

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A Canices Road
Centre ID:	OSV-0002332
Centre county:	Dublin 11
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Anna Doyle
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 September 2016 09:30 To: 06 September 2016 18:50

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

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 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 second inspection of the designated centre. The purpose of this inspection was to follow up on actions from an announced registration inspection carried out in the centre in March 2015, to monitor on-going compliance with the regulations and to inform a registration decision.

Description of the Service:

The centre is operated by St. Michaels House (SMH) and is situated in North Dublin. It comprises of a six bedroom two storey house located, close to local shops and transport links. The centre provides care to six female residents who have an intellectual disability, some of whom have behaviours that challenge. Two of the residents access services on a time share basis. Care is provided using the social care model of support.

How we gathered evidence:

Over the course of this inspection the inspector met six of the residents and one

resident spoke with the inspector formally. They said they were happy living in the centre and liked the staff there. However, they also spoke about the impact of behaviours presented in the centre on their lived experience in the centre.

Some of the residents were unable to express their views on the quality of care provided in the centre. The inspector observed practices, met with staff, reviewed records such as: care plans, risk assessments, policies and procedures and fire records. The person participating in management of the centre was interviewed on the day of the inspection. The person in charge was present for most of the inspection. They had been interviewed at a previous inspection carried out by HIQA in this centre.

Overall findings:

Overall the inspector found that the staff were trying to meet the assessed needs of all residents and residents presented as well cared for. However, significant failings were found in a number of outcomes. The person in charge and staff acknowledged that the changing needs of residents was having a significant impact upon the quality of service delivery at this time. While it was acknowledged that provider had taken measures to address this issue, these measures had not impacted positively on the quality of services provided in the centre to date.

The inspector found that all of the actions from the last inspection had been implemented with the exception of three under Outcome 5, 12 and 18. The actions under outcome 4, 6, 13, 16 and 18 were followed up from the last inspection, however no other aspects of these outcomes were inspected against at this inspection.

Five major non-compliances were found in relation to social care needs, health and safety, safeguarding, governance and management, and workforce. Two of the outcomes were found to be moderately compliant under medication management and documentation. One outcome was found to be substantially compliant with improvements required in healthcare needs. The remaining four outcomes were judged to be complaint. The action plan at the end of this report addresses the improvements 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 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):

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

Findings:

The inspector found that the actions from the last inspection had been completed as the provider had reviewed the contracts of care for residents to ensure that additional charges were now included.

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):

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

Findings:

The inspector found that the action from the last inspection had not been implemented

and significant improvements were required in residents' personal plans to ensure that residents' needs were being met in the centre.

Since the last inspection the provider had undertaken to ensure that a health action plan was in place for all identified healthcare needs. The inspector found from a sample viewed that this had not been implemented to a satisfactory level. There were some health action plans in place. However, some of the interventions contained in the plans were not fully implemented.

In addition one resident had no assessment of need contained in their personal plan and another resident's assessment of need had not been updated since 2014, despite significant changes in their needs over the last year.

The inspector found that in many instances there was no link between residents' personal plans and the care and support that was delivered to them. A lot of the interventions contained in personal plans were out of date or did not reflect the changing needs of the residents and the supports being provided to them. Examples included behaviour support plans, individual risk management plans, restrictive practice interventions, health care plans and intimate care plans.

In addition, a quick reference guide was available at the front of residents' personal plans to guide unfamiliar staff. This record directed staff to areas of the personal plan that were considered important to support residents. The inspector found that most of the information recorded on this document were either not in the personal plan or had not been reviewed to reflect changes. Given the significant amount of agency staff employed in the centre, the inspector found that this was compromising residents care in the centre.

One resident's annual review that had taken place in July 2015 was viewed by the inspector. However, a number of agreed actions had not been completed. These included risk assessments, a review of the resident's behaviour support plan and a goal to increase community participation. The person in charge informed the inspector that the actions had not been implemented due to a decline in the resident's health; however, this update had not been recorded in the personal plan.

Most of the residents in the centre attended day services and one resident had a job in the community. However, one resident did not attend day services. While the inspector acknowledges that this was the residents' choice, the minutes of multi-disciplinary meetings held recorded a number of other options that had been explored for this resident. The records stated that this resident had enjoyed some of the options explored. However, the inspector was informed that they had not been implemented due lack of resources.

There was evidence that residents attended some activities in the evening times for example art therapy took place in the centre some evenings, and some residents spoke about groups that they attended in the evening times.

