Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0002336
Centre county:	Dublin 11
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	John Birthistle
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	1

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:
11 May 2015 13:30	11 May 2015 19:00
13 May 2015 08:00	13 May 2015 18:30

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

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

Summary of findings from this inspection

This was the first inspection of this 6 bed centre for persons with disabilities. 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 members were also sought.

As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider for the purposes of application

to register were found to be satisfactory.
The fitness of the person in charge was assessed through interview and throughout the inspection process to determine fitness for registration purposes and was found to have satisfactory knowledge of their role and responsibilities under the legislation and sufficient experience and knowledge to provide safe and appropriate care to residents. The fitness of the nominated person on behalf of the provider was previously considered as part of this process.

A number of residents and relatives' questionnaires were received by the Authority during and after the inspection. The opinions expressed through both the questionnaires and in conversations with inspectors on site were all satisfactory with services and facilities provided.

Overall, evidence was found that all residents' social, personal and healthcare needs were not being fully met. Residents had access to general practitioner (GP) services and a full time medical officer as part of the overall services provided by St Michael's House Group and although there was some access to allied health professionals these services were limited.

The inspector found there were several aspects of the service needed improvement including admission and discharge processes, assessment and review of care needs, care planning and resources.

These findings were brought to the attention of the provider nominee during the inspection and assurances were given by the provider nominee that actions required to address the most urgent findings had commenced and would continue to ensure the needs of all residents would be fully met.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Daily routines respected individual choice and preferences such as times for rising or returning to bed. Residents' privacy and dignity were respected through personal care practices, maintaining private communications and contacts with relatives and friends and maximising independence. Locks were available on all bedroom doors and residents were provided with their own key where capacity and safety was determined. CCTV or other monitoring devices were not in use in the centre at this time.

Staff were observed to try to facilitate residents' capacity to exercise personal autonomy and to help residents exercise choice and control in their daily lives in accordance with their preferences. Independence was promoted and encouraged in personal care and other activities of daily living relevant to assessed abilities.

However, despite the efforts of staff to promote choice and support residents to have control over their daily lives, difficulties associated with the relationships within the current resident profile and limitations to activities for residents were noted. These are further referenced under Outcomes 4 8 and 16 in this report.

Systems to safeguard finances were in place and supports to facilitate residents to safely manage their finances were reviewed. It was found that residents' belongings and finances were protected on this inspection by robust systems of recording, balancing and auditing. Each residents' bank account statements were regularly audited by the person in charge.

There was a written operational policy and procedure relating to the making, handling and investigation of written complaints. The procedure identified the nominated person

to investigate a complaint and the appeals process. There was a nominated person who held a monitoring role to ensure that all complaints were appropriately responded to and records were kept. The complaints record was viewed and it was found that staff had assisted one resident to make a complaint. This complaint was made in the week preceding the inspection and so a full determination on the management and follow up in line with the organisations policy could not be made. It was noted that the National Advocacy service was contacted and assistance requested for this resident. But the person in charge was told there was no availability and evidence that any other form of advocacy was considered or identified was not available.

Regular residents meetings to discuss and agree the daily or weekly activities programme, menu choices or other group life decisions were held. The inspector was told that opportunities for families or representatives to formally meet with staff to discuss their loved ones care plan took place on an annual basis and social occasions were also held. But a transparent formal consultation process to seek or action the views of residents or relatives on service delivery or development was not in place.

Also as referenced under Outcome 6 archived records were being stored in an openly accessible area. This did not ensure respect for residents' privacy or confidentiality of information as required by the regulations.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Evidence that staff were aware of the different communication needs of residents and that systems were in place including external professionals input where necessary, to meet the communication needs of all residents was found.

Several of the current residents had a variety of communication needs, some were non verbal and others had sight and hearing difficulties. Residents identified with verbal communication difficulties were supported and helped to communicate using alternative methods such as expressive body language and picture prompts. During this inspection it was noted that regular staff were familiar with the expressive body language prompts used by some residents to indicate a need, these included smiling, crying or clapping to indicate contentment, discomfort or accepting something offered.

A file containing a large number of pictures depicting various activities such as shopping, meals and hair dressing were also available and noted to be used by staff as a way of clarifying meaning with residents.

The centre was part of the local community and residents were helped to visit local shops, restaurants and leisure facilities on a regular basis. Those who wished to, had access to radio, television, magazines and information on local events. However, although some residents had their own personal phones, access to social media in the form of internet or Skype were not available. When raised, the person in charge stated she would look at this as a means of development and promoting residents full capabilities.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Evidence that residents were supported to develop and maintain positive relationships with family and friends were found.

However it was noted that due to the age profile of siblings' parents and other relatives for some residents contacts were primarily through regular phone calls. Visits were facilitated by staff at the choice of the resident and their family.

Arrangements were in place for each resident to receive visitors in private without restrictions unless requested by the resident.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Evidence that the service and facilities were meeting the needs of current residents, that the transfer and discharge process was timely, responsive to residents' needs and in line with transparent criteria in the statement of purpose was not found.

The resident profile of the centre was found to be stable and there were no new or recent admissions. But the inspector learned that decisions to change the purpose and function of the centre had been made and this included the transfer of all of the current residents to alternative services.
The person in charge had been informed of this decision approximately six months earlier, although without any details or specific information of how or when the process would commence. The remaining staff and residents' relatives were informed three to four weeks ago although a decision was taken not to inform residents to prevent any undue upset at this time.

However although the decision was taken and communicated, evidence that any actions had been taken to commence the transfer process was not found. This inaction persisted despite the full knowledge of senior managers and clinicians of the inability of the current service and facilities to meet residents needs. This inaction resulted in ongoing negative impacts on all residents using the centre over a prolonged period of time.

Evidence was found of;
-interpersonal conflicts resulting in residents living in an atmosphere of heightened tension on an ongoing basis.
-inability of the service to manage escalation of behaviours that challenges consistent with a deterioration in mental health.
-requests for reviews and supports to clinicians and senior managers made by the person in charge consistently over a prolonged period without success
- transition plan to commence identifying alternative suitable services, linked to a full review of current residents needs not in place.
- admission transfer and discharge policy and processes in place were not found to be implemented. These issues are also referenced under Outcomes 6,8,11 14, and 16 of this report

On a sample of those reviewed it was found that each resident had a written contract agreed within a month of admission. The contract sets out the services to be provided

and all fees were included in the contract. Where additional charges pertained these were also included.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Evidence that residents' well being and welfare was maintained by a good standard of evidence-based care and support was limited.
All residents did not have an individual personal plan in place to support independence or life skill development. Where these were in place, they were not all based on a fully completed personal wellbeing assessment process, were not supported by a detailed process to progress the identified goals and were not fully linked to meeting known wishes and aspirations.
Examples included; goals set in 2014 to develop money management skills for one resident.
-aspects of the personal well being assessment to assess skills ability for numeracy or literacy were not completed.
- two actions were identified; location of funds for access by residents and discussion with day service key worker to consider money management course. But there was no documented plan to identify how they were to be progressed, by whom or when. No other actions were considered to try to achieve the goal.
- the monthly report at April 2015 stated that the goal of gaining understanding of the value of money was not successful for this resident. An explanation on why it was not successful was not documented.

Considerable time and efforts by staff and clinicians recently in the day service with notable supports by staff in this centre to develop skills to enable this resident go on an overnight holiday in 2015 with a very close friend were noted.

Discussions to identify the skills required and actions to progress were agreed and some

actions had taken place such as deciding on the accommodation; building familiarity with restaurant and bedroom layout. Some were also closely linked to the money management goal identified in 2014, including; ordering meals and asking for the bill. However these were not yet supported by individual detailed plans to identify responsible persons, ensure progress and document the outcome.

Some residents did not have any individual personal plans in place for either 2014 or 2015. Whilst there were clear reasons for this in some cases related to changing health care needs, reasons why other residents who did not have personal plans in place were not clear or documented.

