

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0003598
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:	Anna Doyle
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
19 January 2016 10:00	19 January 2016 20:00
20 January 2016 09:30	20 January 2016 14:00

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 centre. The inspection was announced 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 and fire safety procedures.

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 purpose of application to

register were found to be satisfactory.

The designated centre is operated by St Michaels House and comprises of a two storey three bedroom detached property in North Dublin. Three residents reside in the centre. This centre is next door to another designated centre belonging to St Michael's house and over the course of the inspection, the inspector found that both of the houses were operating as a single designated centre. For example, the houses had shared staffing resources and had the same person in charge. As a result of this finding the provider submitted an application to vary the conditions of the attached house in order to register them as a single designated centre subsequent to the inspection.

Two resident's questionnaires were received by the Authority. Two residents met formally with the inspector and the other resident spoke informally with the inspector over the course of the inspection. Residents stated that they felt safe and would know who to report concerns to if an issue arose. They were broadly satisfied with the services and facilities provided.

One family member's questionnaire had been received by the Authority. They stated that they were very happy with the services provided and felt assured that they could raise concerns with any staff members. No family members were interviewed as part of the inspection.

The person in charge was present throughout the inspection. This person had been interviewed at a previous inspection carried out in another designated centre belonging to St Michaels House and was found to be knowledgeable of their responsibilities under the regulations. The service manager who was a person participating in management attended both the opening meeting and the feedback session.

Overall evidence was found that residents' social and healthcare needs were broadly met. The centre was homely however aspects of the design and layout of the centre required improvements. The inspector found that improvements were required in health and safety, safeguarding, safe and suitable premises, the assessment and review of healthcare and social care needs, workforce and governance and management.

The action plan at the end of this 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:

Overall the inspector found that the residents were treated with dignity and respect, however there were aspects relating to the implementation of the complaints policy that required improvements.

Residents were consulted with on the day to day running of the centre. Weekly house meetings were held where residents made decisions and discussed specific supports they may require for the week. For example if they required support to attend activities. They also discussed menu planning, meal preparation and maintenance issues in the house. Residents were found to be strong self-advocates. Some residents, who spoke to the inspector, spoke about being able to exercise their rights and said they make informed decisions about the management of their care.

The complaints policy was in a user friendly format and displayed appropriately. However this was not always implemented in practice and did not respect an individual's right to privacy when making a complaint. For example the inspector found that residents' complaints were logged in a book for all staff to view and were not recorded on the service complaints form. There were a number of complaints logged and while all of them had been acted on, the inspector found that some of the complaints were of a confidential nature and the information contained in them may have an effect on residents who made the complaint. In addition the inspector viewed one complaint for a resident who was not satisfied with the outcome. This resident had not been aware of, or offered the appeals process in line with the service policy and the regulations.

Residents had access to an advocacy service and one resident was being supported by staff to access this service.

Another complaint logged from a family member through the service annual review that related to a safe guarding issue for their relative had not been effectively dealt with. While this has implications under this outcome, it is actioned under Outcome 8.

There were policies and procedures in place for the management of residents' finances. Two of the residents managed their own monies and one resident was supported by staff to manage their finances. There was a financial plan in place for this resident, however some of the details were not correct. For example the amount of money the resident received weekly was not accurately recorded. In addition the plan was not detailed enough to guide staff practice. For example it was not clear what discussions were to take place with the resident before making a purchase on their behalf. However the inspector viewed the financial records for this resident and found that there were effective auditing systems in place to safe guard the residents' monies. Another resident was in the process of receiving support from staff regarding budgeting of their finances. Residents had to contribute to staff costs for activities, meals out and holidays. This was in the service policy and highlighted in the contract of care.

There was a policy in place relating to residents personal possessions, and there was a list of each resident's personal possessions contained within their care plan.

There was no CCTV systems used in the centre.

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:

Overall the inspector found that residents' communication needs were being met. There was a policy on communication in the centre.