Judgment:

Non Compliant - Major

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):

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

Findings:

The inspector found that the actions from the last inspection had been completed.

Since the last inspection the provider had undertaken to review staff facilities and communal space in the centre. This had been completed as the staff room had been moved upstairs and a seomra (a prefabricated building) had been built in the garden to provide additional communal space in the centre. The garden had also been landscaped to a high standard.

In addition the provider had undertaken to complete a deep clean of the centre and to ensure that maintenance work was completed. The inspector found that the centre was clean and well maintained and therefore these actions had been completed since the last inspection.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that while there were policies and procedures on risk management in the centre, significant improvements were required in fire safety and the management of risks in the centre.

There was a fire evacuation plan in the centre. Residents had personal evacuation emergency plans (PEEP's) in place. However, some of the information contained in them was contradictory to what was stated in the fire evacuation plans.

Fire drills had been completed in the centre and actions had been taken to address issues that had arisen at fire drills. However, the learning from this was not always included in the PEEP's. For example, the inspector was informed a resident and had been given a role in the fire drill to try and improve their participation in evacuating the centre. However, this information was not contained in the evacuation plan.

The inspector found that this may compromise a safe evacuation of the centre, given that part of the induction for agency staff in the centre was to read PEEP's in place for all residents. The person in charge intended to rectify this on the day of the inspection as agency staff were due on shift that night.

In addition the safe evacuation of residents could not be assured at times in the centre, as drills were not recorded as having taken place when staff numbers were reduced to one member of staff at night time.

There were records to show that fire equipment was maintained in the centre. However, monthly fire checks that were to be completed as part of the service policy were not consistently recorded. The last monthly fire check had been completed in February 2016.

The inspector found that adequate fire containment measures had not been considered as there were no fire doors in place in the centre.

An individual profile had been developed for each resident, that included the procedure to follow should a resident be absent from the centre.

There was a risk management policy in the centre. General risk assessments were not viewed at this inspection. Some residents had individual risk assessments contained in their personal plans, however they were not reviewed to reflect residents' changing needs and some were no longer active.

The inspector noted one significant known risk in the centre that could compromise one resident's safety in relation to choking. When this was pointed out to the person in charge, the inspector was informed that this resident received one to one support from staff during the day which minimised the risk. However, the inspector found that only one staff was present in the centre at night and that a significant amount of agency staff had been employed at night over the last number of months; therefore the inspector was not satisfied that this risk had been eliminated. In addition, there was no information contained in this residents plan about this risk.

There had been a significant number of incidences in the centre since the beginning of the year and a copy of which was stored in the centre. The incidents had been reviewed at the last unannounced quality review of the centre in May and July 2016. However, this review was not detailed so as to identify trends in order to improve learning and

mitigate risks in the centre.

Judgment:

Non Compliant - Major

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 that while there were policies and procedures in place to safeguard residents in the centre, significant improvements were required in safeguarding, behaviour support plans and restrictive practices in the centre.

One staff spoken with was knowledgeable about what to do in the event of an allegation of abuse. However, not all staff had received up to date training in safeguarding vulnerable adults in line with the HSE policy.

Although residents stated that they were happy living in the centre there were records to show that residents had complained in Feb 2106 about the impact of behaviours in the centre. One resident told the inspector that they were not happy with this and that other house members would have to leave rooms in order to avoid these behaviours. The inspector found that from a review of incidents that residents were required to leave the dining room during meal times due to inappropriate behaviour.

The inspector found that while the person in charge had been highlighting these concerns to management and that regular meetings were being held to discuss the issues, the actions agreed at these meetings were not always implemented. For example three multi disciplinary team meetings had been held in Feb 2016, April 2016 and May 2016 where agreed action had not been fully implemented. In April 2016 immediate actions were agreed to include an increase in staff supports five days a week. However additional staff had only been given for one day in the week due to funding issues.

There was a policy in place on positive behaviour support in the centre. The inspector found that a number of staff had not received training in this area.

Some residents had behaviour support plans in place but they had not been reviewed to include the changing needs of residents. The inspector saw an e-mail from a psychologist dated from February 2016, indicating that a behaviour support plan had been reviewed; however, this was not contained in the personal plan on the day of the inspection.

In addition, some of the information did not guide practice. For example, one intervention stated that staff should respond to a behaviour by blocking a resident; however it did not specify how this should be implemented.