On review of a sample of clinical documentation it was found that a lot of improvements were required to ensure that residents' needs were appropriately met. Needs were not assessed using evidence based tools and care plans which set out arrangements to meet these assessed needs were not clear or detailed enough.
Although staff were aware of changes in needs, had raised their concerns and were actively seeking clinical supports to meet them, residents' needs were not fully or appropriately assessed. Examples included; nutritional assessments were not done where poor diet, increase in weight and episodes of constipation were identified. Where non verbal residents experienced pain an assessment to guide staff on determining increasing levels of severity and decision making on appropriate interventions was not in place.
A care plan was not in place for every identified healthcare need, such as, dysphagia, or breathlessness and where plans were in place all were not found to be detailed enough to manage the specific problem. Did not reference referrals to or recommendations of allied health professionals. Plans were not reviewed as needs changed in order to appropriately determine their effectiveness. Examples included plans for; mobility, pain relief, nutrition and personal hygiene.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Overall the design and layout of the centre was found to meet the needs of most of the

current resident profile in line with the statement of purpose. The centre is a dormer bungalow located in a settled urban community. In general the centre contained all health and safety aspects and appropriate security. Appropriate equipment for use by residents or staff was available and maintained in good working order.
Adequate private and communal accommodation included; Downstairs; large entry hallway; two single bedrooms without ensuite; large fully fitted L shaped kitchen cum dining room; a sitting room and a small room at the front of the house, which was generally used as a quiet room for one person; one large assisted shower room with w.c. and w.h.b.; laundry room; separate bathroom with w.c. and w.h.b. Upstairs; four residents bedrooms, three single and one twin without ensuite; one bathroom containing w.c. and w.h.b. and non assisted bath; separate w.c. with w.h.b. and one staff sleepover bedroom cum office with full shower ensuite.

Externally there was a small paved area front and to the rear and side of the building. The grounds were neat and tidy, with small storage areas for cleaning equipment and domestic bins. The rear of the building was enclosed through a locked gate and railing. There were shrubs and plants to the front of the centre and a small patio and lawn to the rear.

Efforts to reflect residents' individuality and preferences in relation to colour and furnishings in bedrooms were noted and photographs pictures and fixtures which reflected interests and hobbies were evident.

The centre was visually clean and mainly uncluttered. The kitchen was fully operational with sufficient cooking facilities and equipment. The dining area was bright with lots of circulation space. The sitting room overlooking the rear patio and garden contained couches, nest of tables and a TV unit with space for DVD and CD player.

However, although the centre was in general well maintained some aspects needed to be improved such as aspects of wood work on some door frames and skirting's and paint work on walls were marked and scuffed. The hallway although wide did not have any grab rails to assist persons with mobility or balance issues should this be required.

Service records were found to be up to date and maintenance contracts including domestic and clinical waste were in place.
Improvements to the storage of residents' confidential and archived files were needed. These were stored in an unlocked openly accessible cupboard in the hallway. An action relating to this is included under Outcome 1.
Issues relating to the suitability of the centre's environment to fully meet the needs of all current residents and actions arising are referenced under other outcomes in this report.

Judgment:
Substantially 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):

Findings:
The inspector found that in general good governance processes and safe practices implemented by the person in charge with staff promoted and protected the health and safety of residents. Safe and appropriate practices in relation to moving and handling, infection prevention and control and reasonable measures to prevent and reduce risk of accidents were found to be in place.

Overall, the health and safety of residents, visitors and staff was promoted and protected in that policies and procedures for risk management and health and safety were available and staff were aware of them.
Records relating to fire safety were readily available regarding the regular servicing of fire equipment and fire officers' visits. Fire escape routes were unobstructed. Fire equipment and alarms were tested and arrangements were in place for the maintenance of the system and equipment. Individual personal emergency evacuation plans for all residents were in place and were sufficiently specific to guide staff. Staff had received annual training in fire safety as required under the legislation and all staff spoken with demonstrated a good knowledge of the procedures to be followed in the event of a fire, and the contents of the emergency plan. Each resident had a detailed evacuation plan which had been risk assessed.

Arrangements were in place for responding to emergencies including procedures and policies covering responses in the event of a resident being absent or missing without staff knowledge. In conversation with them it was found that staff were fully aware of these procedures.

Evidence of effective review of the systems in place to assess and manage all risks associated with response to emergencies was found. A centre specific emergency plan to direct and guide staff in response to any major emergency such as power failure, flooding or other form of emergency was available and had recently been reviewed. The plan identified all resources available to ensure residents' safety such as alternative accommodation. Some additional equipment to effectively and safely respond to emergencies was available such as search torches, blankets and lists of emergency numbers.

Judgment:
Compliant

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:
The use of audio or visual monitors or CCTV was not in place on this visit. Staff endeavoured to respect residents' dignity and privacy and could tell the inspector what they should do in the event of an allegation, suspicion or disclosure of abuse, including report procedures.
Restrictive measures such as use of lap belts or bed rails were not observed to be in use in the centre at the time of this inspection.

The interactions between residents and staff were observed to be respectful. Residents who were verbal could tell the inspector that they trusted staff and whether they had a favourite. They could also say who they would go to if they had any worries or problems. Where residents were non verbal the inspector observed they appeared comfortable with staff.
But, the inspector was not assured that all residents' privacy dignity and rights were being fully safeguarded through a positive supportive environment.
Although the residents stated or indicated they felt comfortable or safe with the staff team, the inspector found through further conversation and on observation that some were feeling afraid and upset.
This was due to prolonged and recently increasing instances where some residents exhibited aspects of behaviour that is challenging towards other residents and staff. These incidences included; shouting; pushing and intimidating through 'body blocking'. Staff reported and documented where residents were upset and frightened as a result of these incidences which were increasing in intensity duration and frequency.
These forms of behaviours were ongoing over a substantial period of time but had increased in frequency over the past year. 30 incidences were found to have occurred in a four months period between February and May 2015 up to the date of the inspection. As all of these incidences have been found to have had a very negative impact on other residents such that residents were fearful it could be determined that they fall within the definition of abuse.

Some documents viewed showed where the person in charge identified that current positive behavioural support plans in place were not effective.
Reasons included;
-centre is unsuitable for person who requires low arousal environment due to the

number of people with high noise levels.
-lack of consistent routine and staff due to high agency use and roster variability.
-The service provides for time share which also leads to variability of interpersonal relationships and routine.
It was stated that the plans in place were effective in the day service due to a predictable and consistent routine staff and environment.
Documents showed that the person in charge had made repeated requests for clinical reviews relating to these behaviours on several occasions throughout 2014 and twice in 2015 to date. Responses received included a refusal by a psychologist to review the service user in the centre in January 2015; a recommendation by a psychologist for urgent psychiatric review and the need for more suitable living environment in March 2015; recommendation to review behavioural support plans due to reluctance to increase medication and concerns relating to environment in early May 2105.

Despite all of the above, the positive behavioural plans in place, specific to the environment in the centre had not been reviewed by a psychologist since June 2014. There was no evidence that a psychiatric referral had been made since the urgent recommendation in March 2015.
It was found that the provider senior management and clinical support teams were fully aware of the behaviours and associated risks as staff had consistently reported their concerns but an appropriate or adequate response was not received.
An action in relation to this is included under Outcome 5.

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

Findings:
An electronic record of all incidents occurring in the designated centre was found to be maintained and where required were notified to the Chief Inspector within the specified time frames. However, a high incidence of behaviour that challenges was found to have occurred in the centre which was not notified to the Chief Inspector.

As a general rule, behaviour that challenges should not be notified as abuse unless it impacts to such an extent on other resident(s) that it clearly falls within the definition of abuse. As all of these incidences have been found to have had a very negative impact on other residents such that residents were fearful, it could be determined that they fall

within the definition of abuse.

There should be policies and procedures in place within designated centres (that reflect national guidelines and international best practice) which guide decision making by staff regarding when behaviour that challenges should be considered abuse and therefore notifiable to the Chief Inspector.

Judgment:
Non Compliant - Moderate

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):

Findings:
Evidence that an assessment process to establish each residents educational, employment or training goals in accordance with their wishes and capacities was found, and a personal wellbeing assessment had been carried out. This is detailed under Outcome 5 of this report. It was found that due to their assessed capacities that with the exception of one person the current profile of residents were not involved in education or employment programmes. One resident did avail of a supported employment programme involved in a local voluntary group.

Residents were facilitated to participate in social experiences through visits to the cinema, shopping trips and other outings. Although systems were not established for residents to develop new skills or maintain life skills through continuous development or training programmes the current profile of residents were not assessed as having capacity to engage in this level of development.

