Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Ardmore
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	25 April 2018
Centre ID:	OSV-0002353
Fieldwork ID:	MON-0023726

About the designated centre

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

Ardmore is a residential centre which is located in Co. Dublin. The centre is run by St. Michaels' House and caters for the needs of six male and female adults over the age of 18 years, who have an intellectual disability and require a low level of support. The centre comprises one two-storey dwelling which offers each resident their own bedroom, shared bathroom facilities, sitting rooms, kitchen and dining area, utility space and garden area. The centre is located close to public transport, shops and amenities. Staff are available in the centre both day and night to support residents.

The following information outlines some additional data on this centre.

Current registration end date:	07/09/2018
Number of residents on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
25 April 2018	10:30hrs to 16:30hrs	Anne Marie Byrne	Lead

Views of people who use the service

On the day of inspection, there were five residents living in this centre, with one vacancy available. The inspector met with all five residents who live in this centre and three of these residents spoke directly with the inspector. The inspector also met with two family members who spoke with the inspector about the care and support their relative received. Family members told the inspector that their relative was supported and encouraged by staff to live the life that they wanted. Residents who spoke with the inspector said that they were very happy in the centre, were facilitated to take part in positive-risk taking, enjoyed the recreational activities available to them and felt supported by the staff who work in the centre. Over the course of the inspection, the inspector observed residents to be very relaxed in the company of staff and staff addressed residents in a respectful manner.

Capacity and capability

The provider ensured effective governance and management arrangements were in place to ensure residents received a good quality of care and support in accordance with their assessed needs and wishes. The provider had addressed eight of the nine actions required from the last inspection. On the day of inspection, the provider gave the inspector an update on the progress made towards completing the remaining action.

Staffing arrangements ensured the number and skill mix of staff working in the centre met the assessed needs of residents. The person in charge regularly reviewed the centre's staffing levels and ensured care was provided to residents by staff who were familiar with the residents. Staff regularly had supervision meetings with their line manager and training arrangements ensured that all staff received up-to-date mandatory training. Staff told the inspector that regular meetings were held in the centre, which kept them informed of changes within the organisation and gave them an opportunity to discuss specific issues relating to the centre. Throughout the inspection, staff were knowledgeable on all aspects of the service provided and spoke with confidence about how they supported residents' needs in areas such as behaviour management, healthcare and personal goal development.

The provider had systems in place which ensured the care and support delivered to residents was regularly monitored and reviewed. The person in charge was based full-time in the centre, which allowed her to meet regularly with staff and residents and to oversee various practices. Clear lines of accountability and authority were in place and staff were aware of the responsibilities they held as part of their role. The

annual review of the service and six monthly provider-led visits were occurring in line with the requirements of the regulations. Although the provider had identified areas of improvement required in the centre, it was unclear what progress the provider had made towards addressing the improvements highlighted following the most recent annual review.

Although no complaints were being managed at the time of inspection, the provider had a system in place which guided staff on how to respond to, manage and record all complaints received. Residents were regularly informed by staff on how to make a complaint and the complaints procedure was available to residents in an accessible format. Residents had access to an appeals process and the provider had a nominated person to manage complaints within the centre. However, some improvements were required to the complaints procedure that was displayed in the centre.

Regulation 15: Staffing

The provider had adequate arrangements in place to ensure sufficient staff were available to meet the assessed needs of residents. The provider ensured continuity of care to residents and a planned and actual roster was in place which outlined the staff on duty in the centre both day and night.

Judgment: Compliant

Regulation 16: Training and staff development

Staff received up-to-date mandatory training as required by the regulations. All staff received supervision from their line manager and had access to copies of the regulations and standards.

Judgment: Compliant

Regulation 23: Governance and management

Where the annual review identified improvements required within the centre, the provider failed to ensure an action plan was in place to address these.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider did not ensure the statement of purpose contained all information as set out in Schedule 1 of the regulations, including:

- the centre's policy and procedures for emergency admissions

- the description of all rooms in the designated centre, including their size and primary function

- the organisational structure of the designated centre

- clarity around the fire precautions in the designated centre

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider failed to ensure the displayed complaints procedure adequately informed on the appeals process available.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found residents received the care and support they required. Residents told the inspector that they were very happy in the centre, that staff knew them very well and were able to adequately support them. However, the provider had not adequately addressed the fire containment issues that were identified upon the last inspection of this centre.

Residents were supported to access employment, training and education if they wished. Some residents were attending cookery and nutritional management courses while other residents held part-time employment. Residents were supported to attend local community groups and to attend day services as they wished. The centre's visiting policy ensured residents were regularly supported to develop and maintain personal relationships with friends and family, with many residents having frequent overnight stays with their families. The premises allowed for residents to meet with their family and friends in private and family members who met with the inspector said they felt very welcome each time they visited their relative. A wide variety of activities were available for residents to engage in if they wished and the

provider had adequate transport arrangements in place to ensure staff could bring residents to where they wanted to go.