The inspector also found that some restrictive practices in the centre had not been notified to HIQA for the last two quarters and there was no records of some restrictive practices been used on residents personal plan. For example, one plan stated that a door to a toilet was locked at night and this was not recorded as a restrictive practice. Restrictive practices not reported included the use of a bedrail, a locked wardrobe and an all in one body suit.

Samples of intimate care plans were viewed and the inspector found that they were not detailed enough. For example, while they detailed the supports required, they did not detail how these supports should be delivered in order to maintain resident's privacy and dignity. In addition, some of the information recorded on one plan was out of date.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that resident's healthcare needs were being met through timely access to healthcare services. However, improvements were required so as to ensure that the health care needs of residents were clearly documented and reviewed to reflect the changing needs of residents.

The inspector found that residents had access to a range of allied health professionals including GP, chiropody, psychology and speech and language therapy. However the inspector found that a risk assessment completed on one residents mobility had stated that the resident required an assessment by an occupational therapist, however there were no records to confirm whether this had been completed.

Meal times were not observed as part of this inspection.

Judgment:

Substantially 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):

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

Findings:

The inspector found that there were policies and procedures in place on medication management in the centre. However, one of the actions from the last inspection had not been fully implemented and improvements were required in some practices in the centre.

Since the last inspection the provider had undertaken to ensure that unused/discontinued medication would be stored separately from other medications. This had been completed. However, while staff were able to tell the inspector about the procedure to follow for disposing of this medication there was no local policy in place around this.

In addition, the provider had undertaken to ensure that commencement dates of topical medications and a pharmaceutical dispensing label for every medication was in place. The inspector found from the sample viewed that this had been completed.

There was medication policy in place. Some staff had not completed refresher training in the safe administration of medication. In addition, some staff had not received training on the administration of two medications in the centre that were not covered by medication training.

The inspector reviewed a sample of prescription sheets, medication administration sheets (MAS's) and medications stored in the medicines cupboard and found some discrepancies. These included:

- There was no photograph on one resident's prescription sheet.
- A small refrigerator in the centre used for the storage of creams in the centre was unlocked on the morning of the inspection. This was pointed out to the staff member. The person in charge informed the inspector that the lock had been broken the night before and was reported to maintenance that day.

- There were no protocols in place around the administration of as required (PRN) prescribed medication in order to guide practice.

The records available indicated that two medication errors had occurred in the centre since the beginning of the year. However, one medication error had not been reported to the nurse manager on call for advice on the matter.

Some medications were required to be crushed in the centre and this had been signed by the prescriber.

There were no controlled drugs stored in the centre. Residents did not self medicate in the centre.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector found that the actions from the last inspection had been implemented in that there was now a Statement of Purpose maintained in the centre that included all of the information required under Schedule 1 of the regulations. The provider was requested to submit this to HIQA.

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):

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

Findings:

The inspector found that the actions from the last inspection had been completed. However, improvements were required to ensure that effective systems were in place in the centre so as to ensure the quality of care provided in the service was monitored and reviewed.

At the last inspection two documents had been outstanding as part of the registration process. They included fire compliance and insurance certificates, both of which have been submitted to HIQA.

There were management structures in place in the centre. The person in charge reported to the service manager who in turn reported to the provider nominee. The person in charge had been interviewed at an earlier date by HIQA and was found to be suitably qualified and knowledgeable of their requirements under the regulations.

Over the course of this inspection, the inspector found that while the person in charge was knowledgeable of the residents needs in the centre, they had no protected time in order to have sufficient oversight in order to ensure the effective governance, operational management and administration of the centre. The inspector found that staff resources had been highlighted on an ongoing issue to the provider. However, this had not been adequately addressed as the assessed needs of residents had not been consistently met, as identified in the findings within this report.

The person participating in the management of the centre was interviewed at the inspection. They were found to be suitably qualified and had a reasonable knowledge of the regulations and their obligations should they be required to deputise for the person in charge.

An annual review had not been completed for the centre. This had not been available in the centre at the last inspection. A copy of a draft annual review was submitted for this centre after the inspection date.

An unannounced quality and safety review had been completed. The records were not available in the centre on the day of the inspection. A copy was submitted to HIQA after the inspection date. This had been completed over two dates in May 2016 and July 2016. On review some sections were not completed on the form, including the section on personal plans and the review of previous action plans/supports.

