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:	La Verna
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	12 June 2018
Centre ID:	OSV-0002363
Fieldwork ID:	MON-0021666

About the designated centre

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

La Verna provides full-time residential care to adults with an intellectual disability. Support provided at La Verna is based on the social care approach model with a focus on supporting and assisting residents to participate and be involved in their local community, develop daily living skills and sustain relationships with family and friends. La Verna is located in a residential area of a city and is close to local shops and other amenities. The centre is in addition close to public transport links, which enable residents to access leisure amenities and work placements in the surrounding area. The centre is a two-storey house and comprises of six bedrooms of which five are used by residents. The other bedroom is used by the provider as an office and overnight accommodation for staff. Residents have access to a communal sitting room, kitchen and dining room. In addition, a smaller communal sitting room is provided for residents to meet their family and friends in private. Residents have access to laundry facilities which are located in a purpose built shed located in the centre's rear garden. The centre has two upstairs bathrooms which are both equipped with shower facilities, one of which is of a walk-in design to ensure accessibility to residents. A further additional toilet is located on the ground floor of the house. The centre has a rear garden which is accessible to residents and also contains additional premises which are part of a day service operated by the provider, but is not part of the designated centre. Residents are supported by a team of social care workers, with two staff members being available during the day and at evening times to meet residents' assessed needs. At night-time, residents are supported by one staff member who undertakes a sleep over duty and is available to provide additional support during the night when needed. In addition, the provider has arrangements in place outside of office hours and at weekends to provide management and nursing support if required by residents.

The following information outlines some additional data on this centre.

Current registration end date:	17/11/2018
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
12 June 2018	09:10hrs to 16:00hrs	Stevan Orme	Lead

Views of people who use the service

The inspector met all five residents who lived at La Verna and spoke with four of them about the care and support they received. Residents told the inspector that they felt safe and enjoyed living at the centre. Residents spoke about the activities they enjoyed and said that they felt supported by staff to achieve their personal goals and wishes. Residents were aware of their rights and were able to tell the inspector how they would make a complaint if they were unhappy. Residents told the inspector that they had raised complaints in the past and felt that staff had listened to them and had addressed their concerns to their satisfaction. Throughout the inspection, residents appeared comfortable and relaxed with all supports provided by staff, with supports offered in a timely manner and reflective of residents' assessed needs as described in their personal plans.

Capacity and capability

The provider's governance and management arrangements ensured that residents received a good quality of care at La Verna. Residents were supported in-line with their assessed needs and staff promoted residents to both develop and maintain their independence skills in all aspects of their daily life. However, although robust governance and management systems were in place at the centre, the provider had not implemented measures following the centre's last inspection in 2017 to ensure full compliance with all regulations inspected against on the day.

Governance and management arrangements in place at the centre regularly monitored and audited the quality of care and support provided to residents and ensured it met both residents' assessed needs and reflected current good practice developments in health and social care. The outcomes of management audits were discussed with staff at regular team meetings, as well as being shared with the centre's senior management to provide assurances on compliance with the provider's policies and procedures. The provider had arrangements in place for the management of adverse incidents such as fire and the loss of utility services. However, although the provider's management and support arrangements ensured that residents at the centre were safe from harm, they had not implemented measures following the last inspection to effectively manage all identified risks associated with an outbreak of fire at the centre.

The provider ensured an appropriate skill mix and level of staffing was available at all times to support residents' assessed needs and to facilitate them to participate in both planned and ad hoc social activities. The provider further ensured that in the event of a staff absence, suitably qualified and familiar staff were available to the

centre to ensure a continuity of care for residents.

The provider had arrangements in place to update both staff members' knowledge and skills, with regular training opportunities available to ensure their practice reflected current health and social care developments. Staff were knowledgeable on all aspects of the residents' assessed needs as well as the operational running of the centre. The person in charge further ensured that staff were kept up-to-date on any changes to the centre's operations through regular staff meetings and individual formal supervision arrangements. Staff told the inspector that through these arrangements they were able to raise concerns and seek clarity and ensure their practices met both residents' needs and the requirements of the provider organisation.

Registration Regulation 5: Application for registration or renewal of registration

The provider had ensured that all prescribed documentation required for the renewal of designated centre's registration was submitted to the Chief Inspector as required.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was actively engaged in the centre's governance and management and was qualified in accordance with regulatory requirements.

Judgment: Compliant

Regulation 15: Staffing

The provider ensured that an appropriate number of staff were available at the centre to meet residents' assessed needs and enable them to access activities of choice and working towards the achievement of personal goals.

Judgment: Compliant

Regulation 16: Training and staff development

The provider ensured that staff had access to regular training opportunities which ensured their knowledge was up-to-date and reflected residents' needs, organisational policies and current developments in health and social care practice.

