**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:** | ORG-0008544 |
| **Centre county:** | Co. Dublin |
| **Email address:** | deirdre.bolton@smh.ie |
| **Type of centre:** | Health Act 2004 Section 38 Arrangement |
| **Registered provider:** | St Michael's House |
| **Provider Nominee:** | John Birthistle |
| **Person in charge:** | Roisin O'Neill |
| **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:** | 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 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 06 May 2014 11:30 | 06 May 2014 18:30 |

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

| |
|---|
| Outcome 05: Social Care Needs |
| Outcome 07:  Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

**Summary of findings from this inspection**

This was the first inspection of this six bed centre for persons with disabilities. The centre forms part of a diverse number of services nationally delivered by the provider St Michaels House Group. The inspection was announced and took place over one day. As part of the process the inspector met with the person in charge, the senior services manager, staff, and residents. The purpose of the inspection was to assess the level of compliance with the Health Act 2007(Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities 2013 and the standard of care delivered to residents in the facility.

Throughout the inspection it was noted that there was an emphasis on delivering safe suitable and appropriate care in a relaxed and unhurried manner. Daily routines for each resident reflected their general interests and capacities and the pace of care delivery tailored accordingly. Care was provided within a low key atmosphere of domesticity and socialization. Staff were found to deliver care in a low key, unobtrusive and respectful manner.

The findings from this visit are detailed under each outcome in this report, in general evidence of good standards of practice were found although improvements were noted to be required in some aspects of service delivery such as; care planning, risk and medication management and policies and procedures. Where non compliances are identified an action plan is included under each outcome and identifies areas where improvements are required to comply with the regulations and 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 and the National Standards for Residential Services for Children and Adults with Disabilities.**

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Some evidence that resident's well being and welfare were maintained by a good standard of evidence-based care and support was found. Comprehensive personal plans that supported each resident's abilities to achieve their potential for personal development in all spheres of daily life, i.e. personal, social, health and education were in place for some residents. These were found to reflect resident's involvement to the extent that the resident was consulted in relation to their wishes and preferences from the perspective of social needs relating to family and community based contacts, visits and outings. Although plans were not in place for all of those viewed it was found that they were moving to an outcome rather than activity based focus to promote independence and life skills maintenance or development.

Evidence that opportunities for education, training and development were provided was found in that all residents were attending day services to maintain and develop life skills. In conversation with one resident the inspector heard how much the resident enjoyed working in a local cafe and attending the local gym twice weekly.

However, on review of a sample of clinical documentation it was found that improvements were required to ensure that arrangements to meet each resident's assessed needs were set out in a personal plan (or care plan) that reflected their needs and capacities. A care planning system which ensured the comprehensive assessment of every identified healthcare need and included the implementation of evidence based care protocols to manage those needs with ongoing review as required to reflect changes was not established. The person in charge was aware of the need for

improvements to the care planning process within the centre. A care plan was not in place for every identified need, examples included, resident's receiving treatment for dysphagia, incontinence, limited mobility and risk of falls. In some instances where evidence of interventions of allied health professions were found, the guidance was not referenced in a care plan to ensure the recommendations or guidelines for care were implemented and reviewed to determine effectiveness. All risk assessment tools were not evidenced based and the comprehensive assessment of all health needs were not assured. Examples included moving and handling and use of restraints. Staff spoken with informed the inspector that a review of the care planning system was under consideration and improvements to ensure a more person centred focus were planned.

**Outcome 07: Health and Safety and Risk Management**
*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Although all aspects of the lines of enquiry for this outcome were not reviewed on this visit it was found that in general 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. However, improvements to all risk management systems in place and in particular to manage emergency situations were found to be required. A health and safety statement was in place however, the statement was not specific to the centre but related to the corporate organisation of St Michael's House Group, an extensive organisation which provides a myriad of services nationally to persons with disabilities, this statement had not been revised since 2009.

