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:	Ratheanna
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	14 November 2018
Centre ID:	OSV-0002367
Fieldwork ID:	MON-0021668

About the designated centre

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

Ratheanna is a community service providing accommodation for five adult ladies and gentlemen with an intellectual disability. The house is a five bedroomed bungalow located close to numerous amenities such as public transport, schools, shops and recreational facilities. It is in walking distance of seafront promenade and a local village and park. There is a kitchen and dining area and a bright and comfortable sitting room. There are five bedrooms, one of which is a staff sleepover room. Ratheanna is staffed by social care workers. The person in charge is a social care leader. The person in charge is supported by a service manager and social care workers are supported by the person in charge. Residents have continuous support with staff present when residents are at home. Staff shifts are flexible to meet the needs of residents. Each resident is allocated a keyworker who supports them to engage with and participate in decisions about their lives and the running of their home.

The following information outlines some additional data on this centre.

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
14 November 2018	08:30hrs to 17:40hrs	Marie Byrne	Lead

Views of people who use the service

The inspector had the opportunity to meet and spend some time with four residents during the inspection. One resident was on holidays on the day of inspection.

A number of residents who spoke with the inspector described what it was like to live in the centre and how they were supported by staff to spend their time engaging in activities of their choosing. They described how they liked to spend their time including their preferred activities both at home and in their local community. One resident showed the inspector their 'memories book' and their 'all about me' book and described their goals and achievements. They described how they were supported to develop these books and how they were supported to achieve their goals. One residents who met with the inspector indicated that they were happy with the staff support and other aspects of care and support of the centre. However, they indicated that they were not happy with the size of their bedroom or their storage.

The inspector viewed the complaints and compliments folder in the centre and found three recent compliments from family members in relation to the care and support for their family member in the centre. Four residents and one residents' representative completed satisfaction questionnaires prior to the the inspection. The feedback in these questionnaires was mostly positive and they were particularly complimentary towards food and mealtimes, access to activities both at home and in the community, and support from staff. Two residents was complimentary towards how complaints they raised were dealt with and closed to their satisfaction. Two residents indicated in the questionnaire that they had open complaints in place due to their dissatisfaction with sharing their bedroom. One resident indicated their privacy was being affected by sharing their bedroom.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were monitoring the quality of care and support for residents. They were completing regular audits including the annual review and six monthly visits by the provider. These reviews were identifying areas for improvement in line with the findings of this inspection. However, a number of actions from these reviews were not being progressed in a timely
fashion.

Although there were clear management systems and structures in place and staff had clearly defined roles and responsibilities, they were not proving effective as they were not ensuring full oversight of the services. This was due to their failure to act on key concerns which were impacting negatively on residents' experience of service provision. Examples of this include the premises not meeting residents' needs and not closing complaints to the complainants satisfaction.

The staff team reported to the person in charge who in turn reported to the service manager. The person in charge and service manager were having regular fortnightly support meetings and completing monthly governance and safety reports. There was evidence that they were developing actions following these meetings and reviews and completing them to improve care and support in the centre. There was also evidence that they were escalating issues affecting the progression of these actions to the relevant managers. Staff meetings were held regularly and agenda items were found to be resident focused. Audits were being completed regularly including care plan audits, medication audits, residents' finances and monthly health and safety audits. There was evidence that the completion of actions following some of these reviews were bringing about positive changes in relation to residents' care and support.

There was a new person in charge who had commenced in the centre three months before the inspection. They had the relevant qualifications and experience to fulfill the role and were working in a full time capacity. They were familiar with residents' care and support centre and aware of their responsibilities in relation to the regulations. They were meeting regularly with their manager and were working with staff to identify their strengths and in identifying their specific roles and responsibilities within the team. They had plans in place for regular formal supervision with staff.

Throughout the inspection residents appeared happy, relaxed and to be engaging in activities of their choosing. Staff members were observed to be knowledgeable in relation to residents' care and support needs. All residents who spoke with the inspector, spoke fondly of the staff team. There were sufficient numbers of staff with the qualifications and skill mix to meet residents' needs. A number of staffing vacancies had recently been filled and the staff team were in the process of forming and getting to know residents care and support needs.

Staff had completed training and refreshers in line with residents' assessed needs. A training needs analyisis was completed at least anually and training plans put in place to ensure staff were completing mandatory training in line with the organisations' policy. Plans were in place for regular formal supervision with the new person in charge.

Residents were protected by the policies and procedures required by schedule 5 of the regulations. These policies had been reviewed in line with the timeframe identified in the regulations.

There were complaints policies and procedures including a user friendly complaints process. There was a local complaints officer and residents and staff who spoke with

the inspector could describe this process. However, there were a number of residents' complaints which were not being progressed in a timely manner or resolved to the complainants' satisfaction.