All of the residents were strong self advocates and were able to communicate their needs effectively. One resident who had communication difficulties had their communication supports highlighted in their care plan. The inspector noted that efforts had been made to try and enhance the residents' communication skills; however the

resident had chosen not to participate. The inspector met with this resident and found that the communications supports outlined in their care plan assisted the inspector to communicate very effectively with this resident.

The centre was part of the local community and residents independently availed of facilities within the community such as shops, pharmacy and religious services. Residents had access to television, radio and newspapers. All of the residents had their own mobile phones. One resident had access to the internet and paid for this service themselves. This additional cost was highlighted in the resident's contracts of care in the centre. The inspector found that this was a very meaningful service for the resident as they had their own computer and iPad that they used to send e-mails and research issues on the internet.

There was evidence that some aspects of personal plans were in a user friendly format. For example the inspector saw the minutes of a meeting that one resident had had with their social worker that was in a user friendly format.

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:

Overall the inspector found that residents were supported to maintain and develop personal relationships and residents had links with the wider community.

There were no restrictions on visitors to the centre unless it was an express wish of a resident. There was a centre specific visitor's policy in place that welcomed visitors to the centre.

Residents had contact with family members and visited them regularly. One resident had recently returned from a trip abroad where they had visited family. Another resident was being supported by staff to visit a relative who had recently moved overseas. Support had been sought from an allied health professional to support this resident with fears they had about travelling abroad and a provisional date had been set to support the resident to travel.

The inspector saw records of regular contact with family members in residents' care plans. An annual review had yet to be arranged for residents, however the person in charge told the inspector that family were invited to attend these reviews.

Residents were very involved in the community and accessed facilities independently. Staff supports were given if requested by the residents. The inspector observed residents going out for coffee, paying their bills and going to the local pharmacy. The inspector noted other activities in residents care plans that included, volunteering in a local dog trust, supported employment, art classes and literacy classes.

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:

Overall the inspector found that there was a policy in place for admissions to the centre and this was reflected in the statement of purpose. However improvements were required in the admission policy to meet the requirements of the regulations.

The admissions policy considered the wishes, needs and safety of the individual and the safety of the other residents living in the centre. However it did not include details for the temporary absence of residents. The centre maintained a separate policy for discharges and transfers however, this policy was out of date. While this has implications under this outcome, the actions are outlined in Outcome 18.

Each resident had a written agreement which set out the services to be provided and the fees to be charged. Additional fees were also set out in the written agreement.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Overall the inspector found that resident's wellbeing and welfare were being maintained in the centre. However improvements were required in the assessment of need for all residents, the review of social care needs, annual reviews and timely access to allied health professionals.

Residents had a 'personal well being assessment tool' completed yearly by their key worker. However it was not comprehensive enough to include all health care needs. In addition some social care needs identified did not have goals broken down and review dates in place to evaluate the effectiveness of the goals. For example one resident had a goal to cook a meal independently for other residents. While this was recorded in an activity schedule it was not reviewed to assess its effectiveness. However the inspector did see evidence in one personal plan that had an effective review system in place for a residents' social care goals.

There was evidence that residents had access to allied healthcare professionals, however this was not always timely. The inspectors saw a number of examples of this including; one resident who had been referred to a psychologist in September 2015 and was only seen in January 2016. This referral had been considered urgent due to the nature of the residents needs.

There was no evidence on residents' files that an annual review had taken place. The person in charge informed the inspector that one resident had recently had an annual review. The inspector asked for a copy of the minutes of this review. The minutes were found to be incomplete, did not reflect the resident's participation in the review and were not in a user friendly format for residents. In addition it was difficult to assess whether allied health professionals had attended the annual review as the attendance records did not include people's roles.

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 inspector found that the location, design and layout of the centre were suitable for the stated purpose. The centre was clean and homely, however some aspects of the centre in relation to storage and modernisation required improvements.

The centre comprised of a four bedroom two storey detached property. All of the residents had their own bedroom that was furnished to their taste. Some of the residents had a large amount of personal possessions and while the storage was adequate in the rooms it did not meet the needs of some of the residents.