Records were maintained regarding the regular servicing of fire equipment and fire officer's visits. Fire escape routes were unobstructed. Fire procedures were displayed and fire equipment and alarms were tested and arrangements were in place for the maintenance of the fire alarm system and equipment within this centre and personal emergency evacuation plans for all residents were in place. Staff spoken with demonstrated knowledge of the procedures to be followed in the event of a fire and had received annual training in fire safety as required under the legislation.

Although arrangements for detecting, containing and extinguishing fires were found to be in place such as directional signage, fire alarms, extinguishers and fire exits, consideration of a review of these arrangements to ensure sufficiency and adequacy particularly in relation to zoning of corridors, mechanical door closures linked to the fire

alarm and smoke seals on all internal doors to ensure provision of 30-60 minutes fire fighting time is required.

Arrangements were also 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. However, it was noted that the policies in place were not sufficiently specific to guide staff in all aspects of an emergency, for example, although a fire evacuation policy was in place an emergency plan to direct and guide staff in response to any major emergency such as power failure, flooding or other form of emergency was not available. The systems in place to respond to a fire included the use of personal evacuation plans for all residents. These plans purported to identify the specific procedure to be used to evacuate each resident. However, it was found that they were not fully reflective of the actual process used by staff when conducting fire practices and did not reference difficulties associated with residents' individual capacities behaviours or responses in the event of an emergency. Examples included lack of co operation to evacuate, level of assistance required to mobilise and supervision of mobile residents.

The emergency plan in place did not identify all resources available to ensure residents safety for example, alternative accommodation or back up staff resources. Additional equipment to effectively and safely respond to emergencies was not available such as; hi visibility jackets; space blankets, waterproof jackets or sufficient search torches. A missing person's policy to guide staff in the event of the unexpected absence of a resident was also generic and not centre specific. This policy directed staff to commence an initial search and if necessary to undertake a further local search however, the specifics of how far either of these searches should extend was not indicated and reporting procedures during the event were not clear. Evidence of effective review of the systems in place to assess and manage all risks associated with response to emergencies was not found.

**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

**Judgement:**
Non Compliant - Minor

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

**Findings:**
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. In conversation with some staff members, the inspector found they were competent in their knowledge regarding reporting mechanisms within the centre and what to do in the event of a disclosure about actual, alleged or suspected abuse. In conversations with them some residents expressed feeling safe and could tell inspectors the names of staff they were familiar with. Although all residents spoken with were unable to express feeling safe, the inspector observed they appeared comfortable with staff and did not exhibit behaviours associated with distress or anxiety.

Although a restraint-free environment was observed to be promoted within the centre, and behavioural supports to manage behaviour that challenges was not observed during this visit. It was found that restrictive measures such as use of bed rails and lap belts were noted to be in use for some residents, specifically those persons with balance or sitting difficulties who had limited mobility. However, although alternative, less restrictive measures may have been considered or trialled prior to the use of these methods documentation referencing the need for these restraints did not identify whether the restraint used was suitable for the residents needs without restricting the resident unnecessarily and was used for the shortest duration possible. Improvements to clinical documentation were noted to be required and this is discussed under Outcome 5.

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

**Theme:**
Health and Development

**Judgement:**
Compliant

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

**Findings:**
Residents had access to medical services. Some evidence of access to specialist and allied health care services to meet the diverse care needs of residents such as opticians, dentists and chiropody services was found on a review of some clinical documentation, although it was found that all information in relation to reviews of residents health status by medical officers or palliative care specialists, speech and language, physiotherapy and dietician services was not held in the centre, this is further referenced under outcome 18 of this report.

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 evening meals in the centre as appropriate to their ability and preference. Menus were displayed in word and pictorial format and were compiled with consideration to the preferences and nutritional needs of each resident. Drinks such as juices, milk, tea and coffee were freely available and there were ample stocks of fresh food and larder stores to facilitate snacks or meal alternatives as required.

