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: | Belcamp Nua |
| Name of provider: | St Michael's House |
| Address of centre: | Dublin 17 |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 21 January 2021 |
| Centre ID: | OSV-0007807 |
| Fieldwork ID: | MON-0031738 |

## About the designated centre

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

Belcamp Nua is a designated centre located on a campus based setting in North Dublin. In April of 2020 the provider applied to register this centre for the purposes of supporting service users with COVID-19 to self-isolate if unable to do so in their own homes. The designated provides temporary residential care to up to four adults with a disability who have a diagnosis of or are suspected to have a diagnosis of COVID-19. The designated centre is a large, purpose-built day service building which has been adapted to a temporary residential unit. Service users are supported on a full-time basis by a team of clinical nurse managers, nurses, social care workers and care assistants. Housekeeping staff also support the team.

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

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| Number of residents on the date of inspection: | 2 |

## 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 21 January 2021 | 10:20hrs to 15:30hrs | Conan O'Hara | Lead |

## What residents told us and what inspectors observed

From what service users told the inspector and what was observed, it was evident that service users received a good quality of care while they availed of the service. At the time of the inspection, there were two service users availing of the service. The inspector had the opportunity to briefly meet with one of the service users in the designated centre during the inspection. One service user chose not to engage with the inspector during the course of the inspection and this was respected.

In line with infection prevention and control guidelines, the inspector carried out the inspection mostly from a location beside the centre. The inspector also ensured physical distancing measures and use of personal protective equipment (PPE) was implemented during interactions with all service users and staff during the course of the inspection.

Service user rights were respected and the inspector observed the staff team treating service users with respect and dignity. Service users made choices regarding their time in self isolation. These included a choice of meals. For example, each room had access to a kitchenette to prepare snacks and main meals were provided by a kitchen. The inspector was informed that residents also had a choice of take aways if they wanted. In addition, each service user had a separate patio area that they could spend time in. Service users were facilitated to engage with family and friends. While there were restrictions on visiting the self isolation unit, video calls were utilised to support service users to maintain contact with people important to their lives.Service users appeared comfortable and content in the centre and positive interaction were observed between service users and members of the staff team.

The premises is a purpose built day service unit which has been adapted to provide temporary residential care for the purposes of self isolating. The inspector found that the premises was institutional in aesthetic and not suitable for long-term living arrangements. However, the inspector noted that it was suitable for the purposes of an isolation unit for use by service users with COVID-19 and for short period stays. The centre was well lit, ventilated and warm. The inspector observed that the isolation unit could provide service users with large segregated spaces for the purposes of self-isolation. The inspector observed that separate access and entry points were also available for service users and the staff supporting them to leave and enter the premises and ensure a reduced risk of cross-contamination points within the centre. Safe and suitable storage room spaces were available to store personal protective equipment and cleaning supplies.

In summary, based on what service users told the inspector and what was observed, the inspector found that the service users received a good quality of care while they availed of the self isolation unit.

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, the inspector found that there were management systems in place to effectively monitor the quality and safety of the care and support provided to service users while they were availing of the service. However, some improvement was required in the staffing arrangements and in the training and development of the staff team.

There was a clearly defined governance and management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge demonstrated good knowledge of the service users and their needs. The person in charge was also responsible for the management of another designated centre located on the same campus. They were supported in their role by an experienced clinical nurse manager 1(CNM1). There was evidence of regular quality assurance audits taking place to ensure the service provide was safe, effectively monitored and appropriate to service users' needs. These audits included local audits and the provider unannounced six monthly visits as required by the regulations. The quality assurance audits identified areas for improvement and action plans were developed in response.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of the roster which demonstrated that there was an adequate number of staff on duty each day and night to meet service users' assessed needs. In addition, there was evidence that staffing arrangements for the isolation unit occurred on a case-by-case basis. For example, staff may transfer with a service user from their home to the unit and support them during the self-isolation period if familiar staff was required.

However, at the time of the inspection, the arrangements in place for staffing required improvement. For example, the centre was operating with a 4.5 whole time equivalent vacancies and there was a reliance on relief and agency staff to meet the staffing complement. This meant that the service users did not receive a continuity of a care and support at all times while they were availing of the service. The inspector was informed of ongoing recruitment campaign and that a number of staff had been identified to fill the vacancies. On the day of the inspection, positive interactions were observed between service users and the staff team.