Staff ensured that residents were facilitated to engage in activities normally associated with basic life rights such as going for a walk or drive, visits to the park and shopping for groceries or personal shopping.

All of the residents had access to a day care service.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Residents were provided with food and drink at times and in quantities adequate for their needs. All meals were prepared in the centre and residents were encouraged to be involved in the preparation of meals as appropriate to their ability and preference. Food was properly served and was hot and well presented. Residents were facilitated to enjoy their meals independently, privately and at their own pace; where assistance was required it was offered in a discreet and sensitive manner.

Suitable and sufficient arrangements were not in place to meet the assessed needs of residents. Although there was evidence that some of the health care needs of residents were being met through access to medical officers and general practitioners. Access to other clinicians for all residents who were identified as requiring same was not found to have been provided.

Particular concerns related to the level frequency and type of clinical supports and inputs by nursing and allied health professional to the person in charge and the care team in the centre to promote and maintain health. The current profile of residents had a variety of health, personal and socially complex needs. There was limited evidence that these needs were being managed holistically in a timely and responsive manner. The inspector found that although a team of allied health professionals was available within the service, the person in charge and her team had difficulty accessing them due to service constraints.

It was found that repeated referrals for clinical inputs such as psychology, dietician, occupational therapy and psychiatry some up to 12 months previous had not yet received an appointment and in some cases not even a response.

The inspector noted that some of the residents were elderly with underlying conditions such as dysphagia, epilepsy, obesity, chronic constipation cardiac conditions and breathlessness. Staff had found deteriorations in the residents' abilities to manage some activities of daily living such as continence and mobility. However, there were no full time nursing inputs in the centre. Regular and ongoing review processes and assessments to maintain health such as; blood pressure monitoring; weight and body mass index monitoring and blood profile reviews needed to be established.

During the inspection an incident relating to behaviour that challenges was observed and residents were noted to be upset following this. Although identified as a need by

the person in charge clinical staff supports including; nursing; counselling; social work and psychology services to address the interpersonal difficulties pertaining in the centre and to meet residents' emotional and behavioural needs were not in place.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Evidence that the processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation were found and there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

The administration of medication to residents was observed, and it was noted that staff were familiar with each resident's medication and facilitated residents to take their medication at the prescribed time as part of their daily routine. Details of all medicines administered were correctly recorded.
It was found that each of the residents had their prescribed medications recently reviewed by a Medical Officer. Observation of medication administration practice was satisfactory and a record of staff signatures and initials were maintained in line with best practice.
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 and recorded. There were two secure disposal containers for medications although these were stored in the same cupboard as all other medication stock and should be stored separately.

An audit of each resident's medications was completed on a weekly basis by staff; any discrepancies were identified and reported to the service manager by completion of an error form.

There was evidence that medication management practices were broadly in line with current guidelines and legislation although some improvements were found to be required such as;
-topical medications which were opened and in use did not have an identified date of opening so that a determination can be made when the medication should be discarded

in line with manufacturers or pharmaceutical guidance.
- improvements to audit processes to include commencement dates of topical medications and to ensure that each medication has a dispensing label from the pharmacist were needed. A small number of medications did not have a dispensing label.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
A written statement of purpose was available which contained all of the information required by Schedule 1 of the Regulations.
However, the statement did not reflect the service being provided in the centre in that the facilities and services outlined in the document were not in place in order to meet the diverse needs of the current client group.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Some evidence that management systems within the centre were in place was found. An annual review of the quality and safety of care in the designated centre had not yet been conducted although a report on a six month quality review by the service manager was carried out. This included aspects of the service such as; equipment maintenance; emergency procedures and planning; transport maintenance; restrictive practice review; nurse manager on call supports and safeguarding.
The service manager and person in charge met regularly to discuss the service provision budgets and resources for the centre.

The person in charge and the service manager both engaged with the process to determine fitness as part of the inspection and demonstrated sufficient knowledge of the legislation and statutory responsibilities associated with their roles. It was found that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and was clearly resident focused.

As previously referenced under outcomes 4 and 13 a review of the purpose and function of the centre had taken place and a decision made to transfer all of the current residents to alternative services. However, no action had been taken to progress this decision in a six month period. As a result supports, including appropriate management systems were not sufficient to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.
The role of the person in charge or other senior managers in the change of purpose and function of the centre was unclear. Specific roles and responsibilities for managing the transition process were not in place.
Change management supports to ensure the ongoing provision of a safe and effective service and safe planned transfers to alternative services with a review period were not in place. Needs assessments or health and social care reviews to ensure appropriate decisions were made on behalf of existing and prospective residents were not in place. There were limited supports to the staff in the centre to enable them to meet the full needs of the current resident profile.
This centre forms part of a larger service provider with a complex management structure and clinical supports. But the system was not found to be responsive to the needs of residents and supporting the delivery of safe quality care. Evidence of failures to meet residents' needs have already been outlined under outcomes 5, 8 and 11. Responsive appropriate systems to ensure the implementation of personal plans to meet residents' health and social care needs such as; assigned clinical teams; responsiveness to recommendations and prioritisation of the care of residents with complex needs were not in place.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge.

A senior experienced and qualified social care worker was identified to replace the person in charge and was noted to be familiar with residents' social and healthcare needs and aware of the responsibilities of the role in relation to notifications and protection of residents.

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):

Findings:
Evidence that there were sufficient resources to fully meet residents needs was not found.
As already referenced and detailed in findings under Outcomes 5, 8 11, 13, 14, and 17, resources were not targeted or prioritised to meet all care needs of the current resident profile in that;
-centre routines and activities were resource led and not person centred. Activities were dependent on a qualified driver being rostered on duty. There was a heavy reliance on agency staff as there are currently only four permanent staff. Only permanent staff are licensed to drive the centre's bus. Also, due in part to behavioural issues referenced under other outcomes, all residents cannot go on outings together. This limits the number of residents who can be facilitated to enjoy a social activity each day. Staff try

to ensure that every person has at least one activity midweek and one at weekends but this is not always possible.
- as outlined under outcomes 5, 8 and 11 there is limited access to the multi disciplinary team and there has been a lack of timely review of health and social care needs.
- no nursing inputs were available in the centre yet there were some residents with deteriorating health and ageing profile- additional highly skilled clinical staff supports including; nursing; counselling; social work and psychology services to address the interpersonal difficulties pertaining in the centre and to meet residents emotional and behavioural needs were not in place.
- as outlined under Outcome 13 the facilities and services outlined in the statement of purpose were not in place in order to meet the diverse needs of the client group the designated centre is intended to meet.
- as outlined under Outcome 14 There were limited supports to the staff in the centre to enable them to meet the full needs of the current resident profile.
-although a decision was made to transfer all of the current residents to alternative services no action had been taken to progress this decision in a six month period.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
Evidence that the numbers and skill mix of staff were appropriate to meet the assessed needs of residents was not found. Although respectful and attentive interactions were observed between staff and residents and it was noted that staff provided ongoing reassurance to residents, sufficient staff to provide a safe care environment for residents were not always available.

All of the residents in the centre have an intellectual disability. Interpersonal relationships within the centre have broken down between some residents. This had resulted in a tense atmosphere which did not enable staff to foster and develop a supportive living environment.

Emotional and behavioural needs associated with inability to share, attention seeking

and high anxiety levels within the client group had been identified. These needs required a high level of skilled support and some residents had been identified as requiring one to one supports on a regular basis but these were not always in place. Although additional care hours were provided to facilitate the one to one support needs, staff to fill these hours were not always found.
Reasons for this included; short three to four hour shift periods. They were also very changeable to try to give flexibility to meet client needs and so were difficult to fill. This often meant that the support of one to one was staffed three or four days per week instead of every day.

One full time long term vacancy and the one to one support hours of 30 hours per week were covered by agency staff. A full time waking night staff was also covered by agency making up more than half the staffing of the centre on an ongoing basis by agency staff. The person in charge tried to ensure that the agency staff were regular to help build familiarity. This was not always possible and it was noted that there were a lot of staff changes. This did not provide for the consistency required to meet the needs of all residents.

In addition there were no full time nursing inputs in the centre and a full review of the nursing inputs required to meet current residents needs was needed. It was noted that the current profile of residents needs were changing and some were found to have deteriorating abilities.