There was a shower room and bathroom upstairs and an additional toilet downstairs. However the shower room was in need of modernisation. The person in charge informed the inspector that plans were in place to address this.

The kitchen, dining area was compact but suitable considering only three residents lived there. There was a large separate sitting room. However the inspector noted a lot of equipment stored in various parts of the centre and this coupled with the fact that residents had a lot of personal possessions meant that additional storage was required. This was discussed at the feedback session.

A separate utility room was located downstairs and residents were supported to launder their own clothes.

Residents had access to a garden through the dining room. It was observed to be well maintained and had a small seating area for residents to sit out if they wished.

Assistive equipment was in place to support resident's independence. For example handrails were on the stairs and a shower chair had been fitted for residents.

There were effective systems in place for the disposal of clinical waste within the centre.

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):

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

Findings:

Overall the inspector found that there were systems in place to protect the health and safety of residents, visitors and staff in the centre. However improvements were required in fire safety, individual risk management plans and the review and learning from incidences in the centre.

There was suitable fire fighting equipment, an adequate means of escape including emergency lighting and a fire alarm that had been serviced regularly. The person in charge informed the inspector that one resident who had hearing difficulties had a flashing light system installed in their bedroom. The inspector did not see this as the resident had not wished for the inspector to enter their bedroom. There were no fire doors in the centre however the person in charge assured inspectors that this was in the process of being addressed.

There was an evacuation procedure displayed at the front door of the centre. The inspector found that this was not specific to the centre. However the person in charge showed the inspector a new fire procedure that had been developed for the centre. This was been introduced to all staff at a fire safety training session scheduled in the adjacent centre on the second day of the inspection.

All residents had a personal evacuation plan in their care plan. They stated that all residents required some verbal reminders in the event of a fire evacuation. However residents could remain in the centre on their own for short periods during the day. An individual risk assessment had been completed for this, however there was no evidence to show that residents would respond to a fire alarm when they were in the centre on their own, given that the residents required verbal reminders from staff. This was discussed at the feedback session.

Fire drills were carried out regularly in the centre and the inspector viewed a sample of these. They were completed in a timely manner and there was evidence that learning from them had been implemented into practice. The centre also had a daily fire safety check list that was completed by staff.

There was a risk management policy in place along with a health and safety statement. Risk assessments had been completed on the environmental risks in the centre and each resident had individual risk assessments in their care plans. The person in charge completed a health a safety checklist every month. In addition a health and safety audit had been completed in Nov 2015. However the results of this audit had not yet been received by the person in charge and therefore the inspector could not review whether

the actions from this had been completed.

Incidents were recorded on a computer generated form and a copy was maintained in the residents file. However there was no evidence that incidents were being reviewed and learning from them implemented into practice. This had been an action from a previous inspection carried out in another designated centre within this organisation. The inspector discussed this at the feedback session with the person in charge and the service manager. They advised the inspector that this had been escalated up to senior management but that no actions had been implemented to date.

The centre had an emergency plan which outlined procedures to be followed in the event of loss of electricity, water, heating and also in the event of flooding or a gas leak. This plan included evacuation to another nearby centre if necessary. The centre had its own transport which was adequately insured, taxed and underwent the required checks for roadworthiness.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Overall residents told the inspector that they felt safe in the centre; however some incidences of peer to peer abuse had not been effectively dealt with so as to safeguard one the resident in the centre.

On the first day of the inspection the inspector was informed of a complaint that a family member had raised through the annual review of the centre, regarding an ongoing issue of 'bullying' of their relative in the centre. The inspector found through the review of documents that there had been incidents of persistent peer to peer abuse. These incidents had not been notified to the Authority. The inspector viewed minutes of a meeting held in March 2015 acknowledging that this resident was being 'bullied'. The actions agreed from this meeting included, informing the residents' representative of the situation, supporting the resident to find more suitable accommodation as they did not

like living there and referral to psychology to support this resident. The inspector found that the referral to psychology had not been followed through for this resident and there had been no subsequent review meetings to assess the resident's wellbeing. The inspector asked for a multi disciplinary team meeting to be arranged to discuss this issue as a matter of urgency. The service manager assured the inspector that this had been arranged. In addition the inspector met with the resident formally, they informed the inspector that they felt safe in the centre but did not like living there. They confirmed that they had issues with one resident but that it was in relation to housekeeping issues.

