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:	Glendoher
Name of provider:	St Michael's House
Address of centre:	Dublin 16
Type of inspection:	Announced
Date of inspection:	23 May 2018
Centre ID:	OSV-0002401
Fieldwork ID:	MON-0021309

About the designated centre

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

Glendoher is a community based home for six adults with an intellectual disability. There are currently three ladies and three gentlemen living in the centre. The centre is located in a suburban area of County Dublin with access to a variety of local amenities. Glendoher provides supports to residents under a social care model of service delivery. It is staffed by social care workers and managed by a social care leader. Should residents require nursing support it is offered through the nurse on call service. Residents are supported to participate in the local community in line with their wishes and preferences. The centre comprises of one house which is a two-storey dwelling. Each resident has their own bedroom, and there are two communal sitting rooms, a large kitchen come dining area, utility, three shared bathrooms and a large secure back garden at the rear of the property. Staff support is offered 24 hours a day, seven days a week and rosters are changed as required in line with residents' care and support needs.

The following information outlines some additional data on this centre.

Current registration end date:	27/10/2018
Number of residents on the date of inspection:	6

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
23 May 2018	08:20hrs to 16:30hrs	Marie Byrne	Lead

Views of people who use the service

During the inspection, the inspector had the opportunity to meet and speak with five of the six residents living in the centre. Throughout the day residents described to the inspector what it was like to live in the centre. They were very complimentary towards the care and support in the centre and described how staff supported them in line with their needs and wishes.

A number of residents showed the inspector around their home during the inspection. Residents described their bedrooms, the back garden and the large kitchen come dining room as their favourite social spaces in the house. The inspector observed residents spend time in their preferred spaces and to engage in activities of their choosing during the inspection. Residents told the inspector about their social roles and described how they were supported to volunteer, work part time, and enjoy activities in the local community. Residents also described how they were being supported to travel to work and stay at home independently if they so wish.

All residents who spoke with the inspector described their involvement in the running of the centre including their chores, menu planning, decorating rooms and cooking. They also described how and to whom they would make a complaint to if they so wished.

The inspector reviewed a number of satisfaction questionnaires which residents had been supported to complete prior to the inspection. In the feedback received, residents stated that they were happy with the care and support in the centre, including how they were supported to make choices and take part in activities.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents in the centre. However, improvements were required in relation oversight and monitoring in the centre, to maintenance of documentation in the centre, and in relation to recognising and reporting safeguarding concerns in line with national policies and procedures and the organisations' policy. The provider had put measures in place to address all of the actions from the previous inspection.

There were clearly defined management structures which identified the lines of authority and accountability in the centre. The inspector met and spoke with the person in charge and the service manager who both displayed a good knowledge of

the legislation and their statutory responsibilities. Residents who spoke with the inspector, spoke fondly of the person in charge and of the support they received from the entire staff team.

During the inspection residents described the complaints process and told the inspector how they would make a complaint if they so wished. There was a complaints policy and procedure in place which was available in an accessible format and on display in the centre. Residents had access to information about advocacy which was on display in the centre. There were systems in place to investigate and respond to complaints and there was a complaints officer in place.

There was evidence of regular staff meetings in the centre with good attendance and resident focused agenda items. The person in charge was meeting with the service manager on a regular basis and these meetings were also resident focused and bringing about positive changes for residents such as improvements to their home and their safety.

There was an annual review of the quality and safety of care in the designated centre and six monthly visits by the provider which provided for consultation with residents and their representatives. However, the latest six monthly visit by the provider had not been completed in line with the timeframe identified in the regulations. There was evidence of the involvement of residents and their representatives in these review and that actions were developed following these reviews. There was evidence of follow up and completion of some of these actions. The provider had recognised areas for improvement in relation to maintenance and repair in the centre and put plans in place to have works done in the centre.

There were systems in place in the centre for recording and maintenance of documents. Information was easily retrievable and it was clear which folder you went to for the information you required. There was evidence of regular review and update of some documentation in the centre, however the inspector found that some documentation was not consistently signed by staff including, day reports, drug recording sheets and audits.

The inspector found that there were appropriate staffing arrangements in place in the centre. There were the correct number of staff to meet residents' care and support needs. Staff who spoke with the inspector were knowledgeable in relation to residents' care and support needs. They had access to training and refreshers in line with residents' care and support needs and were in receipt of regular formal supervision to support them to effectively carry out their duties. Residents spoke fondly of the staff team and particularly their keyworkers who supported them to develop and reach their goals.

