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

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| Name of designated centre: | Elvira |
| Name of provider: | St John of God Community Services Company Limited By Guarantee |
| Address of centre: | Co. Dublin |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 19 November 2020 |
| Centre ID: | OSV-0003580 |
| Fieldwork ID: | MON-0026663 |

## About the designated centre

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

The designated centre is based in a suburban area of South County Dublin and is comprised of 11 individual apartments across three single storey buildings. The centre is located on a site shared with a nursing home and is a short walk from a variety of village services. There are four single occupancy apartments, two apartments with four bedrooms, two apartments with three bedrooms, and three apartments with two bedrooms in the centre. 24 hours residential services are provided by the centre and a total of 21 residents can be supported. There are three sleep over staff present overnight to respond to resident needs should they arise. The staff team is comprised of a person in charge, a team leader and a number of social care workers.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 19 |

## 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 |
|---|---|---|---|
| Thursday 19 November 2020 | 12:00hrs to 17:00hrs | Amy McGrath | Lead |

## What residents told us and what inspectors observed

The inspector briefly met four of the residents who live in the centre. The inspector did not have an opportunity to speak with all of the residents in the centre due to physical distancing guidelines. The inspector received seven completed resident questionnaires in the days following the inspection.

Two residents greeted the inspector as they were walking through the grounds of the apartment complex. One resident discussed their plans for the day and were looking forward to watching something on television later in the evening. Two residents spoke to the inspector briefly when they passed in a communal area. One resident was on their way to do their laundry and another was getting ready to prepare their own dinner. All residents spoken with appeared comfortable in their environment and were independently accessing the centre's facilities.

Residents who completed the questionnaire all stated that they were happy in the centre. They each were satisfied with the centre facilities and one resident noted that they were very happy with recent renovations to their bedroom. One resident said they would like to have a larger washing machine. A number of residents noted that they were satisfied with the support they received from staff. All seven residents said that they received good quality meals that they enjoyed and one resident stated they would like if there were more meal choices.

The residents who submitted the questionnaires noted that they participated in various activities both in the centre and in the community. They shared that activities were adapted during periods where day services were not available due to public health guidance, for example, residents engaged in online fitness classes. All seven residents noted that they knew how to make a complaint if they chose to, and were satisfied that their complaints would be managed well by staff.

## Capacity and capability

For the most part, the governance and management arrangements had ensured that a quality service was delivered to residents, although corrective action was required to ensure that a fire safety risk was addressed. The provider had ensured that the delivery of care was person centred, with residents directing the care and support they received. The provider had implemented most of the actions required from the previous inspection, however the actions required in relation to fire safety had not been fully completed. Further action was also required with regard to policies.

There was a clear organisational structure in place, with identified lines of authority,

and defined roles and responsibilities. The provider had carried out six-monthly unannounced visits to the centre, which reviewed the quality and safety of the service. A report and action plan was subsequently developed to address areas identified by the provider as requiring improvement. An annual review of the centre had been completed, which included consultation with residents, their representatives, and staff. There were also a range of local audits and monitoring tools in place to oversee the delivery of care to residents.

The inspector reviewed the implementation of the provider's compliance plan actions from the previous inspection. While most compliance plan actions had been addressed, the provider had not taken the necessary steps to address fire safety concerns identified on the previous inspection carried out in 2018. A review of provider-led quality audits for the centre carried out since the last 2018 inspection, found this issue had been identified on all six-monthly unannounced visits and provider annual review report for the centre. The inspector was not satisfied that the governance and management arrangements were effective in ensuring the service provided was safe.

There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage the service. While the person in charge had responsibility for two designated centres, the inspector found that the governance arrangements facilitated the person in charge to have sufficient time and resources to ensure effective operational management and administration of the designated centre.

It was found that there were sufficient staff employed, with the appropriate skills and experience, to meet the assessed needs of the residents. There were planned and actual rosters maintained, and a review of rosters found that the provider had ensured residents received continuity of care and support. Staff spoken with over the course of the inspection demonstrated excellent knowledge and understanding of residents' support needs.

There were arrangements in place to ensure that staff had access to necessary training, including training in a number of areas deemed by the provider as mandatory training; for example, safeguarding and fire safety. The person in charge maintained oversight of staff training requirements, and inspectors found that staff had received training in all areas identified as mandatory; there was also additional training available specific to residents' needs, and staff had availed of this training.

The provider had not prepared in writing, adopted and implemented a policy in relation to the prevention, detection and response to abuse. While the provider had developed procedures under the national safeguarding policy, the provider had not developed an organisational specific policy, and as such did not have the capacity to review or update the policy in use.

## Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced in their role. The position was full time, and while the person in charge had responsibility for two centres, they had sufficient protected time to carry out the required duties of the role

Judgment: Compliant

## Regulation 15: Staffing

There were sufficient staff, with appropriate skills and experience, to meet the needs of residents. The person in charge had ensured continuity of care, and there were appropriate contingency arrangements in place to cover staff leave.
There were planned and actual rosters available that reflected the staffing arrangements in the centre.

Judgment: Compliant

## Regulation 16: Training and staff development

The provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. Training was made available in areas specific to residents' assessed needs.