Staff spoken to were aware of what to do in the event of them suspecting abuse of a resident. However the policy on safeguarding in the centre was not in line with the Health Service Executive (HSE) policy and would therefore not guide practice. In addition while all staff had received training in this area, the training did not reflect the new policy from the HSE.

One resident had an intimate care plan in place and it was found to be detailed to promote their dignity and rights.

There were no residents in the centre that had behaviours that challenge and no restrictive practices were used in the centre.

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:

Overall the inspector found that a record of all incidents occurring in the centre were maintained, however the Authority was not notified of some incidents that had occurred in the centre.

Quarterly notifications had been made to the Authority from the designated centre. However the Authority had not been notified of incidences of peer to peer abuse discussed under Outcome 8 of this report.

Judgment:
Substantially Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

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

Findings:

Overall the inspector found that residents had opportunities for new experiences that were in line with their wishes.

There was a policy in place on access to education, training and development. While none of the residents attended formal day services, they were engaged in various activities in line with their personal preferences both inside and outside of the centre. There were opportunities for new experiences observed in personal plans. One resident had joined a sewing class, another had joined an arts and craft club. Items of artwork were displayed in the centre. Other goals developed for residents included learning to cook a meal for others in the house and attending literacy classes.

One resident was in supported employment two days a week in their community and another resident volunteered at a local dogs trust.

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:

Overall the inspector found that residents' healthcare needs were being met in the centre, however improvements were required in the assessment of need to include all healthcare needs.

Each resident had an assessment of need in their care plan, however it did not include all healthcare needs. For example one resident who had recurrent kidney infections, did not have this highlighted in their assessment of need. In general the inspector found that the health action plans were comprehensive and guided staff practice. For example one resident's diabetic management plan was very comprehensive however the review dates were not consistently recorded. This actioned under Outcome 18.

Residents who did not wish to have medical treatment did not have it highlighted in their assessment of need and it was not clear whether it had been discussed with the residents GP. For example one resident would not engage with the dietician and another would not attend six weekly chiropody checkups.

Food available to residents was nutritious and varied and residents were involved in planning meals and meal preparation in the house. One resident spoke to the inspector about how they enjoyed making smoothies for their breakfast.

Judgment:
Substantially Compliant

Outcome 12. Medication Management

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

Theme:
Health and Development

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

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

Findings:

Overall the inspector found that effective medication management systems were in place to protect residents.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents, including a local protocol for medication management. Medicines were supplied by a retail pharmacy business in blister packs where appropriate, and all medicines were stored securely within the centre.

Medications were delivered by the pharmacy on a weekly basis where they were checked by staff, and drug audit records were maintained for all medicines. There were appropriate procedures in place for the handling and disposal of unused and out of date medicines.

The inspector reviewed two prescription and medication administration sheets which were the standard format used within St Michael's House, and recent medication reviews had been completed.

The person in charge completed a medication management audit tool every month which was used to review and monitor medication management practices within the centre. This audit tool reviewed a wide range of aspects of medication management including policies and guidance documents, storage, prescribing, administration records and practices, and medication related errors. The audit tool also included a section for recommendations following completion of the audit.

One resident in the centre self medicated while out on social activities for the evening. There was a medication management plan in place outlining the necessary safeguards in place to support this resident. The inspector saw evidence of where residents had been given user friendly medication advice sheets from the prescribing doctor.

All staff were trained in the safe administration of medication.

Judgment:
Compliant

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

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

Findings:

Overall the inspector found that there was a written statement of purpose that describes the services provided, however as discussed in the summary of this report aspects of the statement of purpose referred to both designated centres. This is actioned under Outcome 18.

Judgment:
Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Overall the inspector found there were effective management systems in place, however improvements were required in relation to the annual review and the provision of combined services in this centre and the adjoining designated centre.

