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:	Warrenhouse Residential
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Announced
Date of inspection:	20 March 2019
Centre ID:	OSV-0002338
Fieldwork ID:	MON-0022452

About the designated centre

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

Warrenhouse Residential is a designated centre based in a North Dublin suburban area and is operated by St Michael's House. It provides community residential services to five female residents with intellectual disabilities over the age of 18. The designated centre consists of five bedrooms, kitchen come dining room, two sitting rooms, an office, three bathrooms and a utility room. The centre is located close to amenities such as shops, cafes and public transport. 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. All residents attend day services.

The following information outlines some additional data on this centre.

Current registration end date:	26/10/2019
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
20 March 2019	09:15hrs to 18:30hrs	Conan O'Hara	Lead

Views of people who use the service

On the day of inspection, the inspector met with the five residents who were availing of the services of this designated centre and had the opportunity to speak with four of the residents. The inspector observed care practices and interactions on the day of inspection. In addition, feedback on the quality and safety of the service was elicited from a review of questionnaires completed by the residents.

Overall, the residents who avail of the service had positive views and communicated that they were satisfied with the care and support received. Residents noted in their questionnaire that they felt safe in the designated centre. However, some residents noted dissatisfaction with some interactions with their peers. In addition, a resident highlighted that the patio area to the rear of the building was one area they would like to be fixed. The inspector observed that residents appeared comfortable in their home and positive interactions between staff and residents.

Capacity and capability

Overall, there was an defined management structure and an established staff team in place to ensure the service provided was of good quality. Some improvements were required in the oversight of the service and to organisational policies.

There was a clearly defined management structure in place. The designated centre was managed by a person in charge who was suitably qualified and experienced. The person in charge was employed on a full time basis, worked directly with the residents and had protected administration time. There were a number of quality assurance audits in place which included annual reviews and the six monthly unannounced provider visits. However, the oversight arrangements in place required improvement to consistently and effectively monitor the quality and safety of the centre. For example, the findings of the six monthly review dated August 2018 were not accurately reflected in the annual review and the system in place for the reporting and monitoring of adverse incidents required improvement.

The person in charge maintained a planned and actual staff roster. The inspector reviewed a sample of the staff roster and found that, on the day of inspection, there was sufficient staff who were appropriately skilled to meet the assessed needs of the residents. There was an established staff team in the centre and the residents received continuity of care and support. Throughout the inspection, staff were observed treating and speaking with residents in a dignified and caring manner.

There were systems for the training and development of staff. The inspector reviewed staff training records and found that all staff were up-to-date in mandatory training such as fire safety, safeguarding and manual handling.

The service being delivered to residents was observed to be in keeping with the centre's current statement of purpose dated March 2019. The statement of purpose contained all of the information as required by Schedule 1 of the regulations.

The inspector reviewed a sample of incidents and accidents in the centre and found that not all adverse incidents were notified to the Office of the Chief Inspector as required by regulation 31.

On the day of inspection, the inspector found a number of polices required under Schedule 5 of the regulations had not been reviewed, and updated where necessary, at least once every three years or in the time frames outlined as required by the provider.

Regulation 14: Persons in charge

The designated centre was managed by a person in charge who was suitably qualified and experienced and demonstrated good knowledge of the residents. The person in charge was employed on a full time basis, worked directly with the residents and had protected administration time.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual staff roster. There was sufficient staffing levels and skill mix in place to meet the assessed needs of the residents. Throughout the inspection, the inspector observed staff treating and speaking with residents in a dignified and caring manner.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had up to date mandatory training.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose dated March 2019 contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all adverse incidents were notified to the Office of the Chief Inspector as required by the Regulation 31.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A number of policies were found not to have been reviewed and updated if necessary, at least once every three years or in the time frames outlined as required by the provider. These were:

- The management of residents' property and possessions.
- The recruitment, selection and vetting of staff members.
- Provision of behavioural support.
- The use of restrictive procedure and physical, chemical and environmental restraint.
- The creation of, access to, retention of, maintenance of and destruction of records.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The oversight arrangements in place required improvement to consistently and effectively monitor the quality and safety of the service provided.

Judgment: Substantially compliant

Quality and safety

Overall, the residents living in the centre received care and support which was person centred. However, improvements were required in safeguarding, premises, fire containment, risk assessments and medication management.