There were systems in place for the training and development of the staff team. From a review of a sample of staff training, the inspector found that, for the most part, the staff team had up-to-date mandatory training. Additional training and support was also available in relation to particular health care interventions as

required. However, on the day of the inspection, as there were recent changes in the staff team, it was not evident that all members of the staff team were up-to-date in mandatory training. For example, fire safety. This meant it was not evident that all of the staff team had up-to-date knowledge and skills to support all of the assessed needs of the service users. This had been identified by the person in charge and was in the process of being addressed.

The provider had a defined admission pathway and criteria framework in place. Service users were admitted for the sole purposes of supporting them to self-isolate if unable to do so in their own homes. There was a defined admissions team in place to review the referrals and ensure admissions were based on the admission criteria and the needs of the service users.

The provider prepared a statement of purpose for the designated centre which was up to date and, for most part, contained all of the information as required by Schedule 1 of the regulations. However, some aspects of the statement of purpose required review to accurately reflected the service delivered to service users.

The person in charge maintained a directory of residents for the centre which would capture admissions and discharge dates of service users that used the facility. The inspector reviewed a sample of the directory and found that it contained all of the information as required by Regulation 19.

## Regulation 14: Persons in charge

The centre was managed by a full time, suitably qualified and experienced person in charge. The person in charge demonstrated a good knowledge of the service users and their support needs.

Judgment: Compliant

## Regulation 15: Staffing

The person in charge maintained a planned and actual roster. Staffing levels at the designated centre were appropriate to meet the needs of the service users. However, the arrangements in place for staffing required improvement as outlined in the report.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. However, it was not evident that all staff had up-to-date mandatory training.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

The person in charge maintained a directory of residents which contained all of the information as required by Regulation 19.

Judgment: 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 areas that required improvement and actions plans were developed in response.

Judgment: Compliant

## Regulation 24: Admissions and contract for the provision of services

The provider had a defined admission pathway and criteria framework in place which considered the needs and safety of the service users.

Judgment: Compliant

## Regulation 3: Statement of purpose

The provider prepared a statement of purpose for the designated centre which was up to date. However, some aspects required review to accurately reflected the service delivered.

Judgment: Substantially compliant

## Quality and safety

Overall, the inspector found that there were systems in place to ensure that service users' wellbeing and welfare was maintained to a good standard while they availed of the service. However, some improvement was required in the review of restrictive practices and fire safety management.

As referred to previously in this report, the isolation unit was located on the campus setting. While the residential unit appeared throughout as institutional in design, decoration and layout, it was noted as a suitable premises for the purposes of supporting service users with COVID-19 to self-isolate for a short stay. The premises provided large spacious single occupancy bedroom spaces for service users to use during their stay.

The inspector reviewed the personal plans and found that each service user had an up-to-date assessment of need in place. The assessment of need identified service users' health and social care needs and informed the personal support plans while they were availing of the service. The personal plans were adapted and updated when the service user was admitted to the self isolation unit to ensure staff were appropriately guided in meeting the service users needs. In addition, there was evidence that service users' health care needs were appropriately identified and that service users were given appropriate support to enjoy best possible health. Service users were supported to have regular access to allied health professionals including general practitioners (GP), occupational therapy and physiotherapy. The healthcare plans were up to date and suitably guided the staff team to support service users with identified healthcare needs.

There were positive behaviour supports in place to support service users, 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 service users to manage their behaviour. Service users were supported to access psychology and psychiatry supports as required while availing of the service. There were some restrictive practices in use in the centre. For the most part, the restrictive practices were appropriately identified by the person in charge as part of the admission process and reviewed in line with the provider's policy. However, the inspector found that one restrictive practice, which was put in place for the purposes on clinical monitoring, was not appropriately reviewed by the provider's positive approaches monitoring group. This restrictive practice has since been reviewed by the provider and was no longer in use at the time of the inspection.

There were systems in place to safeguard service users while they were availing of the service. Staff spoken with were knowledgeable of safeguarding and on what to do in the event of a concern. Service users were observed to appear comfortable

and content in the service.

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.

The provider had ensured that systems were in place in line with public guidnace 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 plans in place for staffing and the isolation of service users. 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. The centre was supported by the provider's internal COVID19 management team and had access to support from Public Health.

There were systems in place for fire safety management. The provider had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers. Each service user had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting service users to evacuate. However, improvement was needed in relation to ensuring staff and service users were aware of the procedure to be followed in the case of a fire. For example, it was not evident that a fire drill had been undertaken. This had been self-identified by the provider and a fire drill was scheduled to take place. In addition, the arrangements in place for fire containment required review to ensure the fire containment measures were adequate. For example, a fire assessment competed by the provider noted that some fire doors were not fire rated.

