comfortably, two of whom were wheelchair users and one of whom used a mobility aid within the house. It had been refurbished since the last inspection with new sofas and soft furnishings it now looked more homely.

The dining room was large enough to accommodate the eight residents and staff. The kitchen contained all the required equipment and an outer laundry also contained all the required equipment.

Each resident had their own bedroom, they were personalised by residents who confirmed they had selected their own furnishings. An adequate amount of storage space was provided in each bedroom. None of the eight bedrooms were ensuite, however, there were just two bathrooms available for residents use and three toilets. One of the bathrooms contained a large jacuzzi bath. The two wheelchair bound residents occupied the larger of the eight bedrooms. One residents bedroom was situated in the upper area of the house opposite the second smaller communal sitting room used as a de-escalation room by staff. Inspectors observed it contained a lot of furniture, patterned curtains, flooring and sofas none of which would aid de-escalation. The revised usage of the ninth bedroom had not been decided upon to date. Seven resident bedrooms were located at the lower end of the house. The inspector saw evidence that one resident frequently displayed challenging behaviour at night-time and when awake choose to use either of the two communal rooms. The challenging behaviour displayed by this resident often involved a high level of noise and due to the close proximity of the main communal sitting room to seven of the bedrooms this resulted in some other residents in the house been woken. The inspector saw written evidence and staff spoken with confirmed with the inspector that this usually occurred two nights per week.

Residents had access to a very small enclosed garden to the front of the house which was mainly paved and contained a number of flower, vegetable and fruit beds maintained by residents. The upper paved area contained an extremely heavy metal dining set the chairs of which would be difficult for residents to lift. The garden was not independently accessible to wheelchair dependent residents as the doorway was not level with the ground/floor on either side of it.

Residents had access to all the assistive equipment required to meet their needs all had been recently serviced.

Judgment:
Non Compliant - Major

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:
Inspectors formed the view that the health and safety of residents, visitors and staff was promoted and protected. There was a risk management policy in place which met the legislative requirements, the risk register contained a record of perceived risks. Each resident had individualised risk assessments completed. There was a health and safety statement in place and health and safety checks were completed on a quarterly basis by the person in charge and service manager. Required actions were identified, for example, staff training needs were identified and acted upon. There was an emergency plan in place.

The systems used to record accidents and incidents were not streamlined. Accidents and incidents were recorded and submitted on the computerised system. A record was printed off and available for review in each resident's personal file. In addition, staff recorded incidents in residents personal records. Inspectors found that both systems did not correspond with each other. For example, two incidents of behaviour which was of concern to inspectors were recorded for October 2014 on the computerised system, however, the resident's monthly review stated this behaviour was displayed seven times in October 2014. There was no effective system for analysing, investigating and/or learning from all incidents and accidents. Therefore, inspectors could not get a clear picture of the frequency of accidents/incidents occurring in centre, a number of which were having a negative impact on other residents.

Records were available to confirm that fire equipment including fire extinguishers, the fire blanket, emergency lighting and the fire alarm had all been tested by professionals within the required time frame. All rooms within the house had wheelchair accessible fire doors in place, those in the hallways closed automatically when the fire alarm sounded, compartmentalising the building. All staff had completed fire training within the past year and those spoken with had a clear understanding of the procedure to be followed in the event of a fire. The procedure to be followed in the event of a fire was on displayed, however, it was not at a level visible to wheelchair dependent residents. There was a fire evacuation floor plan posted on the wall by the fire panel. However, it did not clearly identify the nearest fire exits. One fire exit to the rear of the building had been revised since the last inspection, it was now accessible to wheelchair dependent

residents.

The inspector saw that each resident had an individual fire evacuation plan in place which detailed how they were evacuated if there was a fire during the day or night. They contained clear instructions on how to evacuate each resident. Records reviewed showed that fire drills were practiced on a regular basis during the day and night by both staff and residents. All residents were safely evacuated within a maximum of four minutes during these drills.

