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:	The Maples
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Short Notice Announced
Date of inspection:	28 October 2020
Centre ID:	OSV-0003601
Fieldwork ID:	MON-0025959

About the designated centre

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

The Maples is a designated centre operated by St. Michael's House. The centre provides a community residential service to five adults. The service can accommodate both males and females with varying ranges of intellectual disability and additional mental health support needs. The centre is a bungalow which consists of a kitchen/dining room, two sitting rooms, five individual bedrooms, a staff room and an office. It is located close to a town with access to shops and local facilities. The centre is managed by a person in charge and the staff team consists of nurses, social care workers and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 28 October 2020	10:15hrs to 16:15hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the four residents of the designated centre and one person availing of an emergency placement during the inspection. One resident was not in the designated centre on the day of the inspection. Residents spoken with said they liked living in the house. Some residents used non-verbal methods to communicate and appeared comfortable in their home and in the presence of staff.

The inspector also observed elements of residents' daily lives at different times over the course of the inspection. Throughout the inspection residents were observed engaging in activities of daily living, including watching TV, listening to music and accessing the community. Overall, the residents appeared happy and comfortable in their home. The inspector also observed positive interactions between residents and the staff team.

Capacity and capability

Overall, the inspector found that the provider and person in charge were monitoring the quality and safety of the care and support provided to residents. However, some improvement was required in the governance and management of the centre.

There was a clearly defined management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was responsible for the management of another designated centre and was supported in their role by an experienced Clinical Nurse Manager. There was evidence of regular quality assurance audits taking place to review the delivery of care and support in the centre, including the annual 2019 report, six-monthly unannounced provider visits, infection control, medication audits and quality care metrics. These audits identified areas for improvement and action plans were developed in response. However, improvement was required in the timeliness of completing the provider's unannounced six-monthly visits as required by the regulations. For example, the last two six-monthly visits were carried out October 2019 and July 2020. In addition, the planning of transferring one resident to an alternative placement required some improvement. This is outlined further under the Quality and Safety section.

The person in charge maintained a planned and actual roster. From a review of the staff roster, there was an established staff team in place. However, the inspector found that staffing levels required further review to demonstrate that staffing levels were appropriate. For example, there was a recent admission to the centre on an emergency basis in September 2020. This admission increased the number of

service users from four to five while staffing levels were unchanged. The provider ensured a continuity of care through covering gaps in the roster with members of the staff team and regular relief staff. Throughout the course of the inspection, positive interactions were observed between residents and the staff team.

The provider prepared a statement of purpose for the designated centre which was up to date and contained all of the information as required by Schedule 1 of the regulations. This meant service users and their representatives had access to a statement of purpose which accurately reflected the service delivered to residents.

The inspector reviewed a sample of incidents and accidents occurring in the centre and found that the Chief Inspector was notified as required by Regulation 31.

Regulation 14: Persons in charge

The centre was managed by a full-time, suitably qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. Staffing required further review to demonstrate that staffing levels were appropriate. Throughout the course of the inspection, positive interactions were observed between residents and the staff team.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. There was evidence of regular quality assurance audits taking place which identified actions to address areas that required improvement. However, improvement was required in the timeliness of completing the provider's unannounced six-monthly visits.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was up to date and contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector was notified of incidents and accidents as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the inspector found that there were systems in place to ensure that residents received a safe service. However, improvement was required in the planning of discharges, premises and fire safety.

The inspector completed a walkthrough of the designated centre accompanied by the Clinical Nurse Manager. The centre consisted of a kitchen/dining room, two sitting rooms, five individual bedrooms, a staff room and an office. Overall, it was homely and well maintained. However, there were areas identified which required review, including the kitchen worktop and peeling paint in one resident's bedroom. These were self-identified by the provider in a hygiene audit undertaken in February 2020.

At the time of the inspection, one service user had been recently admitted on an emergency basis. However, at that time there was no vacancy in the service for an emergency admission. The service user availing of emergency admission was accommodated in a resident's bedroom. Overall, while there was evidence of consultation with all parties regarding the service user's emergency admission, the use of a resident's bedroom to accommodate the service user and the provider exploring an alternative placement for the resident, the inspector found that this discharge of the resident from the designated centre was not carried out in a planned manner.

