Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	A Canices Road
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	27 November 2018
Centre ID:	OSV-0002332
Fieldwork ID:	MON-0021650

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The designated centre is located in North County Dublin. It is operated by St Michael's House and provides services to six female residents who have varied support requirements. At the time of inspection, two of the residents access services on a time share basis. The house is a two story home comprising of a living room, kitchen/dining room, utility room, three bathrooms, an office and six bedrooms. There was a well maintained enclosed garden to the rear of the centre with a seomra. The centre is located close to local shops and transport links. The centre is staffed by a person in charge and social care workers. Staff have access to nursing support through a nurse on call service.

The following information outlines some additional data on this centre.

Current registration end date:	31/08/2020
Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
27 November 2018	10:30hrs to 18:30hrs	Conan O'Hara	Lead
27 November 2018	10:30hrs to 18:30hrs	Sinead Whitely	Support

Views of people who use the service

The inspectors had the opportunity to meet and spend time with four residents during the inspection. One resident was on a trip away from the centre on the day of the inspection. Some residents showed inspectors their rooms and their goals for the year. A number of residents who spoke with the inspectors described how they like to spend their time.

Overall, the residents reported that they were happy with the service they received. Residents were actively involved in the running of the centre and inspectors observed residents returning from work and day services, shopping and preparing meals. The inspectors engaged with residents at meal times and found that they were a pleasant experience. Throughout the inspection, inspectors observed that the residents appeared content and staff treating and speaking with residents in a dignified and caring manner.

Capacity and capability

Overall, there were clearly defined management systems in place to operate the service. However, improvements were required in the effective governance of the service, staffing, training and the notification of incidents.

At the time of inspection, there was a clearly defined management structure which provided oversight of the service. There were a number of audits in place which included a six monthly unannounced provider visit and an annual review for 2017 of the quality and safety of care. The annual review provided for consultation with residents, representatives and staff. The annual review for 2018 was being drafted on the day of inspection. The centre was managed by a suitably qualified and experienced person in charge who demonstrated good knowledge of the residents. However, on the day of inspection the person in charge was supporting the establishment of a separate individualised service which impacted on the effective oversight of this centre. Considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management systems in place ensured a safe and effective service.

The centre maintained a planned and actual roster. The inspectors reviewed a sample of these rosters and found that that there was sufficient staffing levels in the centre to meet the assessed needs of the residents. However, the rosters required some improvement as they did not include the full names of all staff working within the centre. The centre was currently operating with two whole time equivalent vacancies and subsequently there was a reliance on relief and agency

staff in order to maintain the staffing levels. While the provider had made efforts to ensure these were familiar staff and was in the process of a recruitment campaign, the inspectors found that this did not ensure that residents received continuity of care and support at all times. Inspectors observed throughout the day of inspection staff interacting with residents in a respectful and caring manner.

There were systems in place for the training and development of staff. A sample of staff training records were reviewed and inspectors found that staff had up-to-date mandatory training. However, not all staff had completed training in positive behaviour support. The provider submitted information post inspection demonstrating that the remaining staff were in the process of completing this. This meant that the staff team had the skills necessary to respond to the needs of the residents in a capable and safe way.

A sample of incidents and accidents were reviewed and the inspectors found that not all incidents were notified to the Office of the Chief Inspector as required by the Regulations. This was discussed at the feedback meeting.

There was a complaints policy in place dated February 2018 and the centre maintained a log of complaints and compliments. The inspectors reviewed the complaints log and found that complaints were taking seriously and were managed. Residents spoken with were clear on who they would complain to if it was required.

Regulation 15: Staffing

There was an appropriate number of staff to meet the needs of the residents. However, there was a reliance on agency and relief staff due to vacancies which did not ensure the continuity of care and support for residents. There was a planned and actual roster however the rosters did not include the full names of all staff working within the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of staff. A sample of staff training records were reviewed and inspectors found that staff had up-to-date mandatory training. However, not all staff had completed training in positive behaviour support. The provider submitted information post inspection demonstrating that the remaining staff were in the process of completing this.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place in the designated centre which provided oversight of the service. Regular audits including a six month provider visit and annual review were completed. However, these systems and audits did not ensure the service provided was safe and effectively monitored. On the day of inspection the person in charge was supporting the establishment of a separate individualised service which impacted on the effective oversight of this centre. Considering the cumulative non compliances identified on inspection, inspectors were not assured that the governance and management systems in place ensured a safe and effective service

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all incidents were notified to the Authority as required by the Regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place dated February 2018 and a log of complaints and compliments was maintained. The inspectors reviewed the complaints log and found that complaints were taking seriously and were managed.