Where residents presented with behaviour that challenges, these residents received regular review and had clear support plans in place. Staff who spoke with the inspector were aware of their role in supporting these residents and had received up-to-date training in the management of behaviour that challenges. Staff were aware of the safeguarding policy, of their responsibility to report safeguarding concerns and had received up-to-date training in safeguarding.

There were systems in place which ensured residents were protected from identified risks. Residents were supported to take part in positive risk-taking, which facilitated them to spend time on their own in the centre as they wished. Although residents' needs were regularly reviewed using a needs assessment, gaps were identified in the assessment of some residents' specific risks. A risk register was in place to oversee the management of organisational risks and a procedure was in place which supported the person in charge to escalate high rated risk areas to senior management. However, some improvements were required to some organisational risk assessments to ensure they clearly and accurately identified how the provider was responding to and managing risks in the centre

Assessment and personal planning arrangements ensured that annual reviews were occurring and that these reviews were done with residents and their families. Residents and family members who spoke with the inspector said that they were kept informed by staff where any changes to residents' need or circumstances occurred. Staff who spoke with the inspector were aware of the specific healthcare needs that some residents had and of how to support these residents in accordance with their personal plans. Personal goals were developed with residents and key-working arrangements ensured that the progress made by residents towards achieving their goal was regularly monitored and reviewed. However, some improvements were required to ensure that residents had access to their personal plans in a format that was accessible to them.

The provider had some fire safety precautions in place, including, regular fire checks, up-to-date staff training in fire safety and regular maintenance of fire fighting equipment. Staff were aware of how to support residents in the event of a fire and residents told the inspector of their involvement in fire drills to date. However, the inspector observed some improvements were required to residents' evacuation plans, fire drills, emergency lighting arrangements and to the fire procedure. Since the last inspection, the provider had not provided adequate fire containment measures in line with the time frame given to the Chief Inspector following this centre's previous inspection in January, 2017. This was brought to the attention of the person in charge who by the close of the inspection, implemented interim day and night-time fire containment measures to be adhered to by staff working in the centre. The provider informed the inspector that progress was being made towards the completion of adequate containment measures and that they were awaiting a confirmation date for when the works would be completed.

Regulation 10: Communication

The provider had arrangements in place that ensured residents with specific communication needs received regular review and had clear communication plans in place.

Judgment: Compliant

Regulation 11: Visits

The provider facilitated residents received visitors without restriction and suitable communal facilities were available for residents to receive visitors in private.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported by staff to access education, training and employment opportunities. The provider also ensured that residents were encouraged and supported to maintain links with family, friends and the wider community in accordance with their wishes.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider failed to ensure that risk assessments were in place for the assessment and on-going review of some residents' specific needs.

The provider failed to ensure the fire risk assessment clearly identified the specific control measures in place to mitigate against the risk of fire in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider failed to ensure adequate fire containment measures were in place.

The provider failed to ensure the fire procedure clearly guided staff on how to respond to fire in the centre.

The provider failed to ensure all emergency lighting was in working order and that sufficient lighting was available to guide staff and residents from the centre's rear fire exits to the fire assembly point.

The provider failed to ensure residents' personal evacuation plans guided staff on how to support the evacuation of residents residing in upstairs accommodation, where the downstairs fire exits were inaccessible in the event of a fire.

The provider failed to ensure that fire drills considered:

- the evacuation of residents where the downstairs fire exits are not inaccessible
- the specific evacuation of residents who sometimes spend time alone in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider ensured residents received regular assessment and had clear personal plans in place. Personal goals were developed with residents and their families and staff were allocated to support residents to achieve their goals. However, personal plans were not available to residents in an accessible format.

Judgment: Substantially compliant

Regulation 6: Health care

Residents with specific healthcare needs had clear personal plans in place to guide staff on the support they needed. Residents also had access to a range of allied healthcare professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents with behaviours that challenge received regular review and had clear behaviour support plans in place. There were no restrictive practices in place at the time of inspection.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding plans required at the time of inspection. However, the provider had clear guidance available to staff on how to appropriately report, respond to and manage safeguarding concerns. All staff had received up-to-date training in safeguarding.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ardmore OSV-0002353

Inspection ID: MON-0023726

Date of inspection: 25/04/2018

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The designated centre will continue to be resourced to ensure all residents support needs are met. There is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability There are 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; Annual reviews of the quality and safety of care and support are compelted on a yearly basis and as part of this there is a consultation process with residents and their representatives. A copy of the annual review is available to residents and is held in the centre. Six monthly unannounced visits are completed in the centre. These reports are contained in the centre and are available for review. A Quality Enhancement Plan (QEP) has been developed for the centre and this allows the PIC and Service Manager to monitor progress of actions needed to improve the quality and safety of service provision. Relevant actions identified from the 6 Monthly Audits and Annual Review will now be included in the QEP	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of	

purpose:

The Designated Centre has a statement of purpose in place containing the information set out in Schedule 1.