Manual handling practices were not observed during the this inspection. However, the inspector reviewed four staff training records and saw they had up-to-date manual handling training in place. Infection control practices were adequate. An infection control audit had been completed at the end of April, some but not all recommendations made had been implemented to date. The laundry/cleaning room within the house was separated from the living areas. Hand wash and dry facilities were available over wash hand basins.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Inspectors were not satisfied that appropriate measures were in place to protect and safeguard residents at all times. Inspectors found that one resident's frequent display of behaviours that challenged were at times potentially abusive in nature. These behaviours were repetitive, their occurrence and impact on other residents were not being effectively monitored and adequate measures had not been put in place to safeguard residents, particularly the female residents when the resident in question displayed these potentially abusive behaviours. Inspectors issued the provider with an immediate action plan to protect all residents from all forms of abuse, an appropriate response to the action plan was received.

All the exit/entry doors could be secured by locking, the front door was accessed by use

of a key pad and the house was alarmed. As mentioned, under outcome 2, there were keys in the outer door of residents' bedrooms, hence, there privacy and dignity were not maintained at all times. Communication between residents and staff was respectful. Residents who at times displayed behaviours that may challenge had a positive behavioural support plan in place. The resident's psychologist had been involved in the development of this plan. Although, as stated above the plan in place for one resident was not effective in protecting other residents from being exposed to behaviours which had the potential of being abusive in nature.

A number of different forms of restraint were in use in the house. Although each resident had a comprehensive assessment to determine if restraint was necessary, they did not all have a care plan reflecting the care required when restraints were in use.

Residents had intimate care plans in place which were reflective of their care needs and had been update within the past year.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
A record of all incidents occurring in the designated centre was maintained. Quarterly reports had been submitted to the chief inspector in a timely manner. No incidents’ notifiable within three working days had occurred in the centre to date.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
There was no policy on access to education, training and development. The assessment process to establish each resident's educational/employment/training goals was not reflected in their personal file.

Five of the eight residents' attended day care facilities for 3-5 days per week. The three residents who did not have access to a daycare facility had a daily activity schedule in place and were being facilitated to take access activities of their choose by staff working in the house. The management team had facilitated this by scheduling extra staff on duty during the day and inspectors were informed that they were in the process of sourcing appropriate daycare facilities for these residents.

Residents were facilitated where possible to attend activities outside of the centre. Residents' representatives said they were satisfied with the range of activities residents had access too.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
The health care needs of residents were being met and records reflecting this were available for review in each residents file.
Inspectors reviewed four residents' files and saw evidence that they were facilitated to access and to seek appropriate treatment and therapies promptly from allied health care

professionals when required. Completed referral forms were available for review in residents' files and written evidence of relevant reviews were also available.

For example, one resident had recently had his behavioural support plan reviewed by the psychologist. Records were on file to reflect these visits. All residents visited their General Practitioner (GP) on a regular basis and had their health status well monitored. Evidence of this was available in each resident's file.

Inspectors saw that residents had access to adequate quantities and a good variety of nutritious food to meet their dietary needs. A number of residents on specialist diets had access to a dietitian. Inspectors saw evidence that some residents were involved in planning, preparing, cooking, serving and cleaning up after their breakfast and evening meals with support from staff. Others enjoyed doing some baking in their home.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Inspectors found that practices regarding drug administration and prescribing were in line with best practice. There was a medication management policy available which included the ordering, prescribing, storing, administration and prescribing of medicines. Practices were in line with the policy.

There was a safe system in place for the ordering and disposal of medications and the inspector saw records which showed that all medications brought into and out of the centre were checked by staff and residents'. Medications were audited by staff on a weekly basis, any discrepancies were identified and reported to the nurse manager on call by completion of an error form. This was reviewed and recommendations made were fed back to the person in charge who was given a set period of time to implement the recommendations made.

Inspectors saw that the residents used the local pharmacist for supply of their medications. As there was always a staff nurse on duty in the centre, they administered all medications to residents. Inspectors saw that each of the residents had their prescribed medications reviewed by their General Practitioner or a Medical Officer on a frequent basis.

Judgment:
Compliant

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):

Findings:
The statement of purpose given to inspectors on the day of this inspection was reviewed. It included details of the services and facilities provided. It also contained all of the information as required in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013.

A copy was on display in the front hallway and the person in charge stated that a copy had been sent to all residents families.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:

There was a clearly defined management structure that identified the lines of authority and accountability. The centre was managed by a suitably qualified, skilled and experienced clinical nurse manager with authority, accountability and responsibility for the provision of the service. He was the named person in charge (PIC), employed fulltime to manage the centre. The inspector observed that the person in charge was involved in the governance, operational management and administration of the centre on a consistent basis. He had a good knowledge and understanding of the residents, having worked with them for a number of years and was committed to develop professionally. Residents appeared to know him well.