The inspector reviewed residents' files and found that there was an up-to-date assessment of need in place. Residents' social care and health care needs were appropriately assessed and care plans were available to guide the staff team. Residents were supported to access facilities for occupation and recreation in the community in line with their interests and preferences.

The inspector found that the residents were supported to enjoy their best possible health. Residents had access to a General Practitioner and a range of allied health professionals and to nursing support through a nurse on call service if required. The inspector reviewed a sample of health care plans and found that they appropriately guided the staff team on the arrangements and supports in place to support the residents with their health care needs.

There were positive behavioural supports in place for residents as appropriate. The inspector reviewed the positive behaviour support plans and found that they were up-to-date and guided staff in supporting residents manage their behaviour.

The arrangements in place to safeguard residents required review. Information reviewed by the inspector (this included feedback from residents) found that there was a pattern of behaviours which at times impacted negatively on residents. While, the provider had reviewed individual adverse incidences and had responded through the provision of positive behavioural supports, not all incidences were screened in line with the provider's safeguarding policy. There were also no safeguarding plans in place to provide assurances that the measures in place were effective in reducing the negative impact of these behaviours on other residents.

There were arrangements in place for the assessment, management and ongoing review of risk. The provider maintained a risk register which was up-to-date and outlined individual and service risks and the controls in place to manage these risks. However, not all individual risk assessments accurately reflected the risk and the individual controls in place to manage the risk.

The inspector completed a walk through of the centre, accompanied by the person in charge, and in general found that the house was decorated in a homely way. The designated centre consisted of five bedrooms, a kitchen come dining room, two sitting rooms, an office, three bathrooms and an utility room. The bedrooms viewed were decorated in line with residents' preferences and taste. The bathrooms were found to be in contrast with the rest of the house and were not decorated in a homely manner. There were also areas requiring improvement which included the upkeep of some paint work and flooring in some areas of the centre. At the time

of the inspection the person in charge informed the inspector that plans were in place to re-floor and repaint some of the rooms. There was a well maintained garden to the front of the centre and a large garden to the rear of the centre. The patio area to the rear of the building was uneven in places which did not promote accessibility to this area for all residents in the house. This had been highlighted by a resident to the inspector in their feedback questionnaire.

There were systems in place for fire safety management. The centre had suitable fire safety equipment including emergency lighting, fire alarm and extinguishers which were serviced as required. Centre records demonstrated the fire drills were carried out regularly. Each resident had a personal emergency evacuation plan in place which outlined the supports for each resident to evacuate the designated centre. However, improvements were required in relation to containment of fire. For example, a fire safety report dated May 2018 identified that the doors in situ were not fire doors. The provider was taking measures as part of a service wide improvement plan to ensure that fire doors would be in place.

Aspects of medication administration practices required review. For example, the inspector observed that staff did not sign off on the administration of medication for one resident on two occasions. This had not been identified as a medication error as required by the organisation's medication policy. It was observed however that the prescription and administration sheets viewed contained the appropriate information. On completion of a capacity and risk assessment some residents were supported to manage their own medication requirements independently. In addition, guidelines were in place for the administration of a number of as required (PRN) medications.

Regulation 17: Premises

Aspects of the premises required updating to include:

- Painting and flooring in some rooms of the centre.
- The patio area to the rear of the building was uneven in places.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A fire safety report dated May 2018 identified that the doors in situ were not fire doors.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need in place for each resident. Residents' social care and health care needs were appropriately assessed and care plans were available to guide the staff team.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. Residents had access to a range of allied health professionals and to nursing support through a nurse on call service if required. Healthcare plans appropriately guided the staff team on the arrangements and supports in place to support the residents with their health care needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

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 manage their behaviour.

Judgment: Compliant

Regulation 26: Risk management procedures

Not all individual risk assessments accurately reflected the risk and the individual controls in place to manage the risk.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Aspects of medication administration practices required review as it was observed that staff did not sign off on the administration of medication for one resident on two occasions. This had not been identified as a medication error as required by the organisation's medication policy.

