Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	A Middle Third
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	06 June 2018
Centre ID:	OSV-0002360
Fieldwork ID:	MON-0021664

About the designated centre

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

A Middle third is a community based home for five adults both male and female with an intellectual disability. It is situated on the north side of Dublin city close to all the amenities and facilities the city has to offer. The centre is close to public transport links which enable residents to access these amenities and neighbouring areas. The building is a single-storey, five bedroomed home with a homely design and layout. Each resident has their own bedroom, one of which is en-suite. There are two shared bathrooms, one with a bath and shower and the other with a shower. The house is fitted with a ceiling hoist to meet residents' needs. The kitchen is accessible and residents are encouraged to get involved with the preparation of meals and snacks. There is a garden to the rear of the property with two sheds for storage. Staff encourage residents to be active members in their communities and to sustain good relationships with their family and friends. The staff team comprises a person in charge, clinical nurse manager, staff nurses, social care staff, direct care support staff and a household staff. Staffing resources are arranged in the centre in line with residents' needs.

The following information outlines some additional data on this centre.

Current registration end date:	17/11/2018
Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or 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
06 June 2018	08:40hrs to 16:40hrs	Marie Byrne	Lead

Views of people who use the service

The inspector met and spent some time with four residents during the inspection. During the inspection the inspector observed parts of residents' daily lives such as mealtimes, activities, and relaxation time. Residents were observed to choose to go to day services, prepare snacks and spend time in their favoured spaces such as playing the piano in the second sitting room or spending time in their bedrooms. The kitchen come dining room was observed to be most residents' preferred space in the centre.

Throughout the inspection residents appeared relaxed and comfortable with the support offered by staff. Staff described residents' care and support needs and showed the inspector documentation relating to what makes a good day for residents. Residents' meetings were held regularly in the centre which demonstrated residents' involvement in the day-to-day decisions in the centre such as menu and activity planning.

The inspector reviewed satisfaction questionnaires completed by residents and their representatives. Overall, the feedback in these questionnaires was positive. Residents and their representatives were complimentary towards the care and support in the centre and they were particularly complimentary towards the staff team, the food and how complaints were managed in the centre. Areas for further development were identified as planned developments to the back garden to include sensory equipment and raised beds, and the availability of regular staff.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were ensuring a good quality and safe service for residents in the centre. The person in charge was new to the centre and was identifying areas for further development in the centre in line with the findings of this inspection. These included staff training and development, recruitment to fill staffing vacancies, consistency in documentation in residents' personal plans including the development and review of residents' social goals and review of restrictive practice usage in the centre. The provider had put measures in place to complete all of the actions required following the last inspection.

The provider had submitted documentation in relation to the new person in charge in the centre. The inspector found that the person in charge was knowledgeable in relation to the residents' care and support needs and their responsibilities in relation to the regulations. They had plans in place to further enhance systems in the centre

relating to review and upkeep of documentation. They were already completing audits in the centre and tracking the progress of actions developed from these audits.

Overall, the inspector found that the centre was well managed and that this was bringing about positive outcomes for residents. There were clearly defined management structures in place which identified the lines of authority and accountability in the centre. The staff team reported to the person in charge who in turn reported to the service manager. The person in charge, service manager and clinical nurse manager facilitated the inspection, and the provider representative attended feedback at the end of the inspection. The inspector found that they were all knowledgeable in relation to residents' care and support needs. The service manager and provider representative were meeting regularly as were the person in charge and service manager. The inspector reviewed minutes of these meetings and found they were person-centred and bringing about positive changes in relation to residents home and the quality of care and support in the centre.

There was an annual review of the quality and safety in the centre and six monthly visits by the provider or their representative. The inspectors found that learning and improvements were brought about as a result of the findings of these reviews. There were also audits completed in the centre and evidence of follow up on actions from these audits. Staff meetings were held regularly and the agenda items were found to be resident focused. A new template had recently been introduced at staff meetings to track actions and those responsible for completing those actions.

Staff in the centre had completed a number of training courses and refreshers in line with residents' assessed needs. However, a number of staff required positive behaviour support training in line with residents' needs. In addition staff in the centre were not in receipt of formal supervision to support them to carry out their roles and responsibilities to the best of their ability.