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

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Evidence that the processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation were not found and systems were not in place for reviewing and monitoring safe medication practices.

In this centre medication was being administered by social care staff who received' safe administration of medication' training. There were written operational policies relating to the disposal of medications and self administration however, policies for ordering, prescribing, storing and administration of medicines by care staff were not available and it was found that prescribing and administration practices were not in line with best practice or professional guidance. Examples included;
- original prescriptions or in house prescription kardex with general practitioner or medical officer original signature were not in place for all medications;
- staff spoken with informed the inspector that where changes to medications occurred, care staff transcribed from copies of a prescription or from verbal information from a next of kin.
- the transcription was subsequently signed by a medical officer from the St Michael's house team however, a defined time frame for signing the kardex was not in place and in one example noted was not yet signed seven days following transcription;
- no maximum dose prescribed for pro re nata (PRN) or 'as required' medications.

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
A written statement of purpose was available which broadly reflected the service provided in the centre. On review it was found that some improvements were required to ensure the document contained all of the information required by Schedule 1 of the Regulations.

Information which requires to be included in the statement of purpose includes;
- the specific care and support needs the centre intends to meet
- the criteria used for admission including policy and procedures for emergency admissions
- size of all rooms
- range of needs and the facilities and services available to meet those needs
- arrangements for residents access to education, training and employment
- separate facilities for day care
- arrangements for review of personal plans
- details of any specific therapeutic techniques used and arrangements for their supervision.

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
All lines of enquiry in relation to this outcome were not reviewed on this inspection and

concentrated primarily on governance and management of the centre and not on the broader governance of the service by St Michael's House Group.

The inspectors formed the view that within the centre there was evidence of good management systems to support and promote the delivery of safe, quality care services however, this centre formed part of a larger service provider with a complex management structure and associated levels and lines of authority and accountability.

All lines of accountability were not clear to inspectors and the person in charge and services manager referred to many people with responsibility for general governance to whom they report or relied upon for support.

The centre was managed by a full time person in charge who demonstrated good leadership skills and sufficient knowledge to ensure suitable and safe care was delivered to residents. All staff were familiar with each resident's personal and social interests, background, history. All residents' were familiar with staff including the person in charge on sight, those who could communicate verbally called her by name and the interactions between all staff and residents displayed warm and mutually respectful and caring interpersonal relationships. Although the services manager and person in charge had a comprehensive knowledge about the centre and were involved in decisions such as agreeing suitability for admission, they were not involved in all aspects of other key decision making. For example, decisions regarding significant expenditures or additional staffing resources were made by other members of the management team other than the person in charge. The inspector discussed the roles and responsibilities of the provider and person in charge under the Health Act during the introduction to the inspection process at the commencement of the inspection as they did not have a complete understanding of their roles and legal responsibilities in relation to the overall governance and management of the centre under the Care and Welfare Regulations.

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
It was found that at the time of this inspection, the levels and skill mix of staff were

sufficient to meet the needs of residents and staff were supervised appropriate to their role. The inspector observed staff and residents interactions and found that staff were respectful patient and attentive to residents needs. It was noted that staff provided reassurance to residents by delivering care to them in a quiet confident manner.

Evidence that all staff received up-to-date mandatory fire training, moving and handling and vulnerable adult protection was available. However, it was found that a training needs analysis would be of benefit to ensure all staff were provided with up to date evidenced based training in order to meet the assessed needs of the current resident profile. Aspects of training found to be required include; positive behaviour strategies, risk assessment and care planning processes.

A sample of staff files were reviewed and were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013. Records reviewed demonstrated that there were effective recruitment procedures in place and appropriate vetting procedures were in place.

The Inspector checked the staff rota and found that some improvements were required. Although all staff that work in the centre were included on the roster the grade of staff were not identified, also shift times were not clear as the 24 hour clock was not being used to identify the specific time of day, evening or night and could lead to confusion where future reference to determine specific working time of any staff member may be required.