Judgment: Compliant

Regulation 21: Records

The provider's recruitment and selection arrangements ensured that staff were suitability qualified and skilled and all documentation as laid down under the regulations was sourced prior to employment.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that appropriate and up-to-date insurance arrangements were in place for the centre in accordance with the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider's governance and management arrangements at the centre ensured that the standard of care and support provided was regularly monitored and met residents' assessed needs. However, the provider had not ensured that agreed actions from the previous inspection had been implemented to ensure compliance with the regulations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider ensured that the centre's statement of purpose was subject to regular review, reflected the services and facilities provided and contained all information required under the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were knowledgeable about their right to a make a complaint about the care and support they received. Where complaints had been received, the provider had ensured that they were appropriately investigated and records included the complainant's satisfaction with the outcome.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider's policies and procedures were available to staff and subject to regular review which ensured they reflected current developments in health and social care practice.

Judgment: Compliant

Quality and safety

Support arrangements in place at the centre ensured that residents were both protected from harm and supported in-line with their assessed needs and to achieve their personal goals. Support arrangements further enabled residents to both maintain and develop their independence through positive risk taking as part of their daily lives. However, the inspector found that the provider had not ensured that all actions from the centre's previous inspection were fully addressed in relation to the detection and containment of an outbreak of fire. In addition, although personal planning arrangements ensured residents' needs were fully met, a minor improvement was identified to ensure full compliance with the associated regulation.

Residents accessed a range of activities both at the centre and in the local community which reflected their assessed needs. Residents told the inspector that they were supported with both part-time jobs and voluntary work. In addition, residents attended weekday day service placements as well as educational and leisure classes which reflected their needs and interests. The provider further ensured that appropriate supports were available to residents to develop their independence through positive risk taking, with some residents being able to stay at the centre unsupervised by staff for defined periods of time and self-administering prescribed medications. Residents told the inspector that they

independently accessed activities in the local community, but if needed staff were available to support them.

Governance and management arrangements ensured that residents had up-to-date and detailed assessments of their needs which informed ‘well-being’ support plans and staff practices. In addition, the person in charge ensured personal plans were subject to an annual review, which assessed their effectiveness in meeting all aspects of residents’ assessed needs and facilitated them to achieve their personal goals. However, although personal plans ensured that residents received a good quality of care and support, record keeping arrangements did not clearly document the named supports and expected time frames for the achievement of residents' annual personal goals.

The provider ensured that residents were aware of their rights at the centre and actively involved in making decision about their care and support needs and the running of the centre. Residents told the inspector that they attended regular house meetings were they made decisions about the running of the centre and could voice any concerns and complaints they had. In addition, the provider used the regular house meetings to inform residents about how to keep themselves safe from harm, updates to the centre’s risk management arrangements and external issues such as their right to vote in government elections and referendums. Residents were actively involved in both the development and ongoing review of their personal plans and told the inspector about goals they wished to achieve in the year such as going on holiday. In addition, where restrictive practices were in introduced due to residents’ assessed needs, the person in charge ensured that affected residents were consulted with and had given their consent prior to the practice's commencement. In addition, restrictive practices in place at the centre were subject to approval by multi-disciplinary professionals, regular review and the least restrictive in nature

Improvements had been made by the provider to risk management arrangements at the centre following the last inspection, which ensured that residents were kept safe from harm. The person in charge ensured that all identified risks were assessed, subject to regular review and measures were introduced to mitigate their impact. Fire detection and fighting equipment were in place and the provider ensured that both residents and staff were guided on actions to be taken in an emergency through detailed emergency protocols and regular simulated evacuation drills. However, the inspector found that the provider had not upgraded fire doors and installed additional fire detection devices to ensure the effectiveness of the centre fire safety arrangements as recommended in the provider’s own internal audits and the previous inspection of the centre.

Following the last inspection, the provider had improved medication management arrangements at the centre. Improvements ensured that residents' medication was administered as prescribed, securely stored and administered by trained staff. In addition, the provider had arrangements in operation to ensure that medication practices were regularly audited and any incidents of medication errors were subject to review to reduce their re-occurrence.

The centre's design and layout ensured that it was fully accessible and met

residents' needs. Residents told the inspector that they liked living at the centre. Some residents also showed the inspector their bedrooms which were decorated to reflect their personal tastes and interests. The provider also had arrangements in place which ensured that the premises were well-maintained, decorated to a good standard and homely in nature.

Regulation 13: General welfare and development

The provider ensured that residents were supported to maintain their independence and access activities of their choice which reflected their assessed needs, interests and personal goals.

Judgment: Compliant

Regulation 17: Premises

The provider ensured that the centre was well maintained and decorated to a good standard. The centre's design and layout ensured that it was accessible to residents and met their assessed needs.