On review of staff training it was noted that all staff had received required training in areas such as moving and handling safeguarding and fire safety. Other training was also provided in; safe administration of medication and positive behavioural supports. But further training to enable staff meet the full needs of residents and additional training in areas such as; assessment and care planning; attention deficit disorder; autism; bipolar disorder were found to be required. An assessment of competency of staff following training delivered should also be considered.

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):

Findings:
In a sample of those reviewed it was found that general records as required under Schedule 4 of the Regulations were maintained including key records such as the statement of purpose and function, resident's guide, and notifications as required under Regulation 31.

Records were maintained in respect of accident and incidents, clinical records and documentation of reviews and recommendations by clinicians were retained in the centre.
A directory of residents was established which included all the required information and was being maintained.
All of the policies required to be maintained under Regulation 4 and listed in Schedule 5 were available although some clinical policies were in need of review.

Judgment:
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:

Nuala Rafferty
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-0002336
Date of Inspection:	11 May 2015
Date of response:	21 September 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:
Records with residents' personal information were being stored in an openly accessible area. This did not ensure respect for residents' privacy or confidentiality of information.

1. 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:
The PIC contacted technical services and requested additional locked storage space for the purposes of storing personal files securely. Technical services have identified a suitable location for the locked press and the PIC and technical services have agreed the work. Work is scheduled for completion in July 2015.
Update;
All documentation was moved from under the stairs to a vacant room in the designated centre. The door to this room is locked and the key is stored in the office.

Proposed Timescale: 31/07/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A transparent formal consultation process to seek or action the views of residents or relatives on service delivery or development was not in place

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

Please state the actions you have taken or are planning to take:
THE PIC and PPIM will establish a system for consulting with service users and their families regarding the organisation and running of the designated centre.
The system will include:
•The PIC and PPIM will discuss with residents their views and experiences of living in the centre using a standardised format for information gathering.
•The PIC and PPIM will meet with families annually to seek the views of families. If families are unable to attend a meeting the PPIM will make contact by phone/ email/ use of a questionnaire- using a standardised format to solicit their views on the organisation and running of the centre.
•This process will be held annually or sooner if required, and records of the consultation will be maintained.
In light of the proposed relocation of service users, this is no longer applicable.
•The information gathered as part of the consultation will inform the development of the Annual Report for the centre.

Action plan update;
Each service users opinion was sought to determine their view of living in the designated centre. A service user friendly format was designed to assist non verbal service users in the process. Three of the services users offered their opinion.

On the 20th and 22nd of April 2015, all families were invited to individual meetings to discuss the relocation of service users from the designated centre and were given the

opportunity to voice any concerns they had.

Proposed Timescale: 30/08/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that the admissions transfers and discharge process was timely, responsive to residents needs and in line with transparent criteria in the statement of purpose was not found.

3. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The PIC has reviewed the Statement of Purpose to ensure it contains transparent criteria for the admission, transfer and discharge processes. The updated Statement of Purpose will be made available to residents and family members. A copy of the updated Statement of Purpose has been sent to The Authority.
Update;
A copy of the Statement of Purpose was emailed to HIQA on the 12/05/2015 and on 21/07/2015 at 17:06

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Admission transfer and discharge policy and processes in place were not found to be implemented. This resulted in negative impacts on all residents using the centre over a prolonged period of time

4. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
The Service Manager and a member of the internal group known as Residential Approvals will meet with the PIC bi-weekly to ensure the transfer process is in line with the policy, protect residents from abuse by peers and are responsive to residents need The meeting will include:

•Review the transfer process for individual service users to ensure it is in line with the policy.
Update:
All processes are being monitored by the Social Work team leader, the Administration Manager, Service Manager and PIC at the Residential Approvals consultation meetings.
•Review rosters and staff allocations to ensure safe and effective services are delivered while the process of transferring service users is on going.
Update;
A roster review was conducted on the 11/08/2015. The roster will continue to be reviewed as service users depart the centre.
•Review incidents of challenging behaviour, accidents and incidents, and safeguarding concerns and identify strategies to manage these.
Update;
The incidences of behaviours that challenge, accidents and incidents have been reviewed by the PIC. ABC charts are being maintained regarding behaviours that challenge within the centre and these are being reviewed by the Senior Psychologist and the MHID (Mental Health Intellectual Disability) Psychologist. A review has been untaken by the senior Social Worker regarding safe guarding concerns. Reviews are ongoing.
•Review the effectiveness of clinical guidelines to reduce incidents of peer to peer challenging behaviour.
Update;
The effectiveness of the guidelines have been reviewed by the Senior Clinical Psychologist and the PIC and new guidelines have been put in place.
•Review of risk assessments to identify additional controls to support safe and effective services.
Update;
The PIC, Service Manager and Social Work Team Leader, in consultation with the Senior Psychologist have reviewed the risk assessments regarding the provision of a safe and effective service and new guidelines have been issued.
•Make determinations based on assessed needs about how best to support all service users in this process of transition.
Update;
Resident's families and service users have been informed about the moves, regular consultation meetings are held and visits by the resident to their proposed new designated centre are facilitated by the designated centre staff team. Any concerns are discussed at the consultation meetings. Service user friendly transition folders have been developed depicting where the service user currently lives, local areas that they access, photos of people that are important in their lives, pictures of both the inside and outside of the house that they will move to and also a picture of their new key worker. A quick reference information booklet is included outlining likes, dislikes, important contacts and other information concerning the individuals.
•Identify with the PIC the additional training and supports staff require to implement service users support plans including their transition plans.
Update;
All staff are involved in the transition process. They facilitate visits of the service users to the proposed new designated centres. They have supported residents by discussing the proposed moves with them. A number of meetings have taken place with the PIC, service manager, administration manager and the social work team leader.

These meetings will take place from 1st July until all residents are placed in their new designated centres. The service users will transition to their new centres by 30th Sept
Update;
2 residents have now moved from Hazelwood and consultation documents have been issued for the remaining 5 residents. In one case, it was found on closer examination that the proposed designated centre was not suitable to meet the needs of the resident. A further consultation document will be issued for a more appropriate centre. In light of the fact that this could potentially happen with other residents, the closure date must be extended beyond the 30th September to the 30th November 2015.

Minutes of these meetings will be kept and will be available for review.
The minutes of these meetings are available for review.

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 plans were not in place for all residents.
Some individual personal plans were not detailed enough to adequately support resident's continued personal independence and life skills development.

5. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The PIC will review all assessments of need and personal plans. The purpose of the review is to:
•Identify if assessments of needs are comprehensive and up to date.
Update;
Comprehensive assessments of need were completed before the 15th August and are up to date.
•Update personal plans with additional detail when required.
Update;
All personal plans are up to date – completed by 31st July 2015
•Identify plans that require development to support personal independence and life skills development.
Update;
The transition process including consultation meetings, visits to proposed designated centres, supporting service users is underway. It is proposed in the persons new designated centres that personal independence and life skills development will be significantly progressed.
•Develop additional care plans for every identified health care need including dysphagia

and breathlessness
Update;
Care plans have been developed around dysphasia and constipation.
•Identify changing needs and develop care plans to support these needs.
Update;
PIC has reviewed the needs of current residents and no alternate needs were identified.
•Review Positive Behaviour Support Plans that are in place to identify if additional pro-active and reactive strategies could support positive behaviour.
Update;
Positive Behaviour Support Plans were reviewed by the Senior Clinical Psychologist who determined that "no additional material is needed for this plan, including proactive or reactive strategies".
•Consider the appropriateness and effectiveness of each plan in place to support individual service users
Update;
All plans have been reviewed by the PIC and are considered appropriate and effective.

The PIC and Service Manger will discuss with the relevant Clinic Manager the internal processes for referring service users to individual clinicians. The referrals process will be documented in the designated centre and will be available to the PIC and all staff to follow. This will ensure that referrals are made in line with the organisational processes and procedures. Minutes of the meeting will be available for review.

Following this the PIC will make referrals to the clinic team and allied health professionals as indicated in the assessment of need. Additional support from the service manager and if necessary the lead clinician will be available to ensure that referrals are timely and follow the appropriate internal processes. A copy of the referrals and the outcomes will be filed in the service user's individual file.
Update;
A meeting was held with the Clinical Manager, Service Manager and PIC on the 21/07/2015. All relevant referrals have been made to the relevant clinical disciplines in accordance with the referral process.

