Office of the Chief Inspector

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

Name of designated centre:	Clew Bay
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	19 March 2019
Centre ID:	OSV-0002334
Fieldwork ID:	MON-0025759

About the designated centre

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

Clew Bay is a community home for adult residents with an intellectual disability. Residents are supported when required with budgeting, cooking and other activities of daily living. The centre consists of two premises within walking distance of each other. One premises is a two-storey, end of terrace house with five bedrooms, three bathrooms, a kitchen, dining and living spaces. The other premises is a terraced house situated on a cul de sac. Upstairs it has three bedrooms, one of which is ensuite and a bathroom. It has two sitting rooms, a kitchen/dining area and a utility room downstairs. Both premises are connected by adjoining back gardens and situated close to a local village in Co. Dublin. Facilities close by include shops, pubs, churches, garda station, credit union, banks, parks, a swimming pool and a library. The local shopping centre is a 10 minute walk and the area is well served by public transport. Care and support in the centre is provided by a person in charge and social care workers. Residents can access nursing support via the nurse manager on call service if required.

The following information outlines some additional data on this centre.

Current registration end date:	30/09/2021
Number of residents on the date of inspection:	8

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
19 March 2019	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead
19 March 2019	09:00hrs to 17:00hrs	Marie Byrne	Support

Views of people who use the service

As part of the inspection, the inspectors met with five of the eight residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. The inspectors observed warm interactions between the residents and staff caring for them. Two of the residents told the inspector that they enjoyed living in the centre and of the many activities that they were involved in. Two of the residents showed the inspector their bedrooms which had been personalised to their own taste.

There was evidence that residents and their family representatives were consulted with and communicated with, about decisions regarding their care and the running of their house. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspectors did not have an opportunity to meet with the relatives of any of the residents it was reported that they were happy with the care and support their loved ones were receiving.

Capacity and capability

Management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs had significantly improved since the last inspection.

The centre was managed by a suitably qualified, skilled and experienced person who had an in-depth knowledge of the needs of each of the residents. The person in charge had taken up the position in November 2018. She held a diploma in childcare, diploma in social studies and a degree in management. She was in a full time position and had two days protected time each week for her role and was rostered as a front line member of staff on other days. She was not responsible for any other centre, and was found to have a sound knowledge of the requirements of the regulations and standards. Staff members spoken with, told the inspector that the person in charge supported them in their role and promoted a person centred approach to the delivery of care. The person in charge reported that she felt supported in her role and had regular formal and informal contact with her manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. A new deputy manager post had been established in January 2019 to support the person in charge. The person in

charge reported to the service manager who in turn reported to the director of service. There was evidence that the service manager visited the centre at regular intervals. The person in charge and service manager held formal meetings on a two weekly basis.

At the time of the last inspection, suitable arrangements were not in place to effectively monitor care and support for residents. On this inspection, it was found that a detailed service improvement plan and quality enhancement plan had been put in place to address non compliances. These plans were overseen by a service improvement team consisting of members of the senior management team. The person in charge compiled a monthly quality and safety governance data report which was submitted to the service manager and director of service. This report provided data for the month on residents achievements, update on quality enhancement plan, safeguarding, incidents, complaints, finances, behaviours of concern, restrictions and risks. Since the last inspection the provider had submitted a monthly assurance report to the Office of the Chief Inspector. An annual review of the quality and safety of care and six monthly unannounced visits as required by the regulations had been undertaken. There was evidence that the person in charge and or her deputy had undertaken a number of audits in the centre on a regular basis. Examples of audits completed included, medication practices, residents' rights, fire safety, key working and a safety audit. There was evidence that actions were taken to address issues identified in these audits.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were in place. A number of new staff members had joined the staff team since the last inspection following a suitable induction. The staffing levels in the centre had recently been increased to meet the changing needs of one of the residents.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training needs analysis had been completed. A training programme was in place which was coordinated by the providers training department. Training records showed that staff were up to date with mandatory training requirements or training had been scheduled in the case of three staff members who required manual handling training. There were no volunteers working in the centre at the time of inspection.

Suitable staff supervision arrangements had been put in place. However, the inspector reviewed a sample of staff supervision files and found that supervision in the preceding period had not been undertaken in line with the frequency proposed in the providers policy. Supervision undertaken was found to be of a good quality. This was considered to support staff to perform their duties to the best of their abilities.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

The full complement of staff were in place and considered to have the required skills and competencies to meet the needs of the residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. Suitable staff supervision arrangements had been put in place. However, supervision in the preceding period had not been undertaken in line with the frequency specified in the providers policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Quality and safety

The residents living in the centre received care and support which was of a good quality, person centred and promoted their rights. There had been significant improvements since the last inspection in areas such as residents' rights, risk management and safeguarding. However, improvements identified as required in relation to the premises at the time of the last inspection, had not yet been

undertaken.