Judgment: Compliant

Regulation 20: Information for residents

Residents had access to an easy read 'Resident's Guide' which informed them about their rights and the services and facilities they could expect to receive at the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management arrangements ensured that identified risks were subject to ongoing monitoring and the effectiveness of associated control measures were regularly reviewed. The provider further ensured that residents were supported to maintain and develop their independence skills through positive risk taking arrangements such accessing community activities independently and remaining at the centre without staff support for short periods of time.

Judgment: Compliant

Regulation 27: Protection against infection

Following the last inspection, the provider had ensured that their infection control policies effectively guided staff practices and protected residents from the risk of infection.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had not ensured that adequate arrangements were in place for the detection and containment of fire at the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider's medication management practices ensured that medications were securely stored and administered by qualified staff. Where residents were supported to administer their own medication arrangements were in place which ensured it was safely stored and taken as prescribed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans clearly described individuals' assessed needs and associated support interventions, and were available in an accessible version to inform residents about how their needs would be addressed. However, although residents were supported to achieve their personal goals by staff, the person in charge had not ensured that associated records documented both the named staff supports required and expected time frames for each goal's achievement.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to access health care professionals as and when required, which ensured they maintained a good quality of health in-line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents had behaviours that challenge, the provider had ensured that staff had received up-to-date training and positive behaviour support plans were in place to support the person, guide staff practices and reduce any risk to others. In addition, the provider ensured that where restrictive practices were used to support residents they were subject to regular review and were the least restrictive in nature.

Judgment: Compliant

Regulation 8: Protection

The provider had arrangements in place which safeguarded residents from abuse and included clear reporting arrangements and access to up-to-date training for staff.

Judgment: Compliant

Regulation 9: Residents' rights

The provider ensured that residents were aware of their rights and actively involved in decision making about the day-to-day operations of the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	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
Regulation 9: Residents' rights	Compliant

Compliance Plan for La Verna OSV-0002363

Inspection ID: MON-0021666

Date of inspection: 12/06/2018

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 in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
- The organisation has in place a system for prioritising environmental fire deficits arising from internal fire inspections in a systematic risk based way. As such all actions have been prioritised on an organisational fire risk register system and actions have been assigned a risk rating. The organisational fire risk register is managed by the SMH Fire Officer and TSD Manager and the instalment of fire doors for the centre are scheduled to be completed by 30/11/18.
- Alfa security installed fire detection heads in the Hot Press, velux light and the shed on the 15/6/18 in the centre.
- St Michael's House Fire Safety Officer has completed a detailed fire audit of the designated centre on the 12/4/18 and actions identified are in the process of being implemented.
- Annual reviews of the quality and safety of care and support are completed 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 Person in Charge and Service Manager to monitor progress of actions needed to improve the quality and safety of service provision.
- All policies and procedures referred to in schedule 5 are updated and available within the centre.

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.
- The organisation has in place a system for prioritising environmental fire deficits arising from internal fire inspections in a systematic risk based way. As such all actions have been prioritised on an organisational fire risk register system and actions have been assigned a risk rating. The organisational fire risk register is managed by the SMH Fire Officer and TSD Manager and the instalment of fire doors for the centre are scheduled to be completed by 30/11/18.
- Alfa security installed fire detection heads in the Hot Press, velux light and the shed on the 15/6/18 in the centre.
- St Michael's House Fire Safety Officer has completed a detailed fire audit of the designated centre on the 12/4/18 and actions identified are in the process of being implemented.
- All staff have received training in relation to fire prevention, safety and evacuation.
- 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
- Personal Evacuation Plans have been reviewed and updated to reflect supports

required and will be reviewed and updated when required.

- The register provider will continue to ensure that adequate levels of emergency lighting is in place.

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:

- The Person in Charge will continue to ensure that a comprehensive assessment, by an appropriate health care professional, of health, personal and social care needs of each resident is carried out prior to admission or as required to reflect changes in need and circumstances.
- The Person in Charge will continue to meet the needs of each resident, as assessed in acccordance with their needs.
- The Person in Charge will continue to ensure that the designated centre is suitable for the needs of each resident
- The personal plans will continue to be reviewed annually or more frequently by the Person in Charge if there is a change in the needs of the resident.
- All residents will continue to be involved in the person centered planning process and an annual outcome review meeting will continue to take place with the involvement of MDT and the resident is supported to attend this meeting.
- This review and any required changes to the personal plan will be recorded. All relevant stakeholders will be documented as being present.
- Personal plans are available in an accessible format respecting the individual's wishes and requirements, in line with SMH Personal Planning Policy
- The Person in Charge held a staff meeting on the 25/6/18 and informed all staff to ensure all documentation of personal plan meetings and assocaited goals are SMART and all relevant information is captured and reviewd effectively.

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	30/11/18
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/18
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for	Substantially Compliant	Yellow	25/6/18

	pursuing objectives in the plan within agreed timescales.			