Judgment:

Non Compliant - Major

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 inspector found that the actions from the last inspection had been implemented in that the provider had reviewed the staff resources in the centre. As a result of this review the staff compliment had increased by 39hrs per week in the centre and a waking night staff had been introduced to replace the sleep over staff in the centre.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector found that the staffing levels in the centre were not adequate to meet the residents assessed needs in the centre and that there was an over reliance on agency/relief staff in the centre.

The inspector found that there were negative outcomes for residents due to inadequate staffing levels in the centre. While the inspector acknowledges that the provider had taken steps in the last week to address this issue, this had been an on-going issue in the centre over the last six months. The staffing levels were contributing to residents making complaints, not having access to areas of their home, support needs not being met in terms of day services and an increase in behaviours that challenge.

The training records for staff on the day of the inspection were not up to date. The person in charge was asked to submit a copy of up to date training for staff to HIQA for review.

There was no formal supervision in place for staff in the centre. Regular staff meetings were not being held in the centre. For example while one meeting had recently taken place there was no meetings held over a three month period prior to this.

There was an actual and planned rota in the centre. However, the rosters did not include some staff full names or their title. For example, whether they were agency or relief staff.

The inspector found from viewing rotas that there was an over reliance on agency and relief staff in the centre due to staff vacancies. The inspector found that 20 different agency/relief staff had been employed in the centre over a four week period. Night shifts vacancies were primarily filled with agency staff who were required to work on their own at night. For example, over a three week period, 11 nights were filled with agency staff. The person in charge informed the inspector that the provider was recruiting staff for current vacancies, and that two out of the three vacancies in the centre had been filled.

There was an induction sheet in place for agency to sign, however the records were not consistently signed and some of the information was incorrect. The person in charge intended to rectify this that day as agency staff were on duty that night in the centre.

There were no volunteers employed in the centre. Personnel files were not inspected at this inspection.

Judgment:

Non Compliant - Major

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):

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

implemented.

Findings:

The inspector found that the two actions from the last inspection had not been implemented to a satisfactory level.

Since the last inspection the provider had undertaken to ensure that all of the policies under Schedule 2 of the regulations were in place in the centre and that they were kept under review at intervals not exceeding three yearly intervals. The inspector found that this action had not been fully implemented in line with the regulations.

The following records were not available in the centre:

- The policy on the prevention, detection and response to abuse was out of date.
- There was no policy on the provision of intimate care
- There was no policy on the use of restrictive procedures in the centre
- There was no policy on the recruitment, selection and Garda vetting of staff
- There was no policy on the provision of information to residents in the centre
- There was no policy on access to education.

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:

Anna Doyle
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-0002332
Date of Inspection:	06 September 2016
Date of response:	29 November 2016

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 05: Social Care Needs

Theme: Effective Services

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

There was no assessment of need in place for one resident.

One assessment of need had not been updated since 2014 and did not reflect the changing needs of the resident.

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

1. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The PIC will:

- ensure that the assessment of need will be in place for the resident.
- ensure that the assessment of need will be updated to reflect the changing needs of the resident
- develop a system to ensure comprehensive assessments will be carried out for all residents, regularly monitored and updated to reflect the needs of residents.
- this system will be discussed with key-workers at support meetings and checked monthly by the PIC.

Proposed Timescale: 01/12/2016

Theme: Effective Services

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

Information contained in personal plans had not been reviewed.

2. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

- The PIC will ensure that information contained in person plans will be reviewed and updated accordingly.
- The PIC will plan a schedule of review of personal plans for all residents.

Proposed Timescale: 01/12/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Residents individual risk assessments had not been reviewed to reflect changing needs.

An identified risk for one resident in the centre had not been removed and this risk had not been highlighted in the residents personal plan.

The review of incidents in the centre was not detailed enough in order to identify trends and inform learning in the centre.

3. 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:

- On behalf of the Registered Provider the PIC will arrange for individual risk assessments to be reviewed to reflect changing needs and review the identified risk for one resident to include all control methods to minimise the risk.
- On behalf of the Registered Provider the Service Manager, PIC and unit Psychologist will meet on 15th Nov 16 to develop a system to review incidents in the centre in a more detailed fashion in order to inform learning in the centre.

Proposed Timescale: 01/12/2016

Theme: Effective Services

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

Monthly fire safety checks had not been completed since February 2016.

4. Action Required:

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

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

- On behalf of the Registered Provider the PIC will ensure that monthly fire safety checks are completed and recorded.