Proposed Timescale: 15/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some plans in place were not effective and were not reviewed in a timely manner to take account of changes to residents behaviour.

Reviews of health care plans in place were not sufficiently robust to determine their effectiveness or take account of changes in circumstances or new developments.

6. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The PIC will review all assessments of need and personal plans. The purpose of the review is to:
•Identify if assessments of need are comprehensive and up to date.
Update;
All assessments of need have been examined by the PIC and are considered to be comprehensive and up to date.
•Update personal plans with additional detail when required.
Update;
All plans have been reviewed.
•Identify plans that require development to support personal independence and life skills development.
Update;
These plans will now be developed by staff teams in the new centres.
•Develop additional care plans for every identified health care need including dysphagia and breathlessness.
Update;
A plan for all identified health care needs has been developed and each staff member has been briefed in relation to these plans.
•Identify changing needs and develop care plans to support these needs.
Update;
No alternate needs have been identified at this time.
•Review Positive Behaviour Support Plans that are in place to identify if additional pro-active and reactive strategies could support positive behaviour.
Update;
Current Positive Behaviour Guidelines have been reviewed and are considered to be effective.
•Consider the appropriateness and effectiveness of each plan in place to support individual service users
Update;
The PIC has reviewed the individual support plans and deem them to be appropriate.

The PIC and Service Manger will discuss with the relevant Clinic Manager the internal processes for referring service users to individual clinicians. The referrals process will be documented in the designated centre and will be available to the PIC and all staff to follow. This will ensure that referrals are made in line with the organisational processes and procedures. Minutes of the meeting will be available for review.
Following this the PIC will make referrals to the clinic team and allied health professionals as indicated in the assessment of need. Additional support from the service manager and if necessary the lead clinician will be available to ensure that referrals are timely and follow the appropriate internal processes. A copy of the referrals and the outcomes will be filed in the service user's individual file.
Update;
A meeting was held with the Clinical Manager, Service Manager and PIC on the 21/07/2015. All relevant referrals have been made to the relevant clinical disciplines in accordance with the referral process.

Proposed Timescale: 15/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The suitability of the centre to meet the needs of all residents had not been reviewed despite recommendations by clinicians.
This was negatively impacting on other residents in the centre.

7. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
A review of the service provided in the designated centre was carried out by the registered provider in 2014. The review established that the service in its current configuration was not able to effectively meet the needs of all residents. The registered provider and PIC in consultation with a multi-disciplinary team are working to transfer the current residents to more appropriate residential services by 30th September 2015
Update;
2 residents have now moved from Hazelwood and consultation documents have been issued for the remaining 5 residents. In one case, it was found on closer examination that the proposed designated centre was not suitable to meet the needs of the resident. A further consultation document will be issued for a more appropriate centre. In light of the fact that this could potentially happen with other residents, the closure date must be extended beyond the 30th September to the 30th November 2015.

The PIC will continue to support the transition of service users to new designated centres. This will include ensuring an up to date assessment of need and associated care plans are developed and available to support residents in advance of their transition.
The PIC will review all assessments of need and personal plans. The review will
•Identify if assessments of needs are comprehensive and up to date.
Update;
All assessments are comprehensive and up to date.
•Update personal plans with additional detail when required.
Update;
All personal plans have been reviewed.
•Identify plans that require development to support personal independence and life skills development.
Update;
It is proposed in the persons new designated centres that personal independence and life skills development will be significantly progressed.
•Identify new or changing medical/ allied health professional needs. Associated health care plans including plans for managing constipation, dysphagia, breathlessness, weight management and pain management, care plans will be developed and implemented. These plans will be developed in consultation with a doctor, nurse or other allied health professional such as a speech and language therapist. Identify if assessments of need are comprehensive and up to date.
Update;

All assessments of need have been examined by the PIC and are considered to be comprehensive and up to date.
•Update personal plans with additional detail when required.
Update;
All plans have been reviewed and are considered adequate.
•Identify plans that require development to support personal independence and life skills development.
Update;
Plans that require development will be undertaken by the residents' new centre.
•Develop additional care plans for every identified health care need including dysphasia and breathlessness.
Update;
A plan for all identified health care needs has been developed and each staff member has been briefed in relation to the plans.
•Review Positive Behaviour Support Plans that are in place to identify if additional pro-active and reactive strategies could support positive behaviour.
Update;
New positive behaviour support guidelines have been put in place and are considered by PIC and Senior Psychologist to be effective.
•Consider the appropriateness and effectiveness of each plan in place to support individual service users
Update;
The PIC and Senior Psychologist have reviewed plans and consider them to be effective

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessed needs of residents were not being fully met. Residents were exhibiting symptoms of stress related to recurrent incidences of behaviour that challenges.

8. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
•The PIC will review assessments of need and will develop plans to meet the assessed needs of all residents. The assessment of need will include an assessment of symptoms of stress relating to challenging behaviour and a care plan identifying strategies to reduce/ limit the stress will be developed.
Update;
The PIC has reviewed the assessments of need and plans to meet these needs are in place. Due to the implementation of the new guidelines and the transfer of one resident, stress as a result of behaviour that challenges has been dramatically reduced.
•The PIC and staff in the designated centre will be supported by a consultant psychiatrist to implement strategies to reduce the impact of peer to peer challenging

behaviour. The consultant psychiatrist attended the designated centre on June 9th 2015 to observe the environment, service user's interactions with each other and with staff. She updated previous recommendations relating to the environment and the approach to be implemented when working with an individual service user to reduce the occurrence and impact of challenging behaviour. These recommendations are filled in the service user's individual file.
•The PIC will ensure these recommendations are implemented and a record of their effectiveness will be maintained. These will be discussed with the Service Manager and a member of the internal group known as Residential Approvals, on a bi-weekly bases. The PIC will communicate the effectiveness of the guidelines to the Consultant Psychiatrist and if necessary the guidelines will be updated.
Update;
ABC charts are being maintained to document incidences of behaviours that challenge and the Senior Clinical Psychologist and the MHID Psychologist are reviewing these on an ongoing basis. The guidelines are also reviewed by this group to review and to ensure their effectiveness. The relocation of one resident has resulted in behaviours that challenge being dramatically reduced.

These recommendations and clinical guidelines will be updated as part of the overall review of support plans including the positive behaviour support plans.

The Registered Provider will ensure that the residents who are exhibiting symptoms of stress are included in the first group that are being moved to other residential centres.
Update;
The residents who had been exhibiting symptoms of stress were the first to move from the designated centre and have now transferred to their new centres.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A transition plan to support the transfer of residents from their existing service to alternative services were not in place

9. Action Required:
Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Please state the actions you have taken or are planning to take:
The PIC will develop transition plans to support residents to move from the designated centre to a new designated centre. The PIC will be supported by a multi-disciplinary team to develop comprehensive plans to ensure a safe and effective transition from the current location to the next one. The plans will be agreed with the Service Manager and a member of the internal group known as Residential Approvals and will be developed

by 30th July 2015.

The move to new designated centres for the 1st resident will be 31st July and the last resident is expected to move by 30th September 2015
Update;
Due to repair work required to the bedroom in new designated centre, the first move did not take place until 21/08/2015. The individual resident from the designated centre is delighted with her move. In one case, it was found on closer examination that the proposed designated centre was not suitable to meet the needs of the resident. A further consultation document will be issued for a more appropriate centre. In light of the fact that this could potentially happen with other residents, the closure date must be extended beyond the 30th September to the 30th November 2015.
The transition plans will include:
•Meeting with PIC from new designated centres to hand over information and agree a transition plan.
Update;
The first of the meetings took place on the 25th June 2015 and are ongoing.
•Supporting the resident to understand that they are moving to a new centre by developing individualised visual schedules and accessible information relating to the move.