There were 1.5 whole time equivalent staffing vacancies in the centre on the day of inspection. The 0.5 vacancy had been filled and the staff member was due to commence in the centre post the inspection. The provider was in the process of recruiting to fill the other vacancy. While they were in the process of recruiting to fill this position, the provider was attempting to minimise the impact of the vacancy on residents in the centre by regular staff completing overtime and by using regular relief staff.

Regulation 14: Persons in charge

The person in charge was found to be knowledgeable in relation to residents' care and support needs and their responsibilities in relation to the regulations. The person in charge had a clear focus on quality improvement and had plans in place to further develop aspects of care and support for residents in the centre to further improve services and facilities for residents.

Judgment: Compliant

Regulation 15: Staffing

Staff in the centre were delivering person-centred care in line with residents' needs and wishes. There were a number of vacancies in the centre but the provider and person in charge were ensuring this was not negatively impacting on residents through regular staff completing overtime and the use of regular relief staff. This was ensuring continuity of care for residents. One part time vacancy had been filled and the recruitment of the other post was progressing.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in the centre had for the most part access to training and refreshers in line with residents' assessed needs. Training was required in relation to positive behaviour support.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the centre was well managed and residents were in receipt of person-centred care and supports. The provider, service manager and person in charge were meeting regularly to monitor care and support in the centre. The management structure in place clearly identified the lines of authority and accountability and each staff member had specific roles and responsibilities within the centre. There was a suite of audits being completed in the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policies and procedures required by schedule 5 of the regulations were in place and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the safety and quality of the service provided to residents of this centre was good. Each resident was observed to be supported in a person-centred manner in keeping with their individual needs and wishes. Areas for improvement were identified in relation to residents' personal plans and the review of restrictive practices in the centre. The provider had put measures in place to complete most of the actions required following the last inspection.

The premises was found to be clean, well maintained and homely. The design and layout was found to be meeting residents' specific care and support needs. Each resident had their own bedroom which was decorated in line with their wishes and preferences and there was plenty of storage for their personal items. There was adequate private and communal space for residents and there was a private space available for residents to meet visitors in private if they so wished. Residents were protected by appropriate policies, procedures and practices relating to infection prevention and control in the centre. There were adequate hand washing facilities available throughout the centre.

Through audit the person in charge had identified that improvements were required in relation to residents' personal plans including consistency relating to their review and development of their social care goals. This was consistent with the inspectors findings. Residents had a comprehensive assessment of need in place which outlined which care plans were required. The inspector reviewed a number of residents' personal plans and found that care plans were in place in line with residents' assessed needs and that these were clearly guiding staff to support residents. Personal plans were found to be person-centred and each resident had access to a keyworker to support them to develop and achieve their goals.

Residents' healthcare needs were appropriately assessed and care plans were in place in line with these assessed needs. Each resident had access to appropriate allied health professionals in line with their assessed needs. Meal times were observed to be a positive and social event and residents were observed to receive

assistance with their meals in a sensitive manner in line with the recommendations in their personal plans.

Residents' positive behaviour support plans clearly guided staff practice to support them. There was evidence that they were reviewed and updated in line with residents' changing needs. Staff who spoke with the inspector were knowledgeable in relation to residents' behaviour support needs in line with their positive behaviour support plans. There was evidence that restrictive practices in the centre were regularly reviewed by the multidisciplinary team. However, the inspector found that there was a lack of documentary evidence to show that one residents' restrictive practice was the least restrictive measure and that it was being used for the least amount of time. This was discussed with the person in charge and the resident's keyworker during the inspection and they described how the restrictive practice was removed regularly. A document was developed for recording when the restriction was not in place by the end of the inspection.

There were suitable arrangements in place to detect, contain and extinguish fires in the centre. Works had been completed to install fire doors including those to compartmentalise the centre in the event of a fire. There was evidence that equipment was maintained and regularly serviced in line with the requirement of the regulations. Each resident had a personal emergency evacuation procedure in place and there was evidence that these were updated in line with learning from fire drills in the centre. Special arrangements were in place for one resident with a hearing impairment including three lights in key areas in the centre to alert them if there was a fire, and a picture exchange communication system in place to assist them to with the procedure to safely evacuate in the event of an emergency.

Residents in the centre were protected by policies, procedures and practices in place relating to health and safety and risk management. There was a system in place for keeping residents safe while responding to emergencies. There were also systems in place to identify, record, investigate and learn from adverse events incidents in the centre.