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

The information contained in PEEP's was not consistent with the information on the fire evacuation plan for the centre.

Some of the learning from fire drills had not been recorded in one residents PEEP in order to guide practice.

There had been no night time fire drill completed in the centre.

5. 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:

On behalf of the Registered Provider the PIC will:

- arrange for the Personal Evacuation and Emergency Plans (PEEP) to be revised and that the information will be reflected in the fire evacuation plan for the centre
- Record the learning from fire drills in the residents PEEP in order to guide practice in the future
- Complete a night time fire drill (completed on 11th Sept 2016) and arrange for 2 night time fire drills to be completed per annum as per the organisation's policy.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Adequate fire containment measures had not been considered and there were no fire doors in place in the centre.

6. Action Required:

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

Prior to Inspection the Registered Provider had the following fire containment measures in place in the designated centre:

- Fire alarm - L1 Detection System
- Smoke, heat and steam detectors
- Fire extinguishers
- Emergency lighting
- Automatic release on the back door in case of fire
- 5 ground floor exits
- Solid core internal doors when closed giving 20 minutes protection
- All staff members have completed Fire Safety Training

The Registered Provider will escalate the issue of fire doors to the HSE for approval and funding.

In the meantime the Provider will arrange for intumescent strips and cold smoke seals to be fitted to all internal doors.

The Provider has a Fire Safety Management Policy in place to guide staff practice and requires regular fire drills to be carried out including 2 night time drills per annum.

On behalf of the Provider the organisation's Fire Officer carried out a Fire Safety Check in the designated centre on 14/6/16 which includes actions to be completed.

Proposed Timescale: 31/12/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some restrictive practices in the centre had not been notified to HIQA.

Some restrictive practices had not been reviewed in line with the service policy.

7. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

On behalf of the Registered Provider the PIC will:

- Notify HIQA of all restrictive practices on a quarterly basis as per the regulations
- Refer all restrictive practices to the Positive Approaches Monitoring Group for approval
- Develop a system to review all restrictive practices in line with the service policy.

Proposed Timescale: 30/10/2016

Theme: Safe Services

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

Staff had not received training in positive behaviour support.

8. 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 unit Psychologist provided a positive behaviour briefing session to the staff team on 1/7/15 and attended staff meetings to support and advise staff members on 23/3/16, 11/5/16 and 24/8/16.
- 2 staff members will have completed training in positive behaviour support by the end of 2016.
- The PIC has forwarded all staff members names to the Training Dept for dates in 2017. Staff will undertake this 4 day training in turn.

Proposed Timescale: 31/12/2016

Theme: Safe Services

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

Behaviour support plans had not been reviewed to reflect the changing needs of residents.

Some behaviour support plans did not guide practice for staff.

9. 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:

- On behalf of the Registered Provider the unit Psychologist and Key-workers in the designated centre will review behaviour support plans to reflect changing needs of residents.
- 3 behaviour support plans were reviewed in Sept 2016.
- The unit Psychologist will ensure behaviour support plans are revised to guide staff practice.
- The PIC will support staff members to implement behaviour support plans and will monitor this at regular staff meetings.

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

Intimate care plans were not detailed enough to guide practice.

Information on one residents intimate care plan was out of date.

10. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

The PIC and Key-workers will:

- ensure that intimate care plans are revised to include more detail to guide staff practice.
- develop a schedule to review, update and record changing needs on the residents intimate care plan

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

Appropriate arrangements had not been put in place so as to ensure that all residents were protected from all forms of abuse.

Staff had not received up to date training in safeguarding vulnerable adults.

11. 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:

- On behalf of the Registered Provider the PIC and staff team made local changes in the daily routine in order to reduce contact with peer to peer difficult behaviours. This measure proved beneficial in the mornings.
- The PIC and staff team have continued to make great efforts to support all residents by sourcing activities and events of interest, as far as possible provide individualised outings and allocate staff in such a way to limit the impact of the behaviour issues.
- Refresher training in safeguarding for staff is planned for February 2017. Not all staff had received up to date safeguarding training

- Additional information of a confidential nature has been sent to HIQA in relation to this area.
- Safeguarding Training is planned for all residents in January 2017.

Proposed Timescale: 01/03/2017

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:

A referral made for one resident for an occupational therapy assessment had not been completed.

12. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

- The PIC will contact the OT dept to progress this referral and agree a date for completion of the assessment.