Judgment: Compliant

Quality and safety

Overall, the inspectors observed that the quality and safety of the service received by residents was good. However, improvements were required in relation to personal plans, safeguarding, risk, premises, fire safety and medication.

The inspectors completed a walk through of the centre and in general found that the

house was decorated in a homely way. The two storey house consisted of a living room, kitchen/dining room, utility room, three bathrooms, an office and six bedrooms. Inspectors observed residents' bedrooms were personalised to residents' tastes. However, one of the bathrooms was found to be in contrast with the rest of the house as it was clinical in nature. There was a well maintained garden which provided ample space to enjoy outdoor activities and contained a garden room. However, some parts of the residents' home needed to be maintained to a higher standard such as suitable storage and general upkeep of areas such as paint and the carpet on the stairs.

On the day of inspection, the inspectors reviewed a sample of residents' files and found that there was an up-to-date assessment of need in place. However, the assessment of need did not in all cases inform the care plans for each resident. This required improvement to suitably guide staff in supporting the residents with their health and social care needs. For example, an assessment of need identified two health care needs for one resident. The first health care need identified had a care plan but was not up-to-date and in relation to the second health care need there was no care plan to guide staff in how this need was being managed. The inspectors found the staff spoken with on the day of inspection were familiar with the needs of residents and support in place to meet those needs.

From speaking with residents and staff, the inspectors found that each resident was supported to spend their day in a manner that was meaningful and purposeful for them. All of the residents had access to a day service and one resident was in open employment one day a week. Residents availed of many community facilities and amenities. Residents told inspectors about social activities which included holidays, developing positive relationships, attending local clubs and going to events.

There were positive behavioural supports in place for residents as appropriate. The positive behaviour support plans were up-to-date and guided staff in supporting residents with behaviour that challenge. There were a number of restrictive practices in place in the centre including locked doors and window restrictors. The centre maintained a record of all restrictive practices in use in the centre and inspectors found that all restrictions were regularly reviewed by the Positive Approaches Management Group.

There were safeguarding measures in place such as a safeguarding policy and staff had completed training in relation to the prevention, detection and response to abuse. At the previous inspection, it was identified that not all residents were safeguarded from abuse. The inspectors found that the provider had reviewed this and implemented changes to address the safeguarding concern. Staff spoken with were knowledgeable on what constituted abuse and what to do in the event of a concern or allegation. However, inspectors found that the service had not managed all concerns in line with national policy to ensure that all incidents, concerns and allegations of abuse were reported, screened and investigated.

There were arrangements in place for the assessment, management and ongoing review of risk. The service maintained a risk register which was up-to-date and

outlined individual and service risks and the controls in place to manage these risks. Risk control measures were proportional to risks identified and any adverse impacts on residents' quality of life were considered. However, there was identified risks in the centre which may impact on residents' safety which had not been appropriately assessed as to ensure that all potential risks were mitigated in the centre. There was a service vehicle in place which was road worthy, insured and appropriately licensed.

There were systems in place for fire safety management. The centre had suitable fire equipment in place including a fire alarm, emergency lighting and fire extinguishers. Centre records demonstrated the fire drills were carried out regularly. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident and were up-to-date. While the inspectors acknowledge that intumescent fire strips and cold smoke seals were on all doors, improvement was required regarding the containment of fire as fire doors were not in place. The provider was taking measures as part of a service wide improvement plan to ensure that fire doors would be in place.

Overall, there was an established medication management system. A sample of prescription and administration sheets were viewed and were found to contain appropriate information. There was evidence of regular review of prescription sheets with the residents general practitioner (GP). All staff were appropriately trained and supervised by a member of management to safely administer medication. There were appropriate protocols for the administration of as required (PRN) medication. Staff spoken with, appeared knowledgeable when asked about PRN protocols. Residents had access to a local pharmacist, who facilitated any changes in medication. However, some areas of risk were identified in relation to the safe storage of medication on the day of inspection; inspectors observed staff not utilising these measures. Medications to be disposed of, were stored in an unlabelled box in the staff office and not in the provided medication press. In addition, the key for the medication press was stored in an accessible place in the staff office.

Regulation 13: General welfare and development

Each resident was supported to spend their day in a manner that was meaningful and purposeful for them. All of the residents had access to a day service and one resident was in open employment one day a week. Residents availed of many community facilities and amenities.

Judgment: Compliant

Regulation 17: Premises

The house was decorated in a homely way. There was a well maintained garden which provided ample space to enjoy outdoor activities and contained a garden room. Some parts of the residents' home needed to be maintained to a higher standard such as suitable storage and general upkeep of areas such as paint and the carpet on the stairs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The service maintained a risk register which was up-to-date and outlined individual and service risks and the controls in place to manage these risks. Arrangements in place, ensured risk control measures were proportional to risks identified and any adverse impacts on residents quality of life were considered. However, there was identified risks which may impact on resident's safety which had not been appropriately assessed as to ensure that all potential risks were mitigated.