The person in charge was fulltime, suitably qualified and had the necessary skills to manage the centre. The person in charge was in charge of two other designated centres operated by St. Michaels House. One of which was located beside the centre being inspected. Over the course of the inspection, it was evident to the inspector that both of these centres were being run as one centre. There were numerous examples of this including - rosters had staff from both centres on it, staff were allocated to work in both centres, the contracts of care and the statement of purpose referred to the staffing levels for both centres, combined staff meetings were held for both centres, the person in charge and the service manager discussed both centre's at their meetings. The inspector discussed this at the feedback session and subsequently contacted the provider nominee after the inspection to discuss this. The provider nominee agreed to address this issue.

The inspector found that the person in charge provided good leadership skills and staff spoken to felt supported in their role. There were management structures in place, the person in charge reported to the service manager and they reported to the provider. All of the permanent staff employed in the centre were social care workers, care staff or regular relief staff. There was access to a nurse manager on call on a 24hr basis for clinical support.

Meetings were held between the person in charge and the service manager. Regular staff meetings were held and the inspector reviewed a sample of these records and found that there were no actions plans developed from them and therefore it was difficult to assess the effectiveness of these meetings. This is actioned under Outcome 18.

Two unannounced six monthly quality and care reviews had been completed. A copy of the centre's annual review was made available to the inspector. This included consultation with residents, family members and staff. However some details in this review were sensitive and the inspector asked for this to be reviewed.

Judgment:

Substantially Compliant

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:

The inspector was satisfied that the person in charge had not been absent from the designated centre for more than 28 days. There were satisfactory arrangements in place to cover any absences of the person in charge.

The provider was aware of the requirements to notify the Authority in the event of the person in charge being absent.

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):

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

Findings:

Overall the inspector found that the centre was resourced during the day to ensure the effective delivery of care and support, however issues outlined under Outcome 17 requires a full review of the resources required to ensure an effective, safe delivery of care to the residents at night time.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Overall the inspector found that there were appropriate staff numbers and skill mix to meet the needs of the residents during the day, however there were improvements required around night time supervision for residents.

There was a planned and actual roster in place. The residents were seen to receive care in a timely and respectful manner; however concerns were raised by a number of staff about supervision levels for residents at night time. For example one resident returned to the centre some nights after midnight. The resident then liked to make something to eat. An individual support plan stated that the resident needed supervision in the kitchen, and while staff facilitated this it meant that the staff may not finish work until later than they had been rostered. In addition the sleepover staff was then required to be ready to support residents from seven o'clock the following morning. The inspector reviewed a sample of the residents' night reports and found that the resident required staff support up to two thirty in the morning. This meant that staff were getting four and half hours sleep some nights and were then required to support residents the next day. There were no systems in place to formally report this to the manager and the person in charge informed the inspector that staff managed their own time in lieu as a result of being awake at night. The inspector discussed this with the person in charge and the service manager who agreed that this was not a safe practice and agreed to review the arrangements in place.

The person in charge had supervision meetings with staff, however there was no formal staff appraisal system in place for staff. The person in charge informed the inspector that the provider was addressing this issue.

There were no volunteers employed in the centre. The inspector did not review personnel files during this inspection, but they were reviewed at a subsequent date with the organisations head office and were found to be in compliance with the Regulations.

All staff had completed training in behaviour support, manual handling, medication management and safeguarding.

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):

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

Findings:

Overall the inspector found that most of the documentation required by the regulations was maintained in the centre, however some improvements were required to ensure that all of the policies and procedures as per Schedule 5 of the Regulations were in place, subject to review and in line with national policy.

The policies and procedures as per Schedule 5 of the regulations were not all available in the centre. There was no policy in place for, the provision of information to residents, staff training and development, the temporary absence of residents. In addition the policy on safeguarding had not been updated to reflect best practice and the policy on access to education, training and development were out of date.

There was a residents' guide available in an accessible format for residents, however it had not been updated to reflect contracts of care agreements in place for all residents. A directory of residents was effectively maintained in respect of each resident in the centre.

