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:	Royal Oak
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Short Notice Announced
Date of inspection:	26 March 2021
Centre ID:	OSV-0002361
Fieldwork ID:	MON-0032131

About the designated centre

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

Royal Oak 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 three male residents with intellectual disabilities over the age of 18. The designated centre is comprised of two attached houses with an internal door for access. The designated centre consists of five bedrooms, two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. There was a garden to the rear of the centre which contained two small buildings which were used for laundry and storage. 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.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Friday 26 March 2021	10:00hrs to 16:00hrs	Andrew Mooney	Lead

What residents told us and what inspectors observed

In line with public health guidance and residents' assessed needs, the inspector did not spend extended periods with residents. However, the inspector did meet with three residents and speak with them for short periods during the day. The inspector used these discussions with residents, observations, discussions with staff and a review of documentation to inform their judgements.

The inspector found their had been some compatibility issues between residents which had adversely impacted residents quality of life. Not all residents living within the centre were happy with their living arrangements and while the provider had explored some alternative arrangements, they had not been successful in responding to residents preferences. There had been a number of recorded safeguarding incidents in the centre and the provider had responded by putting in place measures to mitigate against further incidents of this nature. Residents who spoke to the inspector, told them they felt safe in their home.

During a walk around of the centre, the inspector observed residents moving around their home freely. However, there were some environmental restrictions in place in part of the centre. These restrictions, limited residents access to certain kitchen presses and a fridge. These restrictions had not been assessed but were in response to securing some residents personal items. This led to residents not having access to all aspects of their home and this detracted from the homeliness of the centre.

The inspector observed some residents spending time in the kitchen doing table top activities and watching TV. Others were supported to access their local community and some went for walks and shopping. Residents appeared comfortable with each other, however there was a requirement for staff to supervise residents' interactions with each other due to known compatibility issues. Staff appeared to know residents very well and they supported residents in a gentle and supportive manner. Staff supported residents to communicate with the inspector in line with their assessed communication needs and this enabled meaningful interactions with the inspector.

A resident showed the inspector around their home. This resident was very proud of their home and showed the inspector their bedroom. This bedroom was large and nicely decorated. The resident had many personal items decorating their room, including posters and photographs.

The inspector found that one part of the centre was cold during the inspection. Staff explained that a residents preference was to have no heating in this part of the centre and this led to this part of the centre being very cold. Staff noted this was not the preference off all residents and while they respected this residents choice, they still endeavoured to ensure the centre was adequately heated throughout the day. Staff reported that at times, the lack of heating adversely impacted other residents lived experience within the centre.

At the time of inspection the provider had implemented all appropriate guidance in response to the COVID-19 pandemic. Unfortunately, this did limit residents access to certain community activities but was in keeping with current public health guidance. Residents told the inspector they understood the reasons behind these restrictions but were looking forward to when they could get back out doing the things they loved in the community. The provider had arrangements in place so that when appropriate and in line with public health guidance, visitors could meet residents in a safe manner. The provider had also facilitated the roll out of COVID-19 vaccinations for staff and residents, in line with their preferences.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall this inspection found that the governance and management arrangements in the centre had been enhanced and this strengthened the capacity and capability of the centre. However, despite this, further improvement was required to ensure that known compatibility issues within the centre were addressed in a timely manner.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. Staff spoken with could clearly identify how they would report any concerns about the quality of care and support in the centre and highlighted that they would feel comfortable raising concerns if they arose. Staff reported directly to the person in charge, who in turn reported to a service manager. The centre had good oversight arrangements in place, including the completion of six monthly unannounced inspections of quality and safety of care. Additionally, an annual review of the quality and safety of care within the centre was completed in consultation with residents. However, this annual review required some improvements, to ensure it took account of the standards. Where areas for improvement were identified by the provider, plans were put in place to address these. For example, the provider had self identified that improvements were required in the identification and reporting of certain incidents. The provider brought this to the attention of staff and rolled out enhanced training to resolve this. However, while some work on compatibility issues within the centre had been undertaken, these measures were not effective in resolving the underlining issues. This demonstrated that while the provider had the ability to self identify issues of concern, they did not always have the capacity to effectively resolve them in a timely manner.

Staffing arrangements at the centre were appropriate to meet the needs of residents and reflected what was outlined in the statement of purpose. From a review of the roster it was clear that there was an appropriate skill mix of staff employed at the

centre. The person in charge had ensured that there was both a planned and actual roster which was maintained. Staff spoken with were knowledgeable and informed of key areas such as residents' needs, safeguarding and infection prevention and control. The inspector observed staff supporting residents in a caring and dignified manor during the inspection.

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, infection control, fire safety and manual handling. The person in charge maintained a register of what training was completed and what was due. This training enabled staff to provide evidence based care and enabled them to support residents with their assessed needs. Staff supervision was structured and completed in line with the providers supervision policy.

During the inspection, the inspector reviewed the centres complaints log. This centre based log identified two complaints, one was resolved locally and the second was escalated to the service manager and resolved in a timely manner. On each occasion, complainants were satisfied with the outcome of their complaints. Furthermore, feedback documented recorded in the annual review of quality of care, noted that residents were satisfied with the complaints procedure and understood how and who to raise concerns with.

Regulation 15: Staffing

There was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times.

There was a planned and actual roster in place.

Judgment: Compliant

Regulation 16: Training and staff development

Suitable training was in place and staff were supervised appropriate to their role.

Judgment: Compliant

Regulation 23: Governance and management

There was an annual review of the quality and safety of care within the centre that was completed in consultation with residents. However, this annual review required

some improvements, to ensure it took account of the standards.