The Statement of Purpose and function has been reviewed and now includes details for this designated centre in relation to emergency admissions.

The Statement of Purpose and function now includes details for this designated centre in relation to the description of all rooms including their size and primary function.

The Statement of Purpose and function includes details for this designated centre in relation to the inclusion of all staff in the Designated Centres Organisational chart.

The Statement of Purpose and function includes revised details for this designated centre in relation to fire precautions.

A copy of the Statement of Purpose is available to residents and their representatives.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

St Michael's House has a complaints procedure in place which highlights the 4 stages of the complaints process including appeals procedure.

The complaints procedure for residents is in an accessible and age-appropriate format; this now includes the appeals procedure. A copy of the complaints procedure is in a prominent position in the centre and residents are assisted to understand the complaints procedure.

All residents and their families have been made aware of the complaints procedure

Residents have access to information in relation to accessing advocacy services and are supported to do so if they so wish.

Staff shall continue to support residents to make any complaint they wish.

All complaints are investigated promptly in line with the complaints procedure and the complainant is informed promptly of the outcome of their complaint and details of the appeals process.

The designated centre shall continue to maintain copies of all complaints and compliments.

A record of all complaints and compliments are reported to the office of the CEO on a monthly basis.

The organisation shall continue to ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

The PIC and all designated centre staff have received training in Complaints

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

There is a Risk Management policy in place. St Michaels House are updating the Risk Management Policy to reflect changes in assessment of risk including methodology, updating of risk assessment template and risk register template to ensure that significant risks are sufficiently managed, tracked and reviewed for effectiveness. Revised policy will be brought to the Quality Safety Executive Committee for approval May 2018

All residents have an up to date assessment of need, all identified risks will be reviewed and assessed to ensure they inform all supporting staff so that risks are managed appropriately. Risk assessments where required will have been updated by 31st May 2018.

St Michael's House Fire Safety Officer has completed a detailed fire audit of the designated centre on the 9th January 2018.

The PIC is trained in the management of risk and will continue to develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies.

Regulation 28: Fire precautions	Not Compliant

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

St Michael's House will continue to ensure that effective fire safety management systems are in place so that there are adequate precautions against the risk of fire in the centre.

There are regular fire checks completed in the centre, and, regular maintenance of all fire fighting equipment.

All staff have received training in relation to fire prevention, safety and evacuation.

St Michael's House Fire Safety Officer has completed a detailed fire audit of the designated centre on the 9th January 2018, and actions identified are in the process of being implemented.

Fire doors will be installed in the centre by the 31st August 2018

Regular fire evacuation drills are conducted in the centre in line with policy requirements and all residents are aware of the procedure to follow in the event of a fire.

There are accessible fire action notices in the centre to support staff and residents in the event fire evacuation is required.

The centre's evacuation plan states in more detail in how staff are to manage a day and night evacuation

All residents' personal evacuation plans will clarify arrangements for day and night time evacuations including upstairs evacuations drills by the 7th June 2018.

A drill for one resident who spends time alone has been completed and there were no issues identified.

The organisation has introduced fire walks in 2018 and this will be used by staff to discuss and walk through with upstairs residents on what to do if their means of escape to downstairs is blocked. These fire walks are due to commence in June 2018 in the centre.

The external emergency lights have been escalated to TSD and are on a schedule of works to be completed by the 3OTH June 2018.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

All residents have a comprehensive personal plan in place outlining their needs and supports in accordance with their wishes.

All residents are involved in the person centered planning process and an annual wellbeing review meeting takes place with the involvement of MDT team as appropriate. The resident is supported to attend this meeting.

All residents living in the designated centre have a comprehensive assessment of need which is reviewed annually or as required with multi disciplinary input as appropriate.

Personal plans have been reviewed to ensure they are available to each resident and their representative in an accessible format which is meaningful to them as an individual.

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	22nd May 2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31st May 2018.
Regulation 28(2)(c)	The registered provider shall provide adequate	Substantially Compliant	Yellow	30th June 2018

	means of escape, including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31st August 2018
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	7th June 2018
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Substantially Compliant	Yellow	31st May 2018.
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	18th May 2018 - completed.
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible	Substantially Compliant	Yellow	18th May 2018 - completed.

	and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31st May 2018.