During the inspection, the person in charge demonstrated sufficient knowledge of the legislation and of his statutory responsibilities. Records confirmed that he was committed to his own professional development. He was supported in his role by another clinical nurse manager, a team of staff nurses, social care workers and care assistants. The clinical nurse manager managed the centre in his absence.

The person in charge reported directly to a service manager who reported to a regional director (also nominated person on behalf of the provider). The nominated person on behalf of the provider reported to the Acting Chief Executive Officer who reported to the board of St Michaels House. Inspectors were informed by the person in charge and saw evidence that regular scheduled minuted meetings took place with the service manager. The nominated person on behalf of the provider attended the centre on occasions, she attended for the feedback meeting at the end of this registration inspection.

The service manager had conducted an unannounced visit to the centre and together with the person in charge conducted a review of the health and safety and quality of care and support provided to residents' within the centre. They identified areas for improvement and issues which required follow-up, by whom and within what time line. However, inspectors found that this unannounced visit was not an adequate form of review to ensure the quality of care provided in the house was being effectively monitored. There were no audit systems developed or implemented in this nursing care house, to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. For example, there were no audits being completed on areas of practice such as complaints, medication errors and an annual review of the service had not been conducted to date.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The Chief Inspector had not been notified of any proposed absence of the person in charge of the centre to date and the inspector was satisfied that arrangements were in place for the management of the centre during his absence.

As mentioned under outcome 14, a clinical nurse manager met on inspection had the required experience and qualifications to manage the centre in the absence of the person in charge.

Judgment:
Compliant

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

Theme:
Use of Resources

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

Findings:
As mentioned under outcome five, residents personal plans had not been implemented for 2014 and were repeated for 2015. Staff spoken they were not adequately resourced to support residents achieving their individual personal plans. However, on this inspection the resources appeared to be available but required personal plans had not been implemented to date for 2015.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
The numbers and skill mix of staff were adequate to meet the needs of the eight residents. Staffing levels included the person in charge a, staff nurses, social care workers, care assistants and a housekeeper. As mentioned under outcome 16, the person in charge managed this well.

Inspectors reviewed staff training records and saw evidence that all staff had up-to-day mandatory training in place and those spoken with had a good knowledge of procedures to follow. The housekeeper now had food safety training in place. Howver, four staff did not and the remaining staff were waiting on dates for refresher food safety.

There were no volunteers working in the centre. The recruitment process was found to be safe, four staff files were reviewed on this inspection they included most documents outlined in schedule 2, however, a full work history was not available in each of the files reviewed.

The person in charge had formal and informal supervisory meetings with staff. Records of formal supervisory meetings were available for review. However, these did not occur every 4-6 weeks in line with the organistaion policy. Inspectors found that in this house where there were a number of residents displaying different complex behaviours, more frequrent formal supervisory meetings were required with staff to ensure debriefing and continuous structured support for all levels of staff.

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Information

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

Findings:
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Residents and Adults) with Disabilities) Regulations 2013 were available for review.

An insurance certificate was provided to inspectors during this inspection, it showed that the centre was adequately insured against accidents or injury to residents, staff and visitors. It also confirmed that the bus used to transport residents was adequately insured. There was a directory of residents available which included all the required information. There was a residents guide available throughout the centre and it met the legislative requirements.

The centre had most of the written operational policies as outlined in Schedule 5 available for review. The policy on access to education, training and development was not yet devised.

Inspectors found residents documents were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

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:

Sheila McKevitt
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-0002386
Date of Inspection:	25 May 2015
Date of response:	30 June 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents right to privacy is not being respected and therefore their dignity is not being maintained.

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
1. The PIC arranged for the removal of the latches which were no longer in use on bedrooms (the upper part of the outer doors) this was completed on the 22nd June 2015.
2. The PIC arranged for the upgrading of locks on bedroom and bathroom doors this was completed on the 22nd of June 2015. The PIC met with staff and discussed the local guideline in place to support all residents with maintaining privacy.
3. The occupational therapist with the PIC will review technical services assessment of doorway motion sensors on bathroom doors to assist and support privacy and will install same.
Proposed Timescale: 1 and 2 completed 22/06/2015. 3 31/07/2015.

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure is not displayed in the centre.

Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The PIC has addressed this and the complaints procedure is now available and is on display in the hall of the designated centre.