Both premises in the centre were found to be warm, clean and comfortable. However, in line with the findings of previous inspections, the significant improvements required in relation to the maintenance and upkeep of the premises remained. These areas for improvement included; damage to the kitchen and counter tops in both houses, damage and mould to ceilings in a number of areas including living rooms and bathroom ceilings, the full completion of maintenance works to the front door and under the stairs storage, the refurbishment of a number of bathrooms and the replacement of windows and doors. Flooring in one house had been replaced since the last inspection. The provider was aware of the areas for improvement and had completed a review and walk through both premises with the maintenance department. They had escalated the required improvements and plans were in place to complete the required works. One premises was not currently meeting the number and needs of residents, however; the provider had recognised this and had plans in place to rectify this.

Overall, residents' personal plans were found to be person-centred and they had access to a keyworker to support them. Each resident had an assessment of need in place which was reviewed and updated in line with their changing needs. Support plans were developed and required and there was evidence that these were regularly reviewed to ensure they were effective. Each resident had an all about me document available in an accessible format which outlined their likes, dislikes, wishes and preferences. Keyworkers were completing a monthly keyworker report and there was a monthly checklist in place to track what information required review in residents' assessment of need or personal plans.

The inspectors found that there were appropriate practices in the centre in relation to keeping residents safe and protecting them from abuse. Staff had access to training to support them to carry out their roles and responsibilities in relation to safeguarding residents. Staff who spoke with the inspectors were knowledgable in relation to their responsibilities in relation to safeguarding and how to escalate concerns. Incidents, allegations or suspicions of abuse were recorded and followed up on in line with the provider's policy. The inspectors found that the organisation's policy on protection of adults from abuse and neglect, contained information and guidance that was contradictory to the national safeguarding policy and it was reported that this was being reviewed. The provider had recognised that there were compatibility issues between a number of residents in the centre and had put effective safeguarding measures and plans in place including additional staffing resources to meet residents' changing needs.

Residents were provided with appropriate emotional and behavioural support. However, the behaviours of a small number of residents were sometimes difficult for staff to manage in a group living environment and this had the potential to have a negative impact on other residents living in the centre as referred to above. The inspector found that the assessed needs of residents were being appropriately responded to. Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual residents. There was evidence that plans in place were

regularly reviewed by the provider's behaviour specialist and psychologist.

It was evident that residents were supported to make decisions about their lives and that they were listened to with care and respect by staff. Their views were taken into account and they were free to choose how they spend their day. It was evident that residents were enabled to take reasonable risks within their day-to-day lives. Residents' meetings were held regularly and it was evident that residents were participating in the running of their home. Residents had access to an independent advocate if they so wished and information in relation to advocacy services were on display in the centre.

Residents were protected by appropriated risk management policies, procedures and practices. The provider had recently reviewed and updated their risk management policy and it was due to be distributed within the organisation. There was a risk register and risk assessments which was reviewed and updated regularly in line with residents' changing needs. There were systems in place to respond to emergencies and systems to ensure the centres' vehicle was roadworthy, regularly serviced, insured and equipped with the appropriate safety equipment.

Regulation 17: Premises

Both houses were clean and homely. In line with the findings of previous inspections, significant improvement was required to the maintenance and upkeep of both houses. The provider was aware of these areas for improvement and had plans in place to complete the required works.

Judgment: Not compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management polices, procedures and practices. General and individual risk assessments and the local risk register were reviewed regularly in line with residents' changing needs.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' personal plans were found to be person-centred. There was evidence of regular review of their assessment of need and support plans to ensure they were effective. These reviews were identifying required changes to documentation in line

with residents' changing needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Regulation 8: Protection

The provider had recognised that there were compatibility issues between a number of residents in the centre. They had put appropriate safeguarding measures in place including additional staffing. The inspectors found that the organisations' policy on protection of adults from abuse and neglect required review as it was not effective in guiding staff practice.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were consulted with and participating in the planning and running of the designated centre. They had access to advocacy services if required and were supported to choose how to spend their day. Personal care practices and documentation in the centre respected residents' privacy.

Judgment: 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Clew Bay OSV-0002334

Inspection ID: MON-0025759

Date of inspection: 19/03/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The Person in Charge will complete a schedule of supervision meetings with the staff team in the centre in line with the revised and updated organisations Staff Supervision and Support Policy. Supervision will be provided to every member of the staff team at a recommended minimum of 4 times per year.

• The Person in Charge will also provide on-going feedback and support to all staff members in addition to supervision and support meetings.</td></tr>
<tr><td>Regulation 17: Premises</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 17: Premises:
• The Registered Provider has liaised with St Michaels House Technical Service Department and all recognised works have been identified and schedule of works will commence: Decoration and painting will be completed by the end of June. Kitchen and bathrooms will be completed by the end of September.

• The Registered Provider has approved funding for the capital works in the centre</td></tr>
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Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Draft 1 of St Michaels House policy on Protection of Adults from Abuse and Neglect will be completed by the 3/5/ 2019 and sent for consultation to all key stakeholders.

• St Michaels House policy on Protection of Adults from Abuse and Neglect will be finalised by the 1/6/2019

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/06/2019
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.	Not Compliant	Orange	30/09/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	01/06/2019