Some work on compatibility issues within the centre had been undertaken, however, these measures were not effective in resolving the underlining issues. This demonstrated that while the provider had the ability to self identify issues of concern, they did not always have the capacity to effectively overcome them in a timely manner.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints process was user-friendly, accessible to all residents and displayed prominently. Complaints were resolved in a proactive and timely manner.

Judgment: Compliant

Quality and safety

Ongoing compatibility issues within the centre negatively impacted the quality and safety of the centre. Additionally, immediate improvements in fire safety precautions were required.

There were appropriate arrangements in place to ensure that residents had a personal plan that detailed their needs and outlined the supports required to maximise their personal development and quality of life. The service worked together with residents and their representatives to identify and support their strengths, needs and life goals. Residents were assisted to find opportunities to enrich their lives and maximise their strengths and abilities in line with current public health advice. However, the current arrangements in the designated centre were not suitable to meet the assessed needs of all residents. As outlined previously, there were long standing compatibility issues in the centre, which resulted in a number of adverse incidents. While some work on compatibility issues within the centre had been undertaken, these measures were not effective in resolving the underlining issues. The arrangements within the centre required improvement to enhance residents lived experience within the centre.

The provider had ensured that there were fire safety measures in place, including a fire detection and alarm system, fire fighting equipment and containment measures. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire and regular fire drills were conducted. However, the inspector observed that a emergency evacuation route was partially blocked and a exit gate was locked. Furthermore, the provider had installed break key glass units

at appropriate exits, however one of these units was broken and the key was not in place. This increased the risk that residents and staff, may not be able to evacuate the premises safely in the event of a fire. An immediate action in relation to these issues was issued to the provider during the inspection and assurances were provided during the inspection that these matters were addressed. Furthermore, the provider had self identified that areas of the centre required upgraded fire doors and automatic fire closing mechanisms. A time bounded organisation plan was in place to address these deficits.

Supports were in place to respond to residents' assessed behaviour support needs. This included the on-going review of behaviour support plans. Staff were very familiar with residents needs and any agreed strategies used to support residents. However, not all restrictive procedures implemented within the centre where assessed in line with the organisations policy. This included the use of environmental restrictions such as locked presses and a locked fridge. Therefore it was unclear if these restrictions were implemented in accordance tot he regulations.

The provider had ensured that there were systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centre's policy. While there had been a number of negative peer to peer incidents, the provider had put in place additional control measures to limit future occurrences. Staff had a good understanding of safeguarding processes and this ensured residents were safeguarded at all times.

The provider had adopted a range of infection prevention and control procedures to protect residents from the risk of acquiring a healthcare associated infection. The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. There were appropriate hand washing and hand sanitising facilities available throughout the centre. There were suitable arrangements for clinical waste disposal. Staffing arrangements were reviewed and staff rosters had been designed to limit any potential outbreak of COVID-19.

The provider had put systems in place to promote the safety and welfare of residents. The centre had a risk management policy in place for the assessment, management and ongoing review of risk. This included a location-specific risk register and individual risk assessments which ensured risk control measures were relative to the risk identified. This enabled residents to live full lives without undue restriction. Incidents that occurred were reviewed for learning and where appropriate, additional control measures were put in place to reduce risk.

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were in place and were relative to the risk identified.

Judgment: Compliant

Regulation 27: Protection against infection

There were appropriate resources in place to support staff and residents during the COVID-19 pandemic.

Judgment: Compliant

Regulation 28: Fire precautions

A fire evacuation route was blocked and the exit gate was locked.

A break key glass unit was broken and the emergency exit key was missing.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment which was used to inform their personal plan.

However, the designated centre was not suitable to meet the needs of all residents within the centre. There was an ongoing compatibility issue within the centre, which had negatively impacted residents lived experience within the centre.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Not all restrictive practises within the centre had been appropriately reviewed in line with the providers on policy. For example, restricted access to some kitchen presses and a fridge, had not been risk assessed or approved by the providers positive approaches management group (PAMG).

Judgment: Not compliant

Regulation 8: Protection

The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse. While there had been a number of negative peer to peer incidents, the provider had put in place additional control measures to limit future occurrences.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Royal Oak OSV-0002361

Inspection ID: MON-0032131

Date of inspection: 26/03/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Annual Review reexamined and updated by Service manager and PIC to take into account both standards and regulations. Complete as of 12/05/2021 • Supports are in place to address any compatibility issues within the centre. PIC and staff team have linked in with 1 resident that this has become an issue for. Multi disciplinary team are reviewing residents Assessment of Need to identify additional supports. Independent living skills assessment is to take place with resident. Resident remains on residential transfer list. Outcome of assessments will be reviewed and plan will be made in consultation with resident and their representatives.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The fire evacuation route that was blocked is now completely clear as of 26/03/2021 • both exit gates are now unlocked. The padlocks have been removed as of 26/03/2021 • The break key glass unit that was broken has now been repaired and the emergency exit key is placed inside as of 01/04/2021	

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: • Supports are in place to address any compatibility issues within the centre. PIC and staff team have linked in with 1 resident that this has become an issue for. Multi disciplinary team are reviewing residents Assessment of Need to identify additional supports. Independent living skills assessment is to take place with resident. Resident remains on residential transfer list. Outcome of assessments will be reviewed and plan will be made in consultation with resident and their representatives	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The restrictive practices that was identified by the inspector on the day of inspection was reviewed by multi disciplinary team and deemed not to be a restrictive practice as all resident can use the locks in place. The rubber child lock mechanisms were put on the fridge and the press to act as a psychological support to one resident on their request.	

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 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	31/08/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	12/05/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency	Not Compliant	Red	26/03/2021

	lighting.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/08/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	12/05/2021
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.	Not Compliant	Orange	12/05/2021