Proposed Timescale: 22/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All complaints had not been dealt with promptly.

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 liaised with the complainant and updated the record for the complaint dated February 2015 and it reflects the outcome. The complainant is satisfied with the outcome.

Proposed Timescale: 27/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All complaints did not have a recorded outcome.

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

Please state the actions you have taken or are planning to take:
The PIC has reviewed the complaints with the complainants and they are satisfied with the outcome. The PIC has completed the recorded outcome for the complaints.

Proposed Timescale: 27/06/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure communication interventions set out in residents' personal plans are consistently implemented to enable residents to communicate effectively at all times.

Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
The PIC and the PPIM met with a speech and language therapist on the 23/06/2015 and developed a plan to support the implementation of communication passports for all residents. The speech and language therapist will meet with staff on the 04/08/2015 to ensure that all valid and relevant information is in the Communication Passport for their key client.
The PIC and speech and language therapist will review the communication passports to ensure they are comprehensive and relevant for each resident.

Proposed Timescale: 30/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal outcome based plans were not available to each resident in a format which was accessible or understood by them.

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

Please state the actions you have taken or are planning to take:
1. The PIC has arranged for the speech and language therapist to provide training to staff on making information accessible. The training will take place on the 06/08/2015. Staff will then commence of making the plans accessible for residents.

2. The chair of the personal planning group will provide training to staff team on personal planning, goal setting and progression. The training will take place on the 06/08/2015.

Proposed Timescale:
1. 04/08/2015 completion 30/09/2015 2. 06/08/2015

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans reviewed did not clearly identify how the resident was going to reach their desired goal and the plans did not include set objectives within agreed timescales to ensure the planned outcome was reached.

Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
1. The PIC will review the personal plans every 2 months. As part of this review goals identified will be set out clearly with agreed timeframes to ensure the planned outcomes are reached.

2. The review of personal plans will be an agenda item at support meetings with all staff. Relevant updates will be discussed at staff meetings.

3. The PIC, PPIM and Service manager will review goals agreed and progress within agreed timeframes every 2 months.

Documents will be available for review.

Proposed Timescale: 1. Commencing 31/07/2015   3. Commencing

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the centre do not meet the aims and objectives of the service and the complex needs of the eight residents living there.

Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
1. The person in charge along with the management team will implement the plan to reduce the number of residents.

2. The person in charge, service manager and architect will meet to develop a plan for the reconfiguration of the enviroment to meet the needs of the reduced number of residents.
Proposed Timescale: 1. 30/11/2015. 2. 31/08/2015

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The small garden area was not independently accessible to wheelchair dependent residents'.

Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
Architectural plans for this area will be available on 06/07/2015 costing and tendering to follow.

Proposed Timescale: 30/11/2015

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:
There was no effective system in place to analyse, investigate and learn from all incidents and accidents.

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

Please state the actions you have taken or are planning to take:
1. The PIC organised a meeting with relevant allied health professionals and PPIM a local system for recording incidents was put in place. The PIC and service manager have established monthly meetings to analyse the information, establish patterns/trends. The PIC, service manager and allied health care professional will identify the learning and amend positive behaviour support plans, guidelines, local policy accordingly.

2. The provider nominee has been advised by the IT department that a new system is undergoing testing at the moment and will start to come on line in August. The PIC will be able to access the incident eforms for their unit via the reports.
Proposed Timescale: 1. Commenced 24/06/2015. 2. 31/12/2015.

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The floor plans on display at the fire panel did not clearly display the fire exits.

Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
The floor plan displayed at the fire panel clearly indicate all fire exits.

Proposed Timescale: 22/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The procedure to be followed in the event of a fire was not displayed at a level visible to wheelchair dependent residents.

Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
The procedure to be followed in the event of a fire is displayed at a level visible to wheelchair dependent residents.

Proposed Timescale: 22/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no care plans to direct the care to be delivered to residents when restraint was in use.

Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
Care plans are in place to direct the care to be delivered to residents when restraint is in use. This was completed using the information from the comprehensive assessments that were already in place. Any restraint or restrictive practise used to support an individual who presents with behaviours that challenge is detailed in their positive behaviour support plan.

Proposed Timescale: 18/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Measures were not in place to protect residents from all forms of abuse.

Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
1. The Designated Person carried out a preliminary screening under the SMH policies and procedures for the prevention of abuse and neglect to adults and children with a disability (2011).
2. The PIC liaised with relevant allied health professional and the positive behaviour support plan was reviewed and updated to reflect how this resident is currently supported.

3. The PIC will ensure that any possible impact due to additional supports for the resident is recorded, examined and reviewed. This review will be completed by the PIC in conjunction with relevant allied health care professionals on a monthly basis. The need for the high level restriction will be reviewed monthly under the principle of least restricted alternative.

4. The Provide Nominee and the PIC will continue to work on the overall plan to reduce the number of residents living in the designated centre as per the original action plan.

5. The PIC will review each residents care plan to ensure that they have identified all appropriate safeguarding needs.

6. The PIC will review risk assessments for each individual. Where any potential risk of abuse is assessed the behaviour support plans will be implemented to minimise the risk.
Proposed Timescale: 1) Completed 12th June. 2) Completed 22nd June. 3) Ongoing review date 21st July. 4) November 2015. 5) 31st July 2015. 6)Scheduled for the end of each month.

Proposed Timescale:

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure the three residents are facilitated to access daycare facilities to meet their required needs and of preference to them.

Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to

access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
1. The PIC has placed two of the residents are on waitlist for individualised day service.
2. The provider nominee has identified a team which includes the PIC and service manager to look at individualised service using the discovery tool to conduct assessment of need.

3. One of the residents has a placement in a day service but due to changing health needs is not in a position to attend at present. This continues to be assessed by the PIC and allied health care professionals.

4. In the interim, the 3 residents are being supported to engage in a daily schedule of activities of their choosing in their community. This is recorded in their daily report. This is facilitated by changes in the roster which were implemented when the residents were no longer attending day service.

Residents have expressed and demonstrated satisfaction with the current supports to engage in activities daily.
Proposed Timescale: 1. 30/01/2015. 2. 31/12/2015

Proposed Timescale:

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 did not ensure that the service provided wass safe, appropriate to residents' needs, consistent and effectively monitored.

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

Please state the actions you have taken or are planning to take:
1. The PIC organised a meeting with relevant allied health professionals and PPIM a local system for recording incidents was put in place. The PIC and service manager have established monthly meetings to analyse the information, establish patterns/trends. The PIC, service manager and allied health care professional will identify the learning and amend positive behaviour support plans, guidelines, local policy accordingly

2. The provider nominee has been advised by the IT department that a new system is undergoing testing at the moment and will start to come on line in August. The PIC will be able to access the incident eforms for their unit via the reports by the end of the

year.

Please see factual accuracy sheet.
Proposed Timescale: 1. Commenced 18/06/2015 2. 30/12/2015

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review conducted regarding the quality and safety of care and support in the designated centre to ensure that the care and support provided was in accordance with standards.

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

Please state the actions you have taken or are planning to take:
The Provider Nominee has nominated the service manager and the PIC to carry out a review of the centre in consultation with residents, their family and staff.
The PIC has consulted residents and their families
The PIC and service manager has consulted with staff team
The PIC and the service manager has reviewed current audit documentation.

Proposed Timescale: 30/09/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that the designated centre is resourced and these resources are managed effectively to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

Please state the actions you have taken or are planning to take:
1. The Provider Nominee has nominated the service manager and the PIC to review resources, change rosters to support the development of personal plans.

2. In support meetings the PIC and PPIM will highlight the importance of prioritising the implementation of personal plans.
Proposed Timescale: 1. Completed 24/06/2015 2. Commencing 15/07/2015

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A full employment history together with satisfactory history of gaps in employment was not available in each employees file.

Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The PIC with the support of the HR department reviewed the employment history of the staff team and ensured there is supporting documentation to account for history of gaps in their employment.

Proposed Timescale: 30/06/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Refresher food training was required by all staff and food training was required by four staff.

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

Please state the actions you have taken or are planning to take:
The PIC has organised food safety for all staff on the 4th of August 2015.

Proposed Timescale: 04/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Ensure all staff receive the appropriate supervision they require and appropriate to their role in line with the organisations policy.

Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The PIC has set up a schedule for staff support meeting as per St Michael's House Policy.
Commencing 15/07/2015

Proposed Timescale: 15/07/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A policy reflecting access to education, training and development had not yet been devised.

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:
The Policy on Access to Education Training and Employment will be completed by December 2015.

Proposed Timescale: 31/12/2015