Judgment: Compliant

## Regulation 23: Governance and management

There were management arrangements at a local level that ensured the safety and quality of the service was consistent and closely monitored. However, improvement was required with regard to responding to safety concerns at provider level. It was found that the provider had failed to implement the necessary corrective actions to address a fire safety risk that was identified in 2018.

The provider had carried out an annual review of the quality and safety of the centre, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis.

Judgment: Substantially compliant

## Regulation 4: Written policies and procedures

The provider had developed and implemented most of the policies required under Schedule 5 of the regulations. However, the provider had not prepared in writing, adopted and implemented a policy in relation to safeguarding residents.

Judgment: Not compliant

## Quality and safety

The inspector found that overall residents were supported in a person centred manner and that good quality care and support was being delivered. The oversight mechanisms in place ensured that the standard of care was effectively monitored and reviewed, and that residents' needs and preferences informed the delivery of care. While there were some concerns in relation to the provider's management of a fire safety risk, it was found that management arrangements were ensuring that day to day care and support was delivered in a safe manner.

Residents received support to positively manage their behaviour, with support plans in place where necessary. A review of plans found that efforts had been made to understand the needs of residents, with support measures identified to promote positive mental health. At the time of inspection there was one restrictive practice in place; this was subject to review by a monitoring group, and there were clear indicators that lesser restrictive measures had been implemented in the first instance. The use of a restrictive practice was risk assessed and reviewed regularly for effectiveness, and there was a plan in place to reduce and eventually discontinue this practice.

The inspector reviewed the safeguarding arrangements in place and found that residents were protected from the risk of abuse. All staff had received training in safeguarding adults. While the provider did not have an organisation specific safeguarding policy, there were clear lines of reporting and any potential risk was escalated and investigated in accordance with the national safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency. Where a safeguarding risk had been identified, there were comprehensive safeguarding plans in place that were overseen for effectiveness.

There were systems in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19. There were a range of hygiene checklists and audits in place to ensure that the centre was maintained in a clean and hygienic manner. There were hand washing and sanitising facilities available for use. Staff had received training in relation to infection prevention and control and hand hygiene. There were clear procedures in place to follow in the event of a COVID-19 outbreak in the centre, including individual care plans for residents. There was

adequate personal protective equipment available.

While there were a number of fire safety arrangements in place, such as fire fighting equipment and a fire alarm system, the provider had not implemented the necessary actions to ensure that the premises had suitable fire containment and emergency lighting arrangements in place. The inspector found that the provider had not carried out the actions put forward from the previous inspection to address these risks, and had failed to carry out works as advised by an external competent person. There were a range of local fire safety checks in place and the equipment and facilities that were in place were found to be serviced regularly. Residents participated in fire drills and there were individual evacuation plans in place.

## Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to Covid 19. The centre was maintained in a clean and hygienic condition throughout, hand washing and sanitising facilities were available for use, infection control information and protocols were available to guide staff and staff had received relevant training.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider had not implemented the necessary actions to ensure that the premises had suitable fire containment and emergency lighting arrangements in place.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Residents received positive behavioural support in accordance with their assessed needs. The person in charge was found to be promoting a restraint free environment and any restrictive intervention had been assessed to ensure its use was in line with best practice.

Judgment: Compliant

## Regulation 8: Protection

There were arrangements in place to safeguard residents. All staff had received training in safeguarding adults, and it was found that any potential safeguarding incident was investigated and responded to appropriately. Where necessary, residents had safeguarding plans in place.

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 | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 4: Written policies and procedures | Not compliant |
| **Quality and safety** | |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Elvira OSV-0003580

## Inspection ID: MON-0026663

## Date of inspection: 19/11/2020

**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 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The registered provider will ensure that all outstanding actions relating to fire containment and emergency lighting arrangements are completed. All works will be reviewed by the fire safety consultant. | |
| Regulation 4: Written policies and procedures | Not Compliant |
| Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:<br>Elvira Designated Centre, has in place a robust and comprehensive Local Operating Safeguarding Procedure to support the full implementation of the principals /standards and practice of the HSE National Safeguarding Vulnerable Adults Policy which was approved in its entirety by the Board of Saint John of God Community Services clg in 2014 .<br>This Safeguarding Procedure was updated in November 2019 and is being fully adhered to by all staff working in this Designated Centre.<br><br>When the HSE fully approve and launch their revised National Safeguarding Vulnerable Adults Policy the Board of SJOGCS will fully adopt this National Policy and plan to develop a policy/ SJOGCS Standard Operating Procedure to support its full implementation. | |

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Self-Closing mechanisms were fitted to all fire doors in the Designated Centre in November 2020.

All outstanding actions from the fire safety consultant report were scheduled to commence on January 11th 2021. Unfortunately having spoken with the fire safety consultant, these works are not permissible under the current government restrictions as it is not deemed as essential works. We will start works as soon as the government restrictions are eased and it is permissible to do so. The works still remain a priority and we are still hopeful that the completion date for the works will be the 31st of March. All actions will be followed through by the Person In Charge and upon completion of works the fire safety consultant will return to inspect the works carried out.

## 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 | 31/03/2021 |
| Regulation 28(2)(c) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 31/03/2021 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/03/2021 |
| Regulation 04(1) | The registered provider shall prepare in writing and adopt and | Not Compliant | Orange | 31/08/2021 |

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| | implement policies and procedures on the matters set out in Schedule 5. | | | |