A visual timetable was not necessary for the first lady who moved. However, a calendar was drawn up once it was established that the new designated centre was suitable in order that she could count down the days to her move. An accessible information folder has been compiled for all other service users. A user friendly transition passport has been implemented for all residents that are moving. A "my moving story" is a pictorial record of the designated centre that they will be moving from to their new centre. This includes all significant people and places in their lives.
Meeting with family members and supporting them to visit the new designated centre.
Update;
The meetings with the families were conducted on the 20th and 22nd of April. The Social Work team leader facilitated family members to visit the new designated centres.
•Supporting the resident to visit the new centre as often as they wish. This will be individualised for each resident but is likely to include visits at times that the new centre is quiet, visiting for lunch or dinner, spending one or two overnights in the new centre, spending time at the new centre for activities, visiting with family members.
Update;
Visits to the new designated centres are ongoing. The format being followed is that staff from the current residential service accompany the service user on the first two visits. If the staff member and service user feels that it is appropriate, they will leave the service user in the care of staff in the new designated centre where they will go for dinner etc and a minimum of 2 overnight stays will then take place. However, if a service user needs more or less support that will be taken in to consideration and respected.
•Supporting the resident to identify how they wish to decorate and personalise their new bedroom and to identify what furniture/ belongings/ soft furnishings they would like to bring to the new centre.
Update;
This is organised in consultation with the referred resident and by the new centre staff

to which the resident will be moving.
•Supporting the staff in the new centre to understand and implement all care plans to enable them to provide safe and effective care.
Update;
Following the first consultation meeting that is held regarding the transition of a resident, their Personal Wellbeing Assessment Tool and all of their individual care plans are forwarded to the PIC of the proposed new centre.
•Staff from the current designated centre will work alongside staff from the new designated centre for a period of time when the resident moves to support the staff from the new centre to get to know the service user.
Update;
The first resident to move did not wish to be accompanied by staff from the existing designated centre. However Staff from the designated centre are liaising with the centre to which the 2nd resident has moved and are providing support as required.
•Reviewing the move to the new centre after a period of 3 months to ensure the service users needs are being met and that the transition to the new centre has been successful for the service user and those currently living in the new designated centre.
Update;
As the 1st move only took place on the 21/8/2015, a three monthly review will not be due until the 21/11/2015.
•This review will include a review of the assessment of need and care plans to identify if they require updating or new plans require developing.

Proposed Timescale: 30/09/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some aspects of the environment required to be improved such as aspects of woodwork on some door frames and skirting, paint work on walls were marked and scuffed. Grab rails were not in place in the downstairs hallway.

10. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
The PIC will ensure that technical services complete the necessary remedial paint work including filling and painting the walls, door frames and skirting boards.
Update;
This was completed in May 2015.
The PIC with support from an Occupational Therapist will assess the requirement for grab rails in the downstairs hallway. If the assessment indicates the requirement for

grab rails the PIC with support from the Occupational Therapist will order them and arrange for their installation.
Update;
As the only person that may have required grab rails has moved, this is no longer relevant.

Proposed Timescale: 31/08/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Therapeutic supports to manage symptoms of stress and supports to prevent and reduce the incidence of the behaviours were not provided

11. 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:
The PIC organised for a full review of one service user on 3rd June 2105. It was attended by family members, The PIC and Key Worker from the designated centre, day service staff, and two psychologists. The purpose of the meeting was to review individual service users and the supports they receive to establish if additional interventions would support their wellbeing. This includes a review of therapeutic interventions to reduce the impact of the behaviour of another other resident. Minutes of the meeting are available for review in the service users green file.

One outcome of the review meeting is that the PIC and staff in the designated centre will be supported by a consultant psychiatrist to implement strategies to reduce the impact of challenging behaviour. The consultant psychiatrist attended the designated centre on June 9th 2015 to observe the environment, service user's interactions with each other and with staff. She made recommendations relating to the environment and the approach to be implemented when working with an individual service user to reduce the occurrence and impact of challenging behaviour. These recommendations are filled in the service user's individual file.

The PIC will ensure these recommendations are implemented and a record of their effectiveness will be maintained. These will be discussed with the Service Manager on a bi-weekly bases. The PIC will communicate the effectiveness of the guidelines to the Consultant Psychiatrist and if necessary the guidelines will be updated.
Update;
All staff are aware of the guidelines that are in place. ABC charts are being completed and are being reviewed regularly by the Senior Clinical Psychologist and the MHID Psychologist.

Following on from the visit to the designated centre the Consultant Psychiatrist and Psychologist will jointly observe and review one individual in his day service and in his residential services and further updates to clinical guidelines and positive behaviour support plans will be made. This observation and review will take place on 1st July 2015.
Update;
This meeting has taken place. Updated clinical guidelines have been implemented. All staff members in the designated centre have been briefed in relation to these guidelines.

A second outcome from the review meeting is that the PIC will make additional appropriate referrals to other clinical disciplines, using the internal clinic cluster support model for integrating appropriate clinical and management support for individual service users. Additional support for the PIC from the service manager and if necessary the lead clinician to make these referrals is in place. A copy of the referrals and the outcomes will be filed in the service user's individual file.
Update;
In the circumstances of service users moving, if a referral in the designated centre is deemed to be required the PIC will make an immediate referral to the named clinician.

A third outcome from the review meeting is for the PIC to develop a comprehensive visual timetable for resident(s) who would benefit from having reassurances about their schedule of activities. The visual schedule will be hung on the wall in the kitchen and in the person's bedroom. The schedule will be updated weekly or more often if required.
Update;
Individual visual timetables have been developed and are accessible in the bedroom of each service user. There is also a timetable accessible in the kitchen area. A user friendly transition passport has been implemented for all residents moving from the designated centre. A "my moving story" including all significant people and places in their lives forms part of this transition process.

Proposed Timescale: 25/07/2015

Theme: Safe Services

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

12. 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:
The PIC has requested the Designated Person attend the centre to review documentation and practices. The Designated person is responsible for managing and dealing with all allegations of abuse in line with the organisational policy, The purpose

of this review is to identify if peer to peer interactions could be considered abusive. If the interactions are considered abusive the organisational safeguarding policy will be implemented. All allegations of abuse will be notified to The Authority using the appropriate 3 day notifiable events forms.
Update;
The designated person reviewed files in the designated centre and issued his report on the allegation of abuse on 7/08/2015. The abuse allegation was notified to the Authority on the 15/05/2015.

The PIC and Consultant Psychiatrist and Psychologist will review the individual's positive behaviours support plan to identify if additional supports to reduce the frequency and impact of challenging behaviour can be implemented.
Update;
A new strategy has been implemented by the Senior Psychologist to support the resident displaying challenging behaviour. To date this strategy is effective and all staff members of the designated centre have been appropriately briefed.
Update;
A review of safeguarding measures and their effectiveness will be included in 2 weekly meetings between the PIC and Service manager and member of the residential approvals group.
Update;
Incidences of challenging behaviour have diminished considerably since one resident has moved from the centre.

Proposed Timescale: 08/07/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A high incidence of behaviour that challenges was found to have occurred in the centre which was not notified to the Chief Inspector.
As all of these incidences have been found to have had a very negative impact on other residents such that residents were fearful, it could be determined that they fall within the definition of abuse.

13. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
The PIC and Designated Person for the centre will review peer to peer interactions to identify if they could be considered abusive. If the interactions are considered abusive the organisational safeguarding policy will be implemented. All allegations of abuse will be notified to The Authority using the appropriate 3 day notifiable events forms

Update;
As the new guidelines that were put in place are more effective and with the departure of one of the residents, the incidents of behaviours that challenge have decreased. There have not been any further incidences of behaviours that challenge that justify notification to the Authority.

Proposed Timescale: 08/07/2015

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:
Clinical staff supports including; nursing; counselling; social work and psychology services to address the interpersonal difficulties pertaining in the centre and to meet residents' emotional and behavioural needs were not in place.

14. 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 review all assessments of need and personal plans.

The review will

•Identify if assessments of needs are comprehensive and up to date.
Update;
All assessments of need have been compiled before the 15th August and are up to date.
•Update personal plans with additional detail when required.
Update;
All personal plans are up to date – completed by 31st July 2015
•Identify plans that require development to support personal independence and life skills development.
Update;
The transition process has made reference to individuals needs in respect of personal independence and life skill development. It is proposed in the persons new designated centres that personal independence and life skills development will significantly progress.
•Identify new or changing medical needs and develop and implement appropriate health care plans including plans for the management of constipation, dysphasia, breathlessness, weight management and pain management care plans. These plans will be developed in consultation with a doctor, nurse or other allied health professional such as a speech and language therapist.