Regulation 15: Staffing

There were appropriate staffing arrangements in place in the centre. There were

enough staff to meet residents' assessed needs in line with the centres' statement of purpose. There were planned and actual rosters in place and evidence that rosters were amended in line with residents' needs. The inspector found that staff in the centre were knowledgeable in relation to residents care and support needs.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in the centre had access to training and refreshers in line with residents' care and support needs. They were supported to carry out their duties by the person in charge and were in receipt of regular formal supervision.

Judgment: Compliant

Regulation 21: Records

All the records required by schedule 3 and 4 of the regulations were available and kept secure in the centre. However, not all records were consistently signed by staff including drug recording sheets, audits and daily reports.

Judgment: Substantially compliant

Regulation 22: Insurance

Valid insurance certificates and written confirmation of insurance cover was available in the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were systems in place in the centre to monitor the quality of care and support in the centre including an annual review and six monthly visits by the provider of their representative. However, the latest six monthly visit by the provider was not completed within the timeframe identified in the regulations. There were systems in place for storing and maintaining documentation in the centre which made accessing information very easy. However, improvement was required in relation to

oversight and monitoring of documentation in the centre to ensure staff were supported to complete and follow up on documentation in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose in the centre 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 31: Notification of incidents

On reviewing documentation in the centre the inspector found incidents relating to safeguarding residents which had not been notified in line with the requirement of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were policies and procedures including a user friendly complaints process in the centre.There was a local complaints officer and residents and staff who spoke with the inspector could describe the complaints process.

Judgment: Compliant

Regulation 4: Written policies and procedures

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

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents in the centre were being supported to enjoy valued social roles and a good quality of life in line with their wishes. The provider and person in charge had systems in place to monitor the quality and safety of care in the centre. However, some improvement was required in relation to the premises, oversight and monitoring of documentation, and recognising and reporting safeguarding issues in the centre. The provider had put measures in place to address the majority of the actions from the previous inspection.

In the annual review of quality and safety of care in the centre the provider recognised that there were areas of the centre in need of maintenance and repair. These included the need for two bathrooms in the centre to be upgraded and areas of the centre which needed to be painted. There was also damage to the carpet on the stairs in the centre. Residents in the centre showed the inspector around their home and described their favourite places to spend time and their involvement in decorating their bedrooms in line with their wishes and preferences. The inspector found that overall the premises was designed and laid out to meet the needs of residents and that it was clean throughout on the day of inspection.

Each resident had a recent assessment of need completed and a review of their personal plan. Each residents' assessment of need and personal plan was reviewed annually at their 'all about me' meeting. Two residents walked the inspector through their personal plans outlining their favoured activities and the supports they were receiving from the staff in the centre particularly their keyworkers to develop and reach their goals every year. Each resident had an activity tracker, and goal tracker in place which included progress on goals and pictures of residents taking part in activities associated with these goals.

Residents in the centre were supported to achieve best possible health. Each resident had their healthcare needs appropriately assessed and had access to allied health professionals in line with these assessed needs. There was accessible information available for residents in relation to health promotion.

The inspector found that the provider was responsive to risk in the centre and residents were safe. Risk assessments were developed as necessary and there was evidence of positive risk taking including residents travelling to work independently, engaging in activities in the local community independently and staying at home independently. Health and safety audits were completed in the centre and there was evidence that actions were developed following these audits. There was evidence that these actions had been followed up on and were leading to improvements in relation to residents' safety and to their home. There was a system in place for identifying, recording and learning from incidents in the centre.

On reviewing documentation in the centre the inspector found that there had been a number of peer-to-peer safeguarding incidents in the centre which had not been

followed up on in line with national policies and procedures, or the organisations' policy. The person in charge or the provider had not been made aware of these incidents so there were no safeguarding plans in place for residents.

The inspector found that the provider had put some measures in place against the risk of fire in the centre including equipment for detecting and extinguishing fires. However, suitable arrangements were not in place in relation to fire containment due to the quality of the doors in the centre. The provider recognised the need to upgrade doors in their annual review and had plans in place to have these works completed once funding was secured. Fire procedures were on display and fire drills were completed regularly in the centre. Residents and staff described how they would safely evacuate the centre in the event of a fire. Each resident had a personal emergency evacuation plan in place and there was evidence that they were updated following learning from fire drills.