The inspector reviewed the personal plans and found that each resident had an up-to-date assessment of need in place. On the day of the inspection, one assessment of need was in the process of being reviewed. The assessment of need informed

the residents' personal plans which were found to be up to date and appropriately guided the staff team in supporting residents with identified health and social care needs.

Residents' healthcare needs were managed to an adequate standard. Residents were supported to manage their health care conditions and had regular access to allied health professionals including general practitioners (GP), speech and language therapists and occupational therapists. The healthcare plans were up to date and suitably guided the staff team to support residents with identified healthcare needs.

There were positive behaviour supports in place to support residents, where required. The inspector reviewed a sample of the positive behaviour support plans and found that they were up to date and guided the staff team in supporting residents to manage their behaviour. There were a number of restrictive practices in use in the designated centre. There was evidence that these were identified and reviewed regularly by the provider's positive approaches management group.

There were systems in place to safeguard residents. There was evidence that safeguarding concerns were identified, responded to and appropriately reported on. There were safeguarding plans in place to manage identified safeguarding concerns. Staff spoken with were knowledgeable of safeguarding and on what to do in the event of a concern. Residents were observed to appear comfortable and content in the service throughout the inspection and some residents spoke positively about living in the designated centre.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre-specific and individual risks and the measures in place to mitigate the identified risks. On the day of the inspection, three risk assessments were identified as requiring a minor review to ensure they accurately reflected the risk rating. This was addressed on the day of the inspection.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting residents to evacuate. There was evidence of regular fire evacuation drills and fire walks being completed. However, some improvement was required in fire safety. On the day of inspection, the inspector observed a fire door wedged open which negated the purpose of the fire door in the event of a fire. The

inspector identified the wedge to the Clinical Nurse Manager and it was removed on the day of the inspection. In addition, some improvement was required in the containment and detection fo fire. This had been identified by the provider's fire safety feedback report in May 2019 and prepared by the provider's fire safety officer. The provider was putting measures in place as part of a service wide improvement plan to ensure that an appropriate fire containment and detection would be in place.

Regulation 25: Temporary absence, transition and discharge of residents

A discharge of the resident from the designated centre was not carried out in a planned manner as outlined in the report.

Judgment: Not compliant

Regulation 26: Risk management procedures

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

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with infection.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. However, improvement was needed in the containment and detection of fire as outlined in the report.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of needs in place for all residents which identified residents' health and social care needs. The assessment of need informed the development of support plans which guided the staff team.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were well managed and residents were supported to access allied professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place which were up to date and guided the staff team.

There were some restrictive practices in use in the designated centre and these were reviewed regularly by the provider's positive approaches monitoring group.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents.

Judgment: Compliant

Regulation 17: Premises

The centre was well maintained and decorated in a homely manner. However, there were areas which required attention as outlined in the report.
Judgment: Substantially 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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 17: Premises	Substantially compliant

Compliance Plan for The Maples OSV-0003601

Inspection ID: MON-0025959

Date of inspection: 28/10/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of staffing Levels and shift Patterns was completed by The PIC and Service Manager on the 24/11/2020. Shifts patterns will change on the roster in line with residents needs. This will be Reflected on the roster from the 01/01/2021.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC will ensure the 6 monthly unannounced visits by a service Manager to The Maples will be completed within the 6 month time frame.	
Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents: St. Michael's House has Identified a suitable placement for the Resident and is following admissions and discharge policy. .	

On the 08/10/2020 a consultation meeting was held with all relevant clinicians and staff. The residential approvals committee met on the 27/11/2020 and the consultation process is continuing. The Principle social worker and PIC from The Maples are working closely with the family.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Precaution is discussed at every staff meeting. The last staff meeting was on the 03/11/2020 and fire precaution was discussed. The housing Association has commenced the roll out of door closures since September 2020. The time line for this roll out has had to be adjusted due to COVID. The roll out is continuing and is estimated to be completed for The Maples by the 31/12/2021. Funding is secured for the upgrade of the fire alarm program and is due to commence in 2021. The fire alarm panel has being identified for replacement, additional heads will be installed in the corridor and store room as part of this upgrade. The work will be completed for The Maples by 31/12/2021.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Maintenance dept have started completing some of the required work and all areas Identified will be completed by the 31/01/2021.	

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/01/2021
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	31/01/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	31/01/2021

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	31/01/2021
Regulation 25(4)(b)	The person in charge shall ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.	Not Compliant	Orange	31/03/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2021