Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Grangemore Rise
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Announced
Date of inspection:	15 January 2020
Centre ID:	OSV-0002341
Fieldwork ID:	MON-0028656

About the designated centre

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

Grangemore Rise is a designated centre operated by St Michael's House. The centre is located in North County Dublin. It provides community residential services for up to seven residents, over the age of 18 years, with intellectual disabilities and with support needs. The designated centre consists of a house and a detached apartment located to the rear of the house. The house is a two storey building and provides accommodation for up to six residents and consists of a storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The apartment is home to one resident and consists of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The designated centre is located close to local shops and transport links. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 15 January 2020	10:00hrs to 19:15hrs	Conan O'Hara	Lead
Wednesday 15 January 2020	10:00hrs to 19:15hrs	Ann-Marie O'Neill	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with six residents living in the centre on the day of the inspection. At the time of the inspection the centre was operating with one vacant bed. Some residents communicated their thoughts and opinions verbally while others used non-verbal methods to communicate. Some residents chose not to engage with the inspectors.

The inspectors observed residents as they prepared to engage with their daily activities which included accessing the community and day services. The inspectors also observed residents engaging in activities of daily living such as enjoying meals, watching TV and relaxing in their home. In addition, on the day of the inspection, inspectors observed that some residents appeared more content and relaxed in their home than previous inspections. Overall, residents were observed to be comfortable in their home. Throughout the day of inspection, the inspectors observed positive interactions between staff and residents.

In addition, the inspectors had the opportunity to meet with three of the residents' representatives. Overall, the representatives noted that they have seen recent improvement in the care and support provided and improved governance and management arrangements in the centre.

Residents' representatives did highlight continued concerns in relation the compatibility of the resident group in the house. Others expressed their dissatisfaction with aspects of their resident's care and support arrangements outlining some examples in relation to the laundering of residents' clothes and meal provision. Inspectors did note however, these examples had occurred prior to the recent change in governance and staffing arrangements for the centre, which representatives indicated were starting to bring about improvements.

Capacity and capability

This inspection report sets out the findings of an inspection carried out by the Health Information and Quality Authority (HIQA) in January 2020. The purpose of the inspection was to assess the provider's implementation of a service improvement plan and to inform a recommendation for the renewal of registration for this centre.

The provider submitted the service improvement plan to the Chief Inspector, in response to escalated regulatory processes which occurred following a number of inspections carried out in this centre from December 2018 to September 2019. The purpose of the service improvement plan was to bring about improved compliance with the regulations and standards, to change and enhance the governance and

management systems in the centre with aim of improving the quality of service provision for residents living in the designated centre.

Three inspections were carried out of the centre in December 2018, April 2019 and September 2019. These inspections found significant levels of non-compliance with the provider failing to demonstrate there were adequate governance structures and systems in place to effectively manage and monitor the service in order to meet residents' needs and provide them with a safe, good quality service.

Following the April 2019 inspection, the provider set out their plan to change the centre's service provision to a social care model and to change the management structure in the centre in order to address the non-compliances found. An inspection was carried out in September 2019 to assess if this action had brought about improvements. Inspectors however, found high levels of non compliance during the inspection. While the provider had made changes to the governance and management, staffing and service model provision these changes had just been implemented and had not brought about enough improvement in compliance or quality of care for residents in order to demonstrate they were effective.

In response to these findings and continued non-compliance found across a number of inspections of the centre, the provider was requested to attend a cautionary meeting in HIQA offices in October 2019 where they were verbally informed of the potential enforcement consequences should continued non compliance occur in this designated centre. Following the meeting, the provider was required to submit a service improvement plan to the Chief Inspector of Social Services, in order to demonstrate how the provider would bring the centre into compliance and improve the quality of life for residents.

This inspection found that the provider and the management team had made substantial improvements to the quality of service provision in the centre, which was in line with the service improvement plan they had provided the Chief Inspector. Inspectors noted there was an improved standard of care being provided to the residents which in turn was demonstrated in the increased compliance with the regulations found during the inspection.

The centre now had a clearly defined management structure in place. As noted above, in September 2019, the provider reorganised the centre's management and had appointed a new person in charge and service manager to manage the centre. The person in charge was full-time, suitably experienced and demonstrated a good knowledge of the residents and their support needs. The person in charge was supernumerary in their role and was supported by two experienced social care workers. The previous inspection identified that not all matters in relation to Regulation 14 were met. There was evidence that this was being addressed at the time of the inspection.