Regulation 14: Persons in charge

The person in charge had the relevant qualifications, skills and experience to fulfill the role and they were working in a full time capacity. They were familiar with residents' care and support centre and aware of their responsibilities in relation to the regulations.

Judgment: Compliant

Regulation 15: Staffing

Staff were suitably qualified and knowledgeable in relation to residents' care and support needs. Residents were observed to receive assistance in a kind, caring, respectful and safe manner throughout the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs and had the required competencies to deliver safe care and support for residents. A training needs analysis was completed regularly and training was provided as necessary. Staff told the inspector they were supported by the person in charge and person participating in the management of the designated centre. Plans were in place for staff to receive regular formal supervision.

Judgment: Compliant

Regulation 22: Insurance

Residents were protected by appropriate insurance in place against personal injury and property damage.

Judgment: Compliant

Regulation 23: Governance and management

Although there were clearly defined management structures which identified the lines of authority and accountability for each staff member, they were not not proving effective due to lack of progress following reviews of the quality of care and support for residents. A suite of audits were being completed regularly and there was evidence that the actions completed following these reviews were positively impacting on residents lives and their home. However, progress had not been made in relation to a number of actions from these reviews.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were complaints policies and procedures including a user friendly complaints process. There was a local complaints officer and residents and staff who spoke with the inspector could describe this process. However, there were a number of residents' open complaints which were not being progressed in a timely manner or resolved to the complainants' satisfaction.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policies and procedures required by schedule 5 of the regulations had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was good. The centre was managed in a way that maximises residents' capacity to exercise independence and choice in their daily lives. Residents lived in a caring environment where they had opportunities to make their own choices and decisions. Residents who spoke with the inspector stated that they liked their home and were happy and felt safe. However, a number of residents had open complaints relating to the premises.

The houses was warm, clean, comfortable, homely and decorated in line with residents' wishes. However, the inspector found that the premises was not meeting the number or needs of residents. In line with the findings of the last inspection there was insufficient private and communal space to meet the number and needs of residents. There were areas of the centre which were not accessible to all residents. Two residents were sharing a bedroom and another resident was not happy with the size of their bedroom. This resident also indicated that they were not satisfied with the storage available in their bedroom. In addition, the inspector found that there was not sufficient storage facilities available resulting in large equipment being stored in the hallway/office. Residents did not have sufficient space in their bedroom to store equipment such as wheelchairs and rollators. The provider recognised that the premises was not suitable to meet residents' needs and plans had been drawn up to increase the size of the centre. However, these plans were not being progressed in a timely manner.

It was evident that residents were supported to make decisions about their lives and that they were listened to and supported by staff. Residents' meetings were held regularly. Through discussions with residents it was evident that they found these meetings useful and they outlined to the inspector how they were participating in the running of their home at these meetings. All residents had access to an independent advocate if they so wished. The inspector found that a number of residents' privacy and dignity were being affected within their home. In one residents' questionnaire they completed prior to the inspection they indicated that their privacy was being affected by sharing their bedroom with their peer. In addition their personal plan indicated that they preferred to spend time alone in their room at certain times of the day and that this was not always possible. One resident had a sleeping support plan in place as routine was particularly important to them. This resident was sharing their bedroom. Two residents had open complaints relating to these issues.

Residents' personal plans were found to be person-centred. Each resident had an assessment of needs and care plans and risk assessments developed in line with their assessed needs. Residents were supported to develop goals and there was a

goal tracker in place to track progress of these goals. Well being review meetings were held at least annually. Residents had access to a keyworker to support them and they were doing monthly reports in relation to residents' health and development for the month. One resident walked the inspector through their personal plans and all about me document and told the inspector how they were progressing towards their goals. There was evidence of regular review and update of residents' personal plans to ensure they were effective.

Residents' positive behaviour support plans clearly guided staff practice to support them. There was evidence that they were reviewed and updated regularly in line with residents' changing needs. There was evidence that restrictive practices were regularly reviewed to ensure the least restrictive measures were used for the least amount of time.

The inspector found that the provider and person in charge were proactively protecting residents from abuse. In response to a number of safeguarding concerns in the centre the provider had responded by putting appropriate measures in place to keep residents safe.

Residents had communication support plans and passports in place which outlined how they liked information to be presented, how they received information, how they made decisions and how staff could support them to understand. In addition residents had an all about me document which outlined important information staff need to know to support that resident. Pictures were in use throughout the centre such as picture menus. Visual schedules and objects of reference were available to support residents as required.