Residents were protected by suitable arrangements which were in place for ordering, receipt, prescribing, storage and disposal of medicines in the centre. However, on reviewing medication administration sheets in the centre, staff were not consistently signing this document after administering medicines to residents. Audits were being completed relating to stocks of medicines in the centre. However, they were not being completed in relation to other aspects of medicines management so not picking up on documentation and procedure errors.

Regulation 17: Premises

There were areas of the centre in need of repair and maintenance including damage to the carpet on the stairs, upgrade works to two bathrooms and painting in areas of the centre. These areas for improvement had been identified by the provider in their annual review and the inspector viewed documentary evidence that they had secured funding and quotes for these works to be completed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate policies, procedures and practices in the centre relating to risk management. There was a risk register in place which was updated in line with residents' changing needs. There were systems in place for recording and learning from incidents in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector found that effective fire containment systems were not in place in the centre due to the quality of doors in the centre. The provider had identified this in their annual review and was awaiting funding to complete works to doors in the centre. Staff had completed suitable fire training and residents had personal emergency evacuation plans in place. There was evidence of regular fire drill and learning following these drills. Fire equipment was serviced in line with the requirements of the regulations.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were policies and procedures in place relating to medicines management in the centre. Audits on medicines stocks were completed regularly. However, on reviewing a number of medication administration records they were not being consistently signed by staff once they had administered medicines to residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a detailed personal plan and assessment of need in place. They were available in an accessible format and there was evidence of regular review and update of personal plans to ensure they were reflective of residents' care and support needs.

Judgment: Compliant

Regulation 6: Health care

Residents in the centre were supported to enjoy best possible health. Each residents' health needs were appropriately assessed and they had access to relevant allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of regular review of restrictive practices in line with the organisations' policy. One restrictive practice was recently reviewed and removed in line with residents' changing needs.

Judgment: Compliant

Regulation 8: Protection

At the time of inspection there were no safeguarding plans in place. However, on reviewing documentation in the centre the inspector found a number of incidents between residents in the centre which had not been recognised as such, recorded or followed up on in line with national policy and procedures, or the organisations' policies.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Glendoher OSV-0002401

Inspection ID: MON-0021309

Date of inspection: 23/05/2018

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The PIC will ensure all records required under schedule 3 and 4 are maintained in the centre. This will include ensuring they are appropriately maintained and signed by staff. The PIC will discuss at the next staff meeting and will address it at supervision meetings with all staff	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Service Provider will ensure that the six monthly visits will be completed within the timeframe identified in regulation 23 the last six monthly visit was carried out June 2018 documentation available in the centre for inspection. The next six monthly visit will be carried out in December 2018. The PIC will review management systems are in place that are appropriate to meet residents needs. This will include ensuring staff are supported to complete and follow up on documentation in the centre through individual Wellbeing meetings for residents, support meeting for staff and at staff meetings.	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The PIC and the PPIM will review all notifications submitted and ensure that in future all notifications of incidents will be submitted to HIQA.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The PIC will review the premises with the technical services manager to identify outstanding maintenance works required. A minor capital work plan will be submitted for approval evidence will be maintained in the centre.

In the interim carpet will be replaced on the stairs by the end of August 2018.

Areas that require painting will be complete by the end of September 2018.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The registered provider will ensure that effective fire safety management systems are in place doors in the designated centre will be upgraded to FD 30s.

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 will ensure that the 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 to the resident for whom it is prescribed and to no other resident. The PIC will discuss at the next staff meeting and will ensure all staff to sign off on all medication administered at the time of administration. This will reflect in

the staff meeting minutes that will be available in the centre for inspection.
The PIC will also carry out medication audit quarterly this will be available in the centre for inspection.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The concern raised under regulation 8 was referred to the principle social worker for review. Following the review and in consultation with the clinical team additional supports are now in place to support service user. Evidence of the review is in place in the designated centre.

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	31st October 2018
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31st August 2018
Regulation 21(1)©	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the	Substantially Compliant	Yellow	31st August 2018

	chief inspector.			
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	31st August 2018
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31st December 2018 (next due visit)
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	1st December 2018
Regulation 28(3)(a)	The registered provider shall	Not Compliant	Orange	1st December 2018

	make adequate arrangements for detecting, containing and extinguishing fires.			
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	31st August 2018
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 centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31st July 2018
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31st July 2018