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during 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**

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

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by St Michael's House |
| **Centre ID:** | ORG-0008544 |
| **Date of Inspection:** | 06 May 2014 |
| **Date of response:** | 25 June 2014 |

## 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 and the National Standards for Residential Services for Children and Adults with Disabilities.

## 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:**
A personal or health care plan was not in place for every identified need for all residents.

**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 person in charge is currently working on personal plans for the residents who attend the centre on a time-share basis.

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

Individual keyworker's will be supported to complete the five stages of the individual planning process for the service users they support. Minutes of support meetings will be available.
The person in charge will ensure that residents are involved in the process
The person in charge will attend the individual planning (IP) meetings if residents are in agreement.
The person in charge will support the resident to invite significant people to the IP meeting.
Individual plans will be available for inspection.

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Plans in place were not sufficiently specific to appropriately manage residents identified need and risk assessments and health care plans were not always linked.

**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:**
1. The organisation is compiling a comprehensive assessment of need. This is due for completion by the 20/6/2014.Once the template is completed the PIC will ensure that each resident's assessment of need is completed by the 27/7/2014.
2. The registered provider is currently reviewing all clinician supports and ensuring that all relevant documentation will include a date of review.
3. From the assessment of need information will be gathered and the PIC will link with relevant health care professionals such as Physio, OT and ensure all relevant clinician guidelines and recommendation are prepared and are referenced within the personal care plan. These will form an integral part of the personal plan for the residents.

**Proposed Timescale:** 27/07/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Although the interventions of allied health professions were referenced in some plans recommendations or guidelines for care were not included.

**Action Required:**
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

**Please state the actions you have taken or are planning to take:**
1.For each of the residents the PIC will ensure that all documentation from all allied health care professionals are referenced in the residents care plans and will be reviewed annually or as required.

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Although reviews of plans were in place, they did not in all instances determine their effectiveness.

**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 person in charge will ensure the new updated personal plans effective from December 2014 will include a format to review and update annually or as required. This review will include all relevant clinician documentation.

The review will be documented and will be signed by the PIC, keyworker and all relevant clinicians. It will be available for review as needs change or annually. The review will include a determination of the effectiveness of each plan in place and ongoing monitoring as needs change. The PIC will sign and date all personal plans.

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All risk assessment tools were not evidenced based and the comprehensive assessment of all health needs were not assured

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

**Please state the actions you have taken or are planning to take:**
1.The organisation is currently devising a comprehensive assessment of need and the PIC will ensure that each resident will have a completed one by the end of June.

2. Risk assessment tools will be evidence based for each service user.
3. Following on from this assessment of need the PIC will ensure that all health needs are assessed by allied healthcare professionals who will provide up to date guidelines which will be linked to the care plans.
4. As stated the care plans will be reviewed as needs change and annually.
5. The PIC will liaise with the residents, families or advocate and day service to ensure a holistic approach is evident within the plans.

**Proposed Timescale:** 30/06/2014

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Risk Policies and processes in place were not sufficiently specific to guide staff in the event of an emergency. The fire evacuation plan and missing persons policy in place were generic and health and safety statements and processes were not specific to the centre and were last reviewed in 2009.

**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 person in charge has compiled a comprehensive policy relating to missing persons that is specific to the centre. This is in effect now and all centre staff are aware of it. The policy is available for review.

The PIC and the staff team updated the personal evacuation plans of each of the residents to reflect the procedure to follow in case of any evacuation of the centre. The personal evacuation plans are available for inspection.

**Proposed Timescale:** 01/06/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Evidence of effective review of the systems in place to assess and manage all risks including response to emergencies was not found.