There was evidence that management systems were in place to effectively audit and monitor the quality of the service provided. A number of quality assurance audits were in place including six-monthly provider visits and annual reviews, as

required by the regulations. In addition, local audits were in place including medication management, residents' rights and personal plans. The provider had also developed a quality improvement plan outlining an overall action plan to address areas for improvement in the centre. There was evidence of these audits identifying areas for improvement and implementing action plans developed to address these areas.

The person in charge maintained a planned and actual roster. A review of the roster demonstrated that the provider had increased staffing levels since the last inspection and that there was a sufficient level of staffing in place to meet the needs of the residents. The previous inspection had identified that there was a reliance on relief and agency staff and continuity of care was not maintained at all times. The provider had put measures in place to address this. While, the centre was currently operating with 2.2 whole time equivalent vacancies, the provider had ensured continuity of care through block booking regular agency and relief staff. The provider informed inspectors that they were in the process of recruitment to fill these vacancies. The inspectors observed positive, person-centred interactions between staff and residents through out the day of the inspection.

There were systems in place for the training and development of the staff team. The previous inspection found that the staff team did not have up-to-date training. The inspectors found that for the most part this had been addressed. The majority of the staff team had up-to-date training including fire safety and manual handling. However, there remained some gaps including safe administration of medication and de-escalation and intervention techniques.

The inspectors reviewed a sample of incidents and found that incidents and accidents were notified to the Chief Inspector in line with Regulation 31.

The previous inspection found that the improvements required to address complaints made in relation to care and support and safeguarding were not being put in place for a prolonged period of time. The inspectors reviewed the complaints log which demonstrated that all complaints had been reviewed by the complaints officer. At the time of the inspection, there were no open complaints and the areas for improvement identified were being addressed through the quality improvement plan.

Regulation 14: Persons in charge

The person in charge worked in a full-time post. The person in charge was appropriately experienced to mange the service and demonstrated good knowledge of the residents and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. A review of the roster demonstrated that there was a sufficient level of staffing in place to meet the needs of the residents. The provider had ensured continuity of care was provided to residents.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The majority of the staff team had up-to-date training. However, there remained some gaps including safe administration of medication and de-escalation and intervention techniques.

Judgment: Substantially compliant

Regulation 22: Insurance

There was evidence that the centre had an insurance policy in place which insured against the risk of injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place. There were a number of quality assurance audits were in place including the six monthly provider visit and annual review as required by the regulations. A quality improvement plan had also been developed for the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre's statement of purpose dated January 2020 included all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents and accidents were notified to the Chief Inspector in line with Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place. All complaints had been reviewed and closed by the complaints officer.

Judgment: Compliant

Quality and safety

Inspectors found that the strengthened governance and management arrangements had led to improved outcomes for residents. For example, there was evidence of reduced incidents and risks in the centre being identified, reviewed and appropriate control measures in place to manage risk. In addition, inspectors observed staff implementing behaviour management strategies which were effective in supporting residents manage their behaviour. However, some areas required improvement which included the assessment of need, personal plans and review of restrictive practices.

In the previous inspections, personal plans were found not to accurately identify all of the residents needs or appropriately guide the staff team in supporting the residents. The inspectors reviewed a sample of personal plans and found that significant work had been completed by the person in charge and the staff team to carry out a comprehensive assessment of need for each resident and update the personal plans as required. However, this was still in process at the time of the inspection. In addition, improvements were required in the assessment, oversight and review of the compatibility of the resident group. As identified in the previous inspections, there are identified concerns in relation to the compatibility of the resident group living in the centre. The provider did not demonstrate how they were

assured that the resident group were compatible and that the current layout and design of the premises meets the needs of all residents.

There were positive behavioural support plans in place for residents where required. The supports plans were up to date and appropriately guided the staff team in how to support residents manage their behaviour. Residents also had access to psychology and psychiatry as required. There were some restrictive practices in use in the centre. While these restrictive practices had been identified by the person in charge, the inspectors found that some restrictive practices required a more timely review by the providers Positive Approaches Management Group.