Update;
Care plans have been developed to support the relevant health care needs of the residents from the designated centre.
•Identify changing needs and develop care plans to support these needs.
Update;
The PIC has reviewed the needs of the current residents of the designated centre and no additional care needs have been identified.
•Review Positive Behaviour Support Plans that are in place to identify if additional pro-active and reactive strategies could support positive behaviour.
Update;
Positive Behaviour Support Plans were reviewed by the Senior Clinical Psychologist who determined that "no additional material is needed for this plan, including proactive or reactive strategies".
•Consider the appropriateness and effectiveness of each plan in place to support individual service users
Update;
All plans have been reviewed by the PIC and are considered appropriate and effective.

The Registered Provider has allocated additional management and allied health professional support to the designated centre while the review of assessment of needs is being conducted.
This additional support includes:
Psychiatry Support-
Psychology Support-
Social Work Support-
Management Support-
Nursing Support-
OT Support

When this comprehensive review is completed additional support and services from allied health professionals will be identified in a process known as wellbeing outcome reviews.
Update;
Following on from the above, three wellbeing reviews have been conducted and two others are to take place. The PIC is in the process of setting up these wellbeing review meetings.
The PIC will organise and co-ordinate wellbeing outcome reviews for all residents. The wellbeing outcome reviews will be multi-disciplinary and referrals to meet identified need will be made to the relevant clinical disciplines. The PIC and Service Manger will discuss with the relevant Clinic Manager the referrals and the internal processes for ensuring all referrals are responded to and actioned.

Minutes of the wellbeing outcome reviews will be kept and filed in the person's individual file. A copy of the referrals and the associated responses and actions will also be filled in the service user's individual file.

Proposed Timescale: 15/08/2015

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate access to allied healthcare professionals to ensure all residents needs were met in a timely and responsive manner was not available.

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

Please state the actions you have taken or are planning to take:
The PIC will review all assessments of need and personal plans. The review will
•Identify if assessments of needs are comprehensive and up to date.
Update;
All assessments of need were completed before the 15th August and are up to date.
•Update personal plans with additional detail when required.
Update;
All personal plans are up to date – completed by 31st July 2015
•Identify plans that require development to support personal independence and life skills development.
Update;
The transition process has made reference to individuals needs in respect of health care and allied health care. It is proposed in the persons new designated centres that the persons individual health and allied health care needs will be addressed.
•Identify new or changing medical needs and develop and implement appropriate health care plans including plans for the management of constipation, dysphasia, breathlessness, weight management and pain management care plans. These plans will be developed in consultation with a doctor, nurse or other allied health professional such as a speech and language therapist.
Update;
Care plans have been developed to support the relevant health care needs of the residents from the designated centre.
•Identify changing needs and develop care plans to support these needs.
Update;
The PIC has reviewed the needs of the current residents and no changing needs have been identified.
•Review Positive Behaviour Support Plans that are in place to identify if additional pro-active and reactive strategies could support positive behaviour.
Update;
Positive Behaviour Support Plans were reviewed by the Senior Clinical Psychologist who determined that "no additional material is needed for this plan, including proactive or reactive strategies".
•Consider the appropriateness and effectiveness of each plan in place to support individual service users
Update;
All plans have been reviewed by the PIC and are considered appropriate and effective.

The Registered Provider has allocated additional management and allied health

professional support to the designated centre while the review of assessment of needs is being conducted.
This additional support includes:
Psychiatry Support-
Psychology Support-
Social Work Support-
Management Support-
Nursing Support-
OT Support

When this comprehensive review is completed additional support and services from allied health professionals will be identified in a process know as wellbeing outcome reviews.

The PIC will organise and co-ordinate wellbeing outcome reviews for all residents. The wellbeing outcome reviews will be multi-disciplinary and referrals to meet identified need will be made to the relevant clinical disciplines. The PIC and Service Manger will discuss with the relevant Clinic Manager the referrals and the internal processes for ensuring all referrals are responded to and actioned.
Update;
Following on from the above, three wellbeing reviews have been conducted and two others are to take place. The PIC is in the process of setting up these wellbeing review meetings.

Minutes of the wellbeing outcome reviews will be kept and filed in the person's individual file. A copy of the referrals and the associated responses and actions will also be filled in the service user's individual file.

Proposed Timescale: 15/08/2015

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:
Practices in place did not ensure that all medications would be safely administered to the resident for whom it was prescribed in that commencement dates of topical medications and pharmaceutical dispensing labels for every medication was not in place.

16. 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 contacted the Pharmacist to ensure that all medication that is dispensed has an expiry date-effective from 30th May 2015.
The PIC has instructed that any topical medications that are prescribed will have a label indicating the date that this medication was opened. The manufactures instructions for the disposal of medication will be followed including a date for destruction after a certain period of time (eg: 28 days). A note in the communication book to all staff will provide evidence of this instruction.
Update;
Completed 23rd May 2015.

Proposed Timescale: 30/05/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The facilities and services outlined in the document were not in place in order to meet the diverse needs of the current client group.

17. Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
The PIC has review the Statement of Purpose to ensure it contains transparent criteria for the admission, transfer and discharge processes. The updated Statement of Purpose will be made available to residents and family members. A copy of the updated Statement of Purpose has been sent to The Authority.
Update;
The Statement of Purpose was sent to HIQA on the 12/05/2015 and on the 21/07/2015

Proposed Timescale: 30/05/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance and management systems in place were not responsive to the needs of residents or supportive of the delivery of safe quality care.

18. 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 Provider Nominee and PIC with support from a team of senior mangers will review the resources, structures and supports in the centre to assess their effectiveness in providing safe and effective services to residents.
Update;
The designated centre is in the process of transitioning all residents, with two residents having already moved and with five residents in the process of moving. The PIC maintains an ongoing review of peoples needs and any necessary review during this time will be completed.
This review will:
•Be informed by the unannounced 6 monthly reports, annual report and other internal audits carried out in the centre.
•Be informed by the minutes of the 2 weekly meetings between PIC and Service manager and member of the residential approvals committee.
•Be informed by the current Governance and Management Systems in place this includes staff supervision and support, service users finance, meetings with PIC and Service manager medication management processes,
•Consider safeguarding and positive behaviour support needs of the residents and identify if additional safeguarding supports are required. This will be informed by the Designated Person's review of the service and the review of peer to peer challenging behaviour.
Update;
The Designated person has reviewed peer to peer challenging behaviour. The level and intensity of behaviours that challenged has reduced significantly since one service user transferred from the designated centre.
•Consider the management and clinical supports available to the centre to ensure the service is responsive to individual service users needs including nursing needs and access to other allied health professionals if required.
Update;
Access to allied healthcare support for existing residents is in place and nursing support is arranged through nurses in their designated day services.
•Identify additional supports required to effectively manage the centre until such a time that all residents have transitioned to their new centre.
Update;
The PIC has been placed on office days only for the duration of peoples transition. If additional supports are required during the period of transition, they will be discussed at the consultation meetings or sooner as required.
•Review staffing arrangements to identify if the use of agency/ relief staff can be minimised?
Update;
Due to vacancy the use of agency and relief staff remains under review. Staff members who know the centre's needs are hired where possible.
•Consider the skill mix of staff in the centre including the requirement to have nursing supports for individual service users.
Update;
Nursing supports required for service users is arranged through nurses in their respective designated day services

•Review plans for activities to ensure they are in line with residents' personal plans and

identify how resources can be configured to ensure the activities happen.
Update;
Where relevant, activities are designed to support the achievement of personal plans.
•Ensure additional supports identified are put in place as required.
Update;
As there are currently five residents residing in the designated centre, adequate supports are provided.

This review will take place in approximately 4 weeks to allow time for information to be gathered from a variety of sources. Recommendations identified in the review will be implemented including the allocation of additional resources to meet the assessed needs of Service Users

Minutes of the review will be available for inspection.

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The role of the person in charge or other senior managers in the change of purpose and function of the centre was unclear. Specific roles and responsibilities for managing the transition process were not in place.

19. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
A team to manage and support service user's to transition from the designated centre has been established and includes the PIC, Service Manager and two members of the residential approvals group. This team will meet to review the transition process and the roles and responsibilities within the process will be established and documented . This will be based on the organisational policy on admissions to residential services. See attached admissions policy ,and minutes of meetings.

The minutes of the review meeting and the roles and responsibilities will be available for review.
Update;
Consultation meetings involving the PIC, Service Manager, Administration Manager and Social Work Team Leader are ongoing and will continue until all residents have transitioned to their new centres.

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Change management supports to ensure the ongoing provision of a safe and effective service and safe planned transfers to alternative services with review period were not in place.

20. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
(A) The PIC will continue to provide regular support and supervision meetings to the staff team in the designated centre. These one to one support meetings give an opportunity to review performance, review continuous professional development and offer ongoing supports and advice.
Update;
Support meetings between the PIC and staff members are in place..
(B) The team established to support the transition of service users from this designated centre to a new centre will review the supports required by service users. The PIC, Service Manager and a member of the internal group known as Residential Approvals will meet with the PIC every 2 weeks to ensure the transfer process is in line with the policy, protect residents from abuse by peers and are responsive to residents need
The meeting will include:
•Review the transfer process for individual service users to ensure it is in line with the policy.
Update;
The transfer process is reviewed to ensure it is in line with the transfer policy.
•Review rosters and staff allocations to ensure safe and effective services are delivered while the process of transferring service users is ongoing.
Update;
A roster review has taken place and will remain under review as residents move to their designated centres.
•Review incidents of challenging behaviour, accidents and incidents, and safeguarding concerns and identify strategies to manage these.
Update;
The PIC has reviewed incidents of challenging behaviour, accidents and incidents. The frequency of behaviours that challenge have decreased due to a review of behavioural guidelines and the transfer of a resident from the centre. Any accidents or incidents that may occur will be considered by the PIC in terms of pattern.
•Review the effectiveness of clinical guidelines to reduce incidents of peer to peer challenging behaviour.
Update;
The clinical guidelines are considered effective due to the decrease in the amount and severity of incidences of challenging behaviour.
•Review of risk assessments to identify additional controls to support safe and effective

services.
Update;
Following an in depth analysis of behaviours that challenge within the designated centre, the MHID Psychologist is in the process of assisting in developing a Risk Assessment in relation to challenging behaviour for one resident.
•Make determinations based on assessed needs about how best to support all service users in this process of transition.
Update;
Regular reviews of assessed need are part of the consultation meetings.
Identify with the PIC the additional training and supports staff require to implement service users support plans including their transition plans. implement service users support plans including their transition plans
Update;
St. Michaels House is in the process of designing and developing an organisation wide Personal Planning System. This has involved a comprehensive review of current structures which includes: Assessment of Need Documentation, Care Plans, IPs, Cosan and Wellbeing Reviews. A new system has been designed to cover what is important to the person and what is important for the person. This new system is being piloted in 10 units across the organisation. The pilot phase is expected to be completed by October 2015. Following this a review of skills gaps and training needs will be undertaken and training for all staff will be rolled out from January 2016.

In the interim period staff in this house will be supported by the PIC and Service Manager to complete detailed support/ transition and personal plans for all residents within the 28 day period of moving to a new house. All staff in St. Michaels House are required to complete the PBS FETAC Level 5 Programme- with one of the modules being Person Centred Focus. All staff will be booked in to this training programme over the coming months.

These meetings will take place until all residents are placed in their new designated centres. Minutes of these meetings will be kept and will be available for review.

Proposed Timescale: 01/07/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that there were sufficient resources to fully meet residents needs was not found

21. 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:
As detailed under Outcome 14 The Provider Nominee and PIC with support from a team of senior mangers will review the resources, structures and supports in the centre to assess their effectiveness in providing safe and effective services to residents. This review will take approximately 4 weeks to allow time for information to be gathered from a variety of sources.

The Registered Provider has allocated additional management and allied health professional support to the designated centre while the review is being conducted. This additional support includes:
Psychiatry Support-
Psychology Support-
Social Work Support-
Management Support-
Nursing Support-
OT Support

As part of the review outlined under Outcome 14 The registered provider will undertake a review of the roster and staff allocations and skill mix to ensure safe and effective services are delivered while the process of transferring service users is on going. This will include a review of staffing arrangements, including the allocation of drivers on shift and a review of the need to have access to nursing supports to meet service users need. This review will be dynamic in nature as the service user's move to alternative designated centres the needs in the designated centre will change. The review will be included in the bi-weekly meeting with the PIC and Service Manager.
The recommendations of the review will be implemented to support the service users as they transition to new designated centres.
Minutes of the review will be available for inspection.
Update;
The PIC, Service Manager, Administration manager and Social Work Team Leader hold regular meetings to plan the transition of residents from their designated centre to their new centres and assess the level of support required. To date two service users have moved and the five remaining residents have had consultation documents issued.

Proposed Timescale: 30/07/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence that the numbers and skill mix of staff were appropriate to meet the assessed needs of residents was not found.

22. 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:
As part of the review outlined under Outcome 14 and Outcome 16 the registered provider will undertake a review of the roster and staff allocations and skill mix to ensure safe and effective services are delivered while the process of transferring service users is ongoing.
Update;
Roster reviews have taken place and are ongoing when each resident is relocated to a new residential centre.
The review will include a review of use of agency or temporary staff, staff roster pattern and arrangements, including the allocation of drivers on shift and a review of the need to have access to nursing supports to meet service users need. This review will be dynamic in nature as the service user's move to alternative designated centres the needs in the designated centre will change. The review will be included in the bi-weekly meeting with the PIC and Service Manager.

The recommendations of the review will be implemented to support the service users as they transition to new designated centres.

The recommendations of the review will be implemented to support the service users as they transition to new designated centres.
Update;
Roster reviews have taken place and are ongoing when each resident is relocated to a new residential centre.

Proposed Timescale: 30/07/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no full time nursing inputs in the centre and a full review of the nursing inputs required to meet current residents needs was needed

23. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
As part of the review outlined under Outcome 14 and Outcome 16 the registered provider will undertake a review of the roster and staff allocations and skill mix to ensure safe and effective services are delivered while the process of transferring service users is ongoing.

The review of staff allocated to the designated centre will include a review of the nursing needs of the service users. This will begin with a nursing assessment to identify

the nursing need, identification of key tasks to be carried out by a nurse and the allocation of a nurse/ nurses to carry out these tasks. If indicated a nurse will be made available on the team to carry out the nurse led tasks or to oversee the implementation of nurse led care plan.

This review of nursing needs will be dynamic in nature as the service user's move to alternative centres the needs in the designated centre will change. The review of nursing needs will be included in the bi-weekly meeting with the PIC and Service Manager.

Update;
Roster reviews have taken place and are ongoing when each resident is relocated to a new residential centre.
Nursing support is arranged through nurses in service users designated day services.
As part of regular meetings between the service manager and PIC, nursing needs of service users are considered.

Proposed Timescale: 30/07/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further training to enable staff meet the full needs of residents and additional training in areas such as; assessment and care planning; attention deficit disorder; autism; bipolar disorder were found to be required. An assessment of competency of staff following training delivered should also be considered.

24. 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 with the support of the training department has carried out a training needs analysis and has identified additional training requirements based on assessed needs of the resident. The PIC and training department are sourcing additional training for staff to meet the service users needs. This training will be scheduled and delivered on a phased basis to meet training priorities for support staff.
Update;
St. Michaels House is in the process of designing and developing an organisation wide Personal Planning System. This has involved a comprehensive review of current structures which includes: Assessment of Need Documentation, Care Plans, IPs, Cosan and Wellbeing Reviews. A new system has been designed to cover what is important to the person and what is important for the person. This new system is being piloted in 10 units across the organisation. The pilot phase is expected to be completed by October 2015. Following this a review of skills gaps and training needs will be undertaken and training for all staff will be rolled out from January 2016.

In the interim period staff in this house will be supported by the PIC and Service Manager to complete detailed support/ transition and personal plans for all residents within the 28 day period of moving to a new house. All staff in St. Michaels House are required to complete the PBS FETAC Level 5 Programme- with one of the modules being Person Centred Focus. All staff will be booked in to this training programme over the coming months.
Proposed Timescale: 01/12/2015