Records maintained within the centre were stored securely but were not always easily retrievable as they were stored in the adjoining designated centre.

Most of the required records as per Schedule 3 of the Regulations were maintained in the centre however, there were gaps in some of the documentation viewed by the inspector. For example the annual review for one resident was not completed in full and minutes of meetings did not always include action plans and follow up so as to review the effectiveness of same.

All general records as per Schedule 4 of the Regulations were available and complete on the day of inspection.

An up to date certificate of insurance had been submitted to the Authority as part of the centre's application to register.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0003598
Date of Inspection:	19 January 2016
Date of response:	3 March 2016

Requirements

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

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

Outcome 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:

One resident was not aware of the appeals process in relation to the outcome of a complaint that they were not satisfied with.

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

1. Action Required:

Under Regulation 34 (1) (b) you are required to: Ensure that each resident and their family are made aware of the complaints procedure as soon as is practicable after admission.

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

The complaints procedure was discussed at a residents house meeting which was held on the 01/03/2016. The PIC will ensure that all family members will be issued with the updated copy of the Complaints and Compliments Policy.

Proposed Timescale: 14/03/2016

Theme: Individualised Supports and Care

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

The nature of one complaint logged by a resident was not stored in a confidential manner and the complaint had not been logged using the centre's own complaints form.

2. Action Required:

Under Regulation 34 (4) you are required to: Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

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

All Complaints are now being stored in a locked press. The PIC has gone through the complaints policy with all staff members and any complaints made from here on in will be recorded on the standardised complaint form.

Proposed Timescale: 19/01/2016

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:

Two residents annual reviews had not been completed.

3. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The PIC will ensure that the key workers in consultation with the residents complete the two outstanding annual reviews.

Proposed Timescale: 16/05/2016

Theme: Effective Services

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

There was no evidence that allied healthcare professionals attended one resident's annual review.

4. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

Going forward all annual reviews will have in attendance the appropriate allied healthcare professionals, thus ensuring a multidisciplinary approach.

Proposed Timescale: 08/03/2016

Theme: Effective Services

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

There was no evidence that residents had participated in their annual review and it was not in a user friendly format.

5. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

The PIC will ensure that all staff include the participation of all residents, and or their representatives in their annual review, and that the annual review is in a friendly user format.

Proposed Timescale: 08/03/2016

Theme: Effective Services

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

There was no review of social care goals for all residents to assess their effectiveness

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:

Monthly reviews will be completed by each residents key worker to assess and review the effectiveness of the residents individual social care goals.

The PIC will also review and document the effectiveness of each plan and take into account changes in circumstances and new developments at the regular individual support meetings between the PIC and the key worker.

Proposed Timescale: 01/03/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Given the large amount of personal possessions belonging to some residents additional storage facilities were required in the centre.

7. Action Required:

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

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

The key worker will work with each individual resident to agree the type of storage that will best meet their needs. The PIC will discuss the agreed storage needs with the Technical Service Department to ensure that the residents storage needs are implemented in full.

Proposed Timescale: 18/03/2016

Theme: Effective Services

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

The shower room upstairs was in need of modernisation.

8. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The PIC has submitted a requisition to the Technical Services Department for the completion of this work.

Proposed Timescale: 30/06/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There was no system in place to review incidences, identify trends and inform practice so as to reduce the likelihood of incidences reoccurring in the centre.

9. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The PIC will ensure that printed copies of accidents, incidents and challenging behaviour forms are printed off and stored in a lever arch folder for review and analysis by the PIC and Service Manager at their regular support meetings. This review will highlight any likely trends so that action can be taken to address this. The PIC will discuss and document the results of this review at each staff meeting.

Proposed Timescale: 30/05/2016

Theme: Effective Services

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

There were no fire doors in the centre so as to ensure the containment of fire.

10. Action Required:

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

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

The PIC will forward a request for the installation of fire doors in the designated centre to the Technical Services Department.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

There was no evidence that residents who stayed on their own in the centre would know what to do in the event of a fire. Their personal evacuation plans stated that they needed verbal prompts for fire evacuations.

11. Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

Two fire drills have taken place on the 23rd of February and on the 1st March 2016 without the intervention of staff members or the residents knowledge. These fire drills were successful on both occasions with the residents evacuating the designated centre under the recommended timeframe. Personal evacuation plans will be updated to include learning from these fire drills. Fire safety will continue to be a Monthly topic at each of the residents meetings.

Proposed Timescale: 08/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Incidences of peer to peer abuse had not been dealt with effectively so as to protect the resident.

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 will meet with every resident on a monthly basis to establish if any peer to peer abuse has taken place. If such abuse has occurred this will be forwarded to the designated Officer and a preliminary screening will be carried out.

Proposed Timescale: 28/02/2016

Theme: Safe Services

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

Safeguarding training provided to staff members did not consider revised national guidance.

13. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

The Organisations policy on Safeguarding has been revised to ensure that it is in compliance with the National Safeguarding Policy. The PIC will request refresher Safeguarding training for the staff team at the designated centre using the new Safeguarding Policy.

Proposed Timescale: 29/02/2016

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 recurring pattern of peer to peer abuse was not notified to the Authority.

14. 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:

All Notifiable Events will be reported to the Authority by the PIC within the designated time frame.

Proposed Timescale: 25/02/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Not all residents healthcare needs were included in the assessment of need.

15. Action Required:

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

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

The PIC will ensure that each residents healthcare needs are assessed and included in each residents assessment of need.

Proposed Timescale: 10/04/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The centre was being run in conjunction with another centre, therefore it was difficult to maintain clear lines of accountability in the centre.

16. 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:

The registered provider as of the 03/02/2016 has determined both units as one centre. An updated Statement of Purpose and Residents Guide has been drawn up to incorporate this change and forwarded to residents and family members.

Proposed Timescale: 15/02/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The assessed needs of residents were being met by staff but the consequences of this could compromise the quality of residents care.

17. 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:

A roster review will take place to ensure that staff members on duty do not exceed the minimum amount of hours when working a sleepover shift. The Service Manager and PIC will meet with one resident to ensure that they return home within an agreed timeframe.

Proposed Timescale: 30/04/2016

Theme: Responsive Workforce

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

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

18. Action Required:

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

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

The Registered Provider is finalising a performance management appraisal system to support, develop and manage staff. Until this system is rolled out the PIC will continue to support /supervise staff at the monthly support meetings.

Proposed Timescale: 30/06/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Some of the policies as per Schedule 5 of the regulations were not available to the inspector.

19. Action Required:

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

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

•The Abuse Policy and Procedures for Protection of Adults from Abuse and Neglect and the Policy on Education and Learning has been updated and was discussed at a staff meeting held on the 25/02/2016. All staff will read and sign policy.

•The Provision of Information policy is being developed and is due to be published by 30/06/2016, the PIC will discuss the policy at the staff meeting in July and all staff will read and sign the policy.

•The Staff Training and Development Policy is due to be developed by the end of April 2016, the PIC will discuss the policy at the staff meeting in May and all staff will read and sign the policy.

•The admissions policy will include Transfer/ temporary absence of a resident and discharge. The policy is under review and will be finalised by end of April 2016, the PIC will discuss the policy at the staff meeting in May and all staff will read and sign the policy.

Proposed Timescale: 30/07/2016

Theme: Use of Information

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

The residents guide did not reflect the contract of care agreements in place for residents.

20. Action Required:

Under Regulation 20 (2) (b) you are required to: Ensure that the guide prepared in respect of the designated centre includes the terms and conditions relating to residency.

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

The Residents Guide has been updated by PIC to include the Contract of Care agreements for all residents.

Proposed Timescale: 20/01/2016

Theme: Use of Information

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

There were gaps evident in the documents stored on residents personal plans, the annual review and minutes of meetings.

21. Action Required:

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

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

The PIC and key worker of the residents will review each resident's file to ensure no information gaps are evident, and to ensure that all personal plans are completed in full and stored appropriately.

Proposed Timescale: 30/05/2016