Judgment: Substantially compliant

Regulation 8: Protection

The arrangements in place to safeguard residents required review. The inspector reviewed information and found a pattern of behaviour which at times impacted negatively on residents. This was not screened in line with the provider's safeguarding policy.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Warrenhouse Residential OSV-0002338

Inspection ID: MON-0022452

Date of inspection: 20/03/2019

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:

Regulation Heading	**Judgment**
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC of the designated centre will ensure that all required notification will be given in writing, following any adverse incidents to the authority within the required timeframe. In response to the area of non compliance found under regulation 31; • All adverse incidents that require notifications will be forwarded in writing to the authority in the appropriate timeframe	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • The registered provider has prepared, adopted and implemented policies and procedures as set out in Schedule 5. • All policies and procedures that are referred to in schedule 5 are now available to all staff in the designated centre. • The organization, currently adopts the HSE Vetting Policy in line with the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016, and are now fully compliant in this regard. In response to the area of non-compliance found under regulation 4;	

• The management of residents' property and possessions - local policy to support each residents personal possessions record is in place • The recruitment, selection and vetting of staff members - the SMH HR folder which contains these policies, is in place. • Provision of behavioural support - currently under review and will be completed by June 2019. • The use of restrictive procedure and physical, chemical and environmental. Currently under review with first draft to be completed August 2019. • The creation of, access to , retention of, maintenance of and destruction of records. Currently under review with first draft to be completed August 2019

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • The designated centre is resourced to ensure all residents' support and care needs are met. • There is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability. • There are management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. • Annual reviews of the quality and safety of care and support are completed in consultation with the resident and their representatives • A copy of the annual review is available to residents and is held in the centre. In response to the area of non-compliance found under regulation 23; • The annual review will going forward accurately reflect all findings from previous reviews to ensure the monitoring of quality and safety in the designated centre • All adverse incidents will be notified to the authority in the appropriate timeframe.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • The register provider will ensure the premises are laid out to meet the aims and objectives of the service and the number and needs of resident. • The designated centre is of sound construction and in good state of repair. • The designated centre is clean and suitably decorated

In response to the area of non-compliance found under regulation 17;
• The designated centre will be painted and new flooring will be placed in areas within the centre, where required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The organization will ensure that effective fire safety management systems are in place to provide adequate precautions against the risk of fire, in the Designated Centre.

In response to the area of non-compliance found under regulation 28;
• Additional fire containment measures that are required in the designated centre form part of the SMH Fire Safety Plan for 2019 and will be completed in order of priority in 2019.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Registered provider has a Risk Management Policy in place.
• All staff are aware of risk management and identified risks within the centre
• Quarterly Hazard Inspections are carried out, and they identify risk within the designated centre.

In response to the area of non-compliance found under regulation 26 (2):

• Individual risk assessments have been reviewed and updated to reflect the risk and the controls measures in place to manage the risk

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The PIC shall ensure that the designated centre has appropriate and suitable practices relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that all medicines are kept securely.
• The Organization has a policy & procedure in place for the Safe administration of Medication, which is underpinned by national policy. This policy guides practices relating to the management of medication: ordering/ receipt/ prescribing/ storing/disposal and administration of medication is in line with best practice.
• The Organization ensures that all staff receives training in the safe administration of medication.
• All residents in the designated centre have access to a pharmacist of their choice.
• There is a system of recording for each resident of prescribed and administered medication and these are kept in a secure location within the designated centre.

In response to the area of non-compliance found under regulation 29;
• Review of medication administration practices with the staff team to ensure the recording of all administration of medication.
• All medication errors will be identified and reported in writing, as required by the organizations medication policy.
• Weekly audit of the medication administration sheets commenced 24/03/19

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• St Michael's House has a policy in place for safeguarding vulnerable adults which is currently under review.
• Safeguarding training for all staff has been completed.
• Each resident is supported to develop skills so that they have knowledge and skills to promote their protection.
• All incidents of a safeguarding nature will be notified in line with regulatory requirements.

In response to the area of non-compliance found under regulation 8;

• Where there are any incidents, allegations or suspicion of abuse, the PIC will ensure this is reported to the organizations Designated Officer and notifications are made as appropriate. These will be made in line with St Michaels House and the National Safeguarding Polices, and notifications will be sent to the authority in the appropriate timeframe

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 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	31/08/2019
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.	Substantially Compliant	Yellow	21/03/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of	Substantially Compliant	Yellow	31/05/2019

	Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2019
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	24/03/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated	Substantially Compliant	Yellow	21/03/2019

	centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	21/03/2019