There were effective measures in place to safeguard residents. Staff were knowledgeable in relation to what constituted abuse and the steps to take if there was an allegation of abuse. A previous safeguarding issue was now being managed appropriately in the centre. There was a safeguarding plan in place and staff described how it was being fully implemented in the centre.

Regulation 17: Premises

The design and layout of the centre was in line with the statement of purpose. There was adequate private and communal space for residents and the physical environment was clean and kept in good structural and decorative repair. There was adequate space and suitable storage facilities fore residents' personal

use.

Judgment: Compliant

Regulation 26: Risk management procedures

Adequate arrangements were in relation for risk management in the centre. There was a risk register in place and risk assessments in place for identified risks. There was a system in place for responding to emergencies and for recording, investigating and learning from incidents in the centre.

Judgment: Compliant

Regulation 27: Protection against infection

Infection prevention and control was effectively managed in the centre. Staff were engaging in appropriate infection control practices and the premises was clean and hygienic. There were appropriate and sufficient facilities in place for hand washing.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements in place to detect, contain and extinguish fires in the centre. Works had been completed to install fire doors throughout the centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Staff had appropriate training and fire drills were held regularly in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were found to be person-centred and each resident had access to a keyworker to support them to develop their goals. There was an assessment of need in place for residents which were reviewed in line with residents' needs. Support plans and risk assessments were in place in line with residents' assessed needs. Plans were in place to develop further assessments and to enhance personal

plans further. This included more consistency in relation in reviewing effectiveness and multidisciplinary review of residents' personal plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents in the centre were being supported to enjoy best possible health. They had the relevant assessments in place and the person in charge had plans in place to further develop these assessments. Residents had access to the allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required them had positive behaviour support plans in place. Staff who spoke with the inspector were knowledgeable in relation to the implementation of positive behaviour support plans. There were restrictive practices in place in the centre and evidence that they were reviewed regularly with the relevant members of the multidisciplinary team. However, one restrictive practice reviewed by the inspector did not demonstrate that the least restrictive measures were used for the least amount of time.

Judgment: Substantially compliant

Regulation 8: Protection

Residents in the centre were protected by safeguarding polices, procedures and practices in the centre. A previous safeguarding issue was now being managed appropriately in the centre. Staff who spoke with the inspector were knowledgeable in relation to this safeguarding plan and had a clear understanding of their role in adult protection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for A Middle Third OSV-0002360

Inspection ID: MON-0021664

Date of inspection: 06/06/2018

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have access to the required competencies to manage person centered, effective and safe services to adults living in the designated centre. Currently three staff are in the process of fully completing Positive Behavioral Supports training. A further ten staff have been scheduled for Positive Behavioral Support training on identified upcoming training courses and will either have commenced or completed the full training by 2019. All staff working on the centre are fully supported and supervised to carry out their duties to protect and promote the care and welfare of adults living in the residence. The PIC has a system / schedule in place to ensure regular support meetings are held with all staff on the centre at regular intervals throughout a calendar year. Training is provided to staff to improve outcomes for adults living in the designated centre.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Each adult has a personal plan which details their needs and outlines the supports required to maximize their personal development and quality of life, in accordance with	

their wishes.

Systems are now in place to ensure personal plans are consistent and reviewed regularly by key worker / PIC and the Multidisciplinary team.

Information pertaining to the wishes of a family member have now been included in the individuals care plan to guide and support staff during intimidate/personal care.

All personal plans are evaluated and updated in line with the changing needs of each individual resident to ensure quality of care delivered.

Personal plans will be made available in an accessible format respecting the individual's wishes and requirements, in line with SMH Personal Planning Policy

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The organization has a positive Behaviour Support Policy; the Positive Approaches Management Group (PAMG) has been set up to promote best practice used within the Organisation.

A specific tracking document has been introduced for one resident to ensure we are using the least restrictive practice for the least amount of time, reviewed monthly by PIC and staff team.

The PIC will identify all restrictive practices and application will be made to the PAMG while taking into account the impact of these practices on the resident's rights.

All restrictive practices will be reviewed to ensure they are the least restrictive possible and for the least amount of time possible.

Systems are currently in place to monitor / review and evaluate all restrictive practices to ensure they are fit for purpose.

All restrictive practices have been referred to the Positive approaches monitoring committee for review and sanction.

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	30/06/ 2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2018
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		Yellow	31/08/2018

	need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(a)	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 be multidisciplinary.	Substantially Compliant	Yellow	31/08/2018
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	19/07/2018