Proposed Timescale: 31/10/2016

Outcome 12. Medication Management

Theme: Health and Development

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

There was no policy in place on the disposal of unused/discontinued medication in the centre.

13. Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

- The Organisations Policy on the disposal of unused/discontinued medication is now in

place.

- The PIC will discuss the policy at the Nov 16 staff meeting and staff members will complete a sign off sheet.
- The PIC and Nurse Manager will review the local policy for disposal of unused/discontinued medication in the centre on 20th Oct 16.

Proposed Timescale: 30/10/2016

Theme: Health and Development

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

There was no photograph on one resident's prescription sheet.

A small fridge in the centre used for the storage of creams in the centre was unlocked on the morning of the inspection.

There no protocols in place around the administration of as required (PRN) prescribed medication in order to guide practice.

Staff had not completed refresher training in the safe administration of medication.

Staff had not received training on the administration of two prescribed medications in the centre.

One medication error had not been reported to the nurse manager on call for advice.

14. 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:

The PIC will:

- Ensure that the residents photograph is on the prescription sheet
- Have the lock repaired on the small refrigerator for the storage of creams (Completed)
- Draw up protocols for the administration of PRN medication to guide staff practice
- Arrange for refresher training in the safe administration of medication for all staff
- Arrange for training on the administration of two prescribed medications (planned for 20th Oct 16)

- Ensure that in future all medication errors are reported to the Nurse Manager as per the policy.

Proposed Timescale: 01/12/2016

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 person in charge did not have protected time in order to ensure effective governance of the centre.

15. 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 ensure the PIC utilises the protected time planned on the roster to ensure effective governance of the centre.
- On behalf of the Registered Provider the Service Manager and PIC will monitor the management input to the designated centre at monthly management meetings.

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

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

An annual review for the centre had not been completed.

16. 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:

- On behalf of the Registered Provider the PIC submitted a draft of the Annual Report to HIQA on 9th Sept.
- The Provider Nominee will review the draft Report with the PIC and Service Manager on 15th Nov.

Proposed Timescale: 18/11/2016

Theme: Leadership, Governance and Management

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

Some parts of the unannounced quality review of the centre had not been completed.

17. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

- The Service Manager will ensure that future quality reviews are completed every 6 months.

Proposed Timescale: 30/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was an over reliance of agency/relief staff in the centre.

18. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

- The Registered Provider has completed a recruitment drive in order to fill the vacancies and maternity leave. 3 successful candidates have been offered posts. 2 of these have accepted and will begin work on 16th Oct and 14th Nov 2016.
- On behalf of the Registered Provide the Service Manager and PIC will develop a workforce plan to minimise disruption of service due to staff vacancies.
- Further interviews are scheduled for 23rd Nov 2016 to fill the vacancies in the designated centre.

Proposed Timescale: 31/12/2016

Theme: Responsive Workforce

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

The actual staff rota's did not include staff's full names.

19. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

- The PIC will ensure that the roster includes each staff members name in full.

Proposed Timescale: 30/09/2016

Theme: Responsive Workforce

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

The staffing levels in the centre were not adequate to meet all residents' needs in the centre.

20. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

- The Registered Provider will undertake a full review of the centre, the number and needs of residents, the number, skill mix and qualifications of staff, the statement of purpose and size and layout of the designated centre.

Proposed Timescale: 30/12/2016

Theme: Responsive Workforce

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

There was no supervision in place for staff in the centre.

21. 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 supervises staff informally and at staff meetings.

- The PIC will arrange a schedule of supervision with the staff team and ensure that a record of supervision is kept.
- On behalf of the Registered Provider the HR Dept is currently developing a Supervision and Support Policy for staff members based on the HSE National Policy which will be customised for staff working in St Michael's House (as the HSE Policy is not specific to the Intellectual Disability Sector). This Policy will be developed by the end of Dec 16.

Proposed Timescale: 30/10/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The policy on the prevention, detection and response to abuse was out of date.

There was no policy on the provision of intimate care.

There was no policy on the use of restrictive procedures in the centre.

There was no policy on the recruitment, selection and Garda vetting of staff.

There was no policy on the provision of information to residents in the centre.

There was no policy on access to education.

22. 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:

- On behalf of the Registered Provider the PIC will ensure that the policies identified in Schedule 5 are present and up to date in the designated centre.
- The PIC will include organisational policies on the agenda at staff meetings.

Proposed Timescale: 30/10/2016