Judgment: Not compliant

Regulation 28: Fire precautions

Centre records demonstrated the fire drills were carried out regularly. Personal Emergency Evacuation Plans (PEEPs) were in completed for each resident and were up-to-date. However, improvement was required in the containment of fire as fire doors were not in place. Intumescent fire strips and cold smoke seals were on all doors in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

An established medication management system was in place. Improvements were required in the safe storage of medication. On the day of inspection, inspectors observed medications to be disposed of were stored in the office and not in the locked medication press. In addition, the key for the medication press was stored in an accessible place in the office.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were up-to-date assessment of need however, the assessment of need did not in all cases inform the care plans for each resident. This required improvement to suitably guide staff in supporting the residents with their health and social care needs. For example, an assessment of need identified two health care needs for one resident. The first health care need identified had a care plan but was not up-to-date and in relation to the second health care need there was no care plan to guide staff in how this need was being managed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There were positive behavioural supports for residents as appropriate. The positive behaviour support plans were up-to-date and guided staff in supporting residents with behaviour that challenge. There were a number of restrictive practices in use which were regularly reviewed by the Positive Approaches Management Group.

Judgment: Compliant

Regulation 8: Protection

Safeguarding measures were evident; the service had a safeguarding policy and all staff had completed training in relation to the prevention, detection and response to abuse. However, not all concerns were managed in line with national policy to ensure that all incidents, concerns and allegations of abuse were reported, screened and investigated.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for A Canices Road OSV-0002332

Inspection ID: MON-0021650

Date of inspection: 27/11/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider will hold interviews on February 12th with a view to filling the Centre's staffing vacancies, with suitably experienced and qualified staff members, so as to ensure the continuity of care and support for the residents. Following successful recruitment, the use of agency staff will be reduced \ eliminated. The PIC will ensure that all rosters will include the full name and title of each staff member.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will ensure that all staff who are awaiting mandatory training, will be listed to attend on the next scheduled training dates, and will complete all training, including positive behaviour support training, in line with the Organisation's training policy.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC has been involved in the management of another (non-designated) centre, which has absorbed a portion of her Management time. The oversight of this centre will cease to form a part of the PIC's brief from the end of January 2019, thus ensuring that she will be allocated an appropriate number of management hours to ensure the effective oversight, governance and management of the designated centre, to support the safe and effective delivery of service.	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC will ensure that all safeguarding incidents are notified to the authority in line with Regulation 31, and with the organisational and national safeguarding policies.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC has contacted the Technical Services Department to request that the carpet on the stairs be replaced, that any necessary painting be carried out, and that the bathroom be decorated to create a homely environment. The PIC will further ensure that all items \ equipment in the centre are safely and appropriately stored.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The PIC will ensure that all identified risks in the Centre, which may impact on residents' safety, will be appropriately assessed, and the necessary control measures put in place to ensure that all potential risks are mitigated in the centre, thus ensuring a safe and comfortable environment for all residents. All Risk assessments and control measures will be reviewed at least three monthly, to assess their effectiveness.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Free swing closers have been installed on both Kitchen doors, to ensure the automatic closure of these doors in the event of the activation of the fire alarm. The PIC has requested, and received assurance that fire doors will be installed in the centre in the second quarter of 2019	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The PIC will ensure that the designated centre operates appropriate and suitable practices relating to the ordering, receipt, storage, audit, administration and disposal of	

medication, to ensure that all medication is stored securely, and that all medication carries an expiry date. The PIC will further ensure that the keys for the medication storage press, are safely and securely stored in a locked key storage lock-box, which can be accessed only by the centre's permanent and appropriately trained staff members.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The PIC will ensure that all assessed health and social care needs, as identified in each resident's assessment of need, are addressed and reflected in care-plans in order to guide staff practice. The PIC will further ensure that all assessments of need, and all identified care-plans are reviewed at least annually, and more frequently where required. This review will assess the effectiveness of each care-plan.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The PIC will ensure that all safeguarding concerns are managed as per the Provider's safeguarding policy, and are notified to the authority in line with regulation 8, and the national safeguarding policies. The PIC will further ensure that training in safeguarding for all staff in the centre, is completed in line with the Provider's training policy.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	28/06/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/01/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional	Substantially Compliant	Yellow	30/04/2019

	development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	28/02/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	01/02/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/06/2019
Regulation	The person in	Not Compliant	Orange	30/01/2019

29(4)(a)	charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Not Compliant	Orange	30/01/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing	Not Compliant	Orange	28/11/2018

	within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	20/02/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/11/2018