There were systems in place to safeguard residents. Inspectors reviewed a sample of incidents and accidents and found that they were being appropriately reviewed, responded to and safeguarding plans were developed were required. The provider also informed inspectors that they were engaging with the Safeguarding and Protection Team regarding safeguarding in the centre. However, there remained concerns regarding the compatibility of the resident group living in the centre – this is outlined under Regulation 5.

The inspectors found that there were systems in place to oversee and support residents to exercise and enjoy their rights. The previous inspection found that some practices in place in the centre did not promote or support residents' autonomy, independence and choice. To address this, the provider had completed a rights review for each resident and identified areas for improvement. In addition, the provider had supported residents to access advocacy services and there was evidence that advocates had meet with residents and their representatives to support residents exercise their rights. While these issues were not addressed on the day of the inspection, there was appropriate oversight and plans in place to ensure residents were supported to exercise their rights.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre specific risks and individual risk and the measures in place to manage the identified risks.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place which outlined the supports for each resident to evacuate the designated centre. Centre records demonstrated that fire evacuation drills were completed regularly. On the day of the inspection, the inspectors identified that improvements were required in the containment of fire. This was addressed by the provider shortly after the inspection.

There were appropriate systems in place for the ordering, storing, disposal and administration of medication. A sample of prescription and administration sheets were viewed and found to contain appropriate information. The previous inspection found that improvements were required in PRN (medication administered as required) medication protocols and in secure storage of medication. The inspectors

reviewed a sample of PRN protocols and found that this had been addressed by the provider. In addition, a new secure medication storage unit was now in place in the centre.

The inspectors completed a walk through of the centre accompanied by the person in charge. The centre was well maintained and decorated in a homely manner. The previous inspection found that the flooring and painting in areas of the house required improvement. This had been addressed by the provider. In addition, the previous inspection identified that the design and layout of the centre did not meet all of the identified needs of the residents. The provider was currently exploring options in relation to the design and layout of the centre, however the assessment of compatibility and assessment of need were still in progress. This is outlined under Regulation 5.

Regulation 17: Premises

The centre was decorated in a homely manner and well maintained.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place and centre records demonstrated that fire evacuation drills were completed regularly.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate systems in place for the ordering, storing, disposal and administration of medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need was not in place for each resident and personal plans required improvement. However, this was in process at the time of the inspection. In addition, improvements were required in the assessment, oversight and review of the compatibility of the resident group. The provider did not demonstrate how they are assured that the resident group were compatible and that the current layout and design of the premises meets the needs of all residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There were positive behavioural support plans in place for residents where required. The supports plans were up to date and appropriately guided the staff team in how to support residents manage their behaviour. Residents also had access to psychology and psychiatry as required.

There were some restrictive practices in use in the centre. While these restrictive practices had been identified by the person in charge, the inspectors found that some restrictive practices required a more timely review by the providers Positive Approaches Management Group.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. However, there remained concerns regarding the compatibility of the resident group living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

There were systems in place to oversee and support residents to exercise and enjoy their rights. The provider had completed a rights review for each resident and identified areas for improvement. The provider had supported residents to access advocacy services and there was evidence that advocates had meet with residents and their representatives to support residents exercise their rights.

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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Grangemore Rise OSV-0002341

Inspection ID: MON-0028656

Date of inspection: 15/01/2020

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge has ensured that all new staff joining the team have been booked into training within one month of their start date. One staff member booked in to complete Safe administration of medication training on 11th and 12th of March 2020. All other staff are now up to date in mandatory training as per time-bound plan submitted to the Authority in January 2020.	
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 Person in Charge and staff team are continuing to gathering relevant information for each resident to ensure each that each individual has a comprehensive assessment of need and personal plans. Briefing in PCP was delivered to all staff on 15th January and 18th February 2020. Specific work on Personal Plans and Assessments of Need will be completed by November 2020. A compatibility assessment will be carried for each resident by 19/03/2020 All residents have a date for a My Life Meeting, all will be complete by 15/03/2020	

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Person in Charge ensures that there is three month review of all Restrictive Practices in line with Organizational Policy. As per policy all restrictions will be reviewed and reduced/ removed as appropriate in consultation with the Psychologist.	

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)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/03/2020
Regulation 05(1)(b)	The person in charge shall 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 subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	20/11/2020
Regulation 07(4)	The registered	Substantially	Yellow	20/02/2020

	provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Compliant		