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

for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
Health and Safety Statement is currently under review and all PIC's will receive a briefing on the changes when circulated by the Health and Safety Manager. In particular Section 4.2 Accident/Incident Reporting Policy will be amended to reflect requirements of Regulatory Requirements on Risk Management by H&S Manager

Local access to accident database to be made available by IT Dept at Breaffy House Residential. This will be completed after an IT infrastructure change is made. This will allow the PIC and Service Manager to periodically review accident/incident reports.
The registered provider has agreed a project plan to facilitate this with the IT manager. The project plan is available for inspection. In the meantime all accident reports are printed and reviewed by the PIC and service manager.
The PIC will ensure that all risk assessments are reviewed annually or as needs change.
The PIC will liaise with all relevant health care professionals to ensure that current best practice is followed.

The person in charge has compiled a comprehensive policy relating to the missing person that is specific to the centre.

**Proposed Timescale:** 30/09/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The Risk Policies and personal evacuation plans in place did not include the specific measures in place to control the risks identified with the safe evacuation of residents and staff in the centre specifically risks associated with one staff evacuating residents exhibiting non co-operative behaviours and those with limited or no mobility who require assistance.

**Action Required:**
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
The PIC and the staff team have updated the personal evacuation plans of each of the residents to reflect the procedure to follow in case of any evacuation of the centre.
The PIC has met with the allied health care professional to request that adequate guidelines are in place to allow for safe and appropriate moving and handling practices specific to each resident.
These guidelines will be included in the care plan and reviewed as needs change or annually.
Currently each resident does have a manual handling risk assessment in place which are reviewed as needs change and annually.
For each resident the PIC can call an individual co ordination meeting which allows for

all allied health care professionals to discuss and review all current practices and guidelines in place to support each resident.
The PIC will ensure that each resident of the centre has at least one of these meetings before the end of the year.
The number of fire drills carried out each year will be increased to ensure that all residents have had adequate fire drills. This will enable the PIC to review and amend the personal evacuations. The personal evacuation plans will be reviewed annually and as the need arises.

**Proposed Timescale:** 01/06/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Arrangements for the detection and containment of fire required to be reviewed to ensure adequacy such as; intumescent smoke seal strips; mechanical door closures linked to the fire alarm system and zoning on corridors.

**Action Required:**
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
Following inspection:
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1.The maintenance department have reviewed all doors within the centre.
2. Each of the doors within the centre has been fitted with intumescent strips and cold smoke seals. All of the resident's bedrooms have been fitted with half hour fire doors as well as intumescent strips.
3. The PIC has arranged additional fire safety training for the staff team that will be unit specific. This training had been planned prior to the initial inspection and will take place on the 2nd of July.
4. The unit specific evacuation plan will also be up dated following on from this training. It will also be reinforced at the training that all doors are closed upon activation of the fire alarm and at night time as part of the bedtime procedure. This will be validated as part of the fire drills and will be monitored by the PIC in this manner.
5. The organisations fire safety advisor has new accessible fire safety notices printed and will be in place within the centre on the 2nd of July.
6. The PIC has also requested support from the fire safety advisor regarding how to effectively involve the residents in the fire drills; this will be discussed at the centre specific training on the 2nd of July.
7. There is a conventional alarm system in place, which divides the house into a number of zones. These zones also include corridor areas, so the system upon activation will inform staff as to what zone the detector has been activated. As this is a small residential house it would be reasonable to have this type of system in place. To complement this there is an L1 detection system in the unit, this is the highest level of detection available and means there is a detector is in place in each room of the centre

including the attic.
8. The organisation has been developing a new fire fact file that is expected to be rolled out to each centre in September 2014.

**Proposed Timescale:** 07/07/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate arrangements for evacuating where necessary all persons in the designated centre and bringing them to safe locations were not available.

**Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
1.An emergency plan is now in place, which includes a safe location to evacuated too. The PIC has put an emergency pack in place within the centre, which contains survival blankets/torches with extra batteries and directions to the safe location.
2.The Health and safety department and the technical services department have also drawn up new polices to support the PIC with other emergencies such as gas leaks, flooding loss of water, loss of heat. This is in place.