## 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 suitable fire safety equipment in place. However, improvement was needed in relation to ensuring staff and service users were aware of the procedure to be followed in the case of a fire and the arrangements in place for fire containment required review as outlined in the report.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Each service user had an assessment of need which identified service users' health and social care needs and informed the service users' personal support plans.

Judgment: Compliant

## Regulation 6: Health care

Service users were supported to have the best possible health while availing of the service.

Judgment: Compliant

## Regulation 7: Positive behavioural support

There were positive behavioural supports in place for service users where required which were up-to-date and guided the staff team in supporting them while they availed of the service.

There were some restrictive practices in use in the centre which were appropriately identified. However, one restrictive practice was not appropriately reviewed by the provider's human rights committee.

Judgment: Substantially compliant

| Regulation 8: Protection |
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| There were measures in place to safeguard service users. |
| 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 | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Substantially 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 | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Belcamp Nua OSV-0007807

## Inspection ID: MON-0031738

## Date of inspection: 21/01/2021

**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 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>• The continuation of on-going recruitment to backfill vacancies within the centre.<br>• Relief/agency staff are in place to cover any gaps on the roster while still providing consistency. This is managed by the PIC and in line with the requirements of the referrals to the centre. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• The PIC has reviewed all training requirements for the centre and scheduling training in line with the current government guidelines.<br>• SMH have online training which all staff are continuing to participate in<br>• Fire safety training is scheduled for staff | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose: | |

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| • Statement of purpose was updated in line with requirements set out in Regulation 3 and submitted to the authority. |

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All staff have completed online fire safety training provided by the service provider
• Fire drill was completed on the 16/02/2021
• Fire precautions and measures will be discussed at staff meeting with staff in February 2021.
• The Person in Charge has consulted with the Organisations fire officer and completion dates for works to be completed have been scheduled and included within the organizational fire register of repairs.
• The training video for the ski sheet has been uploaded onto the OTC website in a specific area for Belcamp Nua and staff team from the unit have been enrolled in same. In addition the interim online frontline fire training is on the website for completion by staff.
• The building pre COVID provided a day service, part of which was split off to create Belcamp Nua (COVID response). As such the closest applicable standard that was applied was residential institutional buildings under TGD B. The guiding principles in this document was applied as much as could be given the retrospective application.
• An FD30s was installed in the corridor to provide a split between both services to accommodate 4 rooms and bathroom facilities. The choice of location for these FD30s on the corridor was limited by the building layout and to accommodate facilities needed. The FD30S was located to line up (as close as was possible) with the separating walls to rooms either side to allow for a continued fire line across the building. This resulted in a travel distance from these doors to the final exit at the end of the corridor of approx. 25m. TGD B table 1 allows for travel distance of 35m where there is escape in more than one direction (bedroom corridor res institution). While one exit route would pass through another occupancy it is the same service provider and would only be used if all other exits were unavailable which would be highly unlikely given the high number available.
• The only time the main corridor would be required to be used for escape purposes would be in these 2 scenarios:
1. There is someone in the bathroom facilities at the time of the fire alarm activation and
2. The person who is in room 5 is non ambulant or has behaviour issues that requires a bed evacuation. The final exit door to this bedroom does not accommodate a bed. Staff are aware of same and ensure an ambulant person is assigned to this room as is reasonably practicable.
There is a simultaneous evacuation in place and the building further compensates by having a final exit in each room directly to outside which requires the main corridor to only be used in the above 2 scenarios. In addition to this an addressable fire alarm system with repeater panel is located in Belcamp Nua for staff to identify exact fire location
• The service providers fire officer has reviewed the arangements in place for fire

containment and concluded that there are adquate measures in place.
• The secondary set of double doors in place forms no fire rated function or contribution to the fire evacuation strategy for Belcamp Nua.

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| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• All restrictive practices going forward will be reviewed by internal Positive, Approaches, Monitoring Group (PAMG).
• Noted restrictive practice on the day of inspection was not in use and continues to be discontinued.

## 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(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Substantially Compliant | Yellow | 31/07/2021 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 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 | The registered | Not Compliant | Orange | 31/03/2021 |

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| 28(4)(b) | provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | | | |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 16/02/2021 |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 25/02/2021 |