**Proposed Timescale:** 01/06/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Where physical restrictions were in use, evidence that alternative, less restrictive measures may have been considered or trialled prior to the use of these methods was not found.

**Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
1. The PIC is identifying all restrictive practices with the centre such as use of bed rails and lap strap.
2. The PIC has requested advice from allied health care. Indivualised risk assessments

are being drawn up.
3. Approval has been requested by the organisations positive approaches committee.

4.The risk assessments will form an integral part of the personal health care plans and will be reviewed as needed or annually. The review will include actions to work towards removing these restrictions.

**Proposed Timescale:** 20/07/2014

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were written operational policies relating to the disposal of medications and self administration but policies for ordering, prescribing, storing and administration of medicines by care staff were not available and prescribing and administration practices were not in line with best practice or professional guidance.

**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:**
Following inspection the organisational policy on Safe administration of medication has been amended and updated to include prescribing, administration and transcribing medication.

1. As the centre is a time share facility medication generally comes form the residents family home .The PIC will write to all family's to request that they forward a copy of any prescription or change in medication by the GP. This will support the staff team to complete the review of medication form, which currently allows for the resident's "medication administration sheets" to be reviewed and amended by a Doctor.
2. An original medication administration sheet will be in place for each of the residents. This will be signed by the prescribing doctor. They will be routinely reviewed every 3 months.

3.The PIC will ensure that a copy of any change to medication is on file for each of the residents.

**Proposed Timescale:** 18/06/2014

**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:**
All of the information required under Schedule 1 of the regulations was not included as follows;
the specific care and support needs the centre intends to
-meet the criteria used for admission including policy and procedures for emergency admissions
- size of all rooms
-range of needs and the facilities and services available to meet those needs
- arrangements for residents access to education, training and employment
- separate facilities for day care
- arrangements for review of personal plans
-details of any specific therapeutic techniques used and arrangements for their supervision.

**Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The management team of the centre are currently reviewing the statement of purpose {SOP} to include a centre specific admissions policy
Include the needs and the facilities and service available to meet those needs,
Arrangements for residents access to education, training and employment,
Separate facilities for day care
Arrangements for review of care plans
The review will focus on the care and support need the centre can facilitate
Any therapeutic techniques used and arrangement for their supervision.

The PIC did include a detailed floor plan with the SOP and has requested that the maintenance department do a measurement of each room within the centre.

**Proposed Timescale:** 01/09/2014

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management structure in place did not clearly define the lines of authority and accountability, specific roles and responsibilities and did not provide sufficient details on the responsibilities for all areas of service provision

**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:**
1.The organisation are currently reviewing the management structure in relation strengthening the PIC authority, accountability and responsibilities:
2.Currently PIC receive budget sheets monthly and these are reviewed, advice and support given by service manager
3.Regular meetings re HR issues, advice and support by service manager
4.Health and safety: PIC liaise with health and safety for advice and support

3.The management structure will be included in the unit essential guide this will outline who is in charge when the PIC is absent, i.e. between 9 and 5 pm Monday to Friday: the service manager, outside of these hours Nurse manager on call.

**Proposed Timescale:** 30/11/2014

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A review of the roster to include the grade of staff and clarify shift times through use of the 24 hour clock was found to be required

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

**Please state the actions you have taken or are planning to take:**
PIC has included the staff grade on the roster and the 24-hour clock is also being used.

**Proposed Timescale:** 01/06/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A training needs analysis was found to be required to ensure all staff are provided with up to date evidenced based training in order to meet the assessed needs of the current resident profile

**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 Staff Training and Development Department will be requested to conduct a Training Needs Analysis for all staff within the unit to determine current training and future training requirements to meet the needs of the residents and to form part of each staff member's continuous professional development".

Proposed Timescale:

Request sent to Staff Training and Development Department by June 20th 2014.
All staff in the unit to have completed a Training Needs Analysis by July 25th 2014.
Targeted plan for staff training to be formulated by October 2014.

**Proposed Timescale:**