There were suitable arrangements in place to detect, contain and extinguish fires. There was evidence that equipment was maintained and regularly serviced in line with the requirement of the regulations. Each resident had a personal emergency evacuation procedure in place and there was evidence that these were reviewed regularly and changes made in line with learning from fire drills. During the inspection a number of residents described what they would safely evacuate in case of an emergency such as a fire. They describe different ways to evacuate depending on where a fire may be.

Residents were protected by appropriated risk management policies, procedures and practices. There was a system for keeping residents safe while responding to emergencies and there was a local risk register in place. Risk assessments were developed as necessary and were reviewed and updated regularly. Incident review was completed as part of the monthly governance and safety reports.

Regulation 10: Communication

Each resident was supported to communicate in line with their needs and wishes.

They had communication passports and support plans in place and access to the support of allied health professionals if required. Objects of reference were used to assist residents to make choices in their day-to-day lives.

Judgment: Compliant

Regulation 17: Premises

The houses was warm, comfortable and homely. However, the design and layout of the centre did not meet the number and needs of residents. There was a multiple occupancy bedroom and one bedroom was very small in size. In addition there were areas of the centre which were not accessible for all residents. There was not sufficient storage to meet residents needs.

Judgment: Not compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management polices, procedures and practices. General and individual risk assessments and the local risk register were reviewed regularly in line with learning following incidents.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements in place to detect and extinguish fires and evidence of servicing of equipment in line with the requirements of the regulations. Staff had appropriate training, fire drills were held regularly and residents had personal emergency evacuation plans.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by appropriate policies and procedures relating to the ordering, receipt, prescribing, storage and disposal of medicines. Medication audits were being completed regularly and there was evidence of review and learning

following medication incidents.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' personal plans were found to be person-centred and each resident had access to a keyworker to support them to develop their goals. They had an assessment of need and care plans in place in line with their identified need. There was evidence that these were reviewed as necessary in line with residents' changing needs and to ensure they were effective.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required them had positive behaviour support plans which outlined proactive and reactive strategies. There was evidence that restrictive practices were reviewed regularly with the relevant members of the multidisciplinary team.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by safeguarding polices, procedures and practices. Staff in the centre had all completed safeguarding training.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were consulted with and participating in the planning and running of the designated centre. They had access to advocacy services if required and were supported to choose how to spend their day. However, the inspector found that improvement was required in relation to protecting residents' privacy and dignity due to a multiple occupancy bedroom.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ratheanna OSV-0002367

Inspection ID: MON-0021668

Date of inspection: 14/11/2018

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.

• 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 PIC and Service Manager to monitor progress of actions needed to improve the quality and safety of service provision.

In response to the area of non-compliance found under regulation 23;

• Actions from the last HIQA Inspection are being followed up.

• Planning application for additions to premises has been submitted - awaiting outcome.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The registered provider has a complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

• The complaints procedure is displayed in the centre in an accessible format.

• Residents are regularly reminded of the procedure at house meetings.

• The PIC ensures all staff follows the complaints policy and procedure.

• All staff received complaints training

• The PIC ensures each residents complaints and concerns are listened to and acted upon in a timely, supportive and effective manner.

• The PIC keeps a log of all complaints in the centre.

• The complainant receives regular documented updates on the progress of the complaint.

• The PIC seeks regular progress updates of the complaint from the Service Manager.

• Staff support residents to make complaints whenever they wish.

In response to the area of non-compliance found under regulation 34
• Actions from the last HIQA Inspection are being followed up.

• The PIC has made a referral on behalf the two residents to the National Advocacy Service. The PIC and residents are due to meet with an advocate early January 2019 - exact date to be confirmed by NAS.

• All residents concerned will be provided with monthly updates from the PIC in relation to their complaints and actions completed to address it.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: In response to the area of non-compliance found under regulation 17; • Actions from the last HIQA Inspection are being followed up. • Planning application for additions to premises has been submitted - awaiting outcome.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The designated centre is operated in a manner that respects each resident. • Each resident, in accordance with their wishes, participates in and consents, with supports where necessary, and participates in the running of the designated centre. • The registered provider endeavours to ensure that each resident's privacy and dignity is respected. • The person in charge seeks regular updates the progress of the renovations plans from the service manager. In response to the area of non-compliance found under regulation 9; • The person in charge and staff team endeavour to protect residents right to privacy and dignity, particularly those who currently share a bedroom. • The person in charge made a referral on behalf of the two residents to the National Advocacy Agency on 12/11/2018. The agency has responded and is due to meet the residents and person in charge in early January 2019.	

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/04/2022
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the	Not Compliant	Yellow	30/04/2022

	designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/04/2022
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	30/11/2018
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	30/11/2018
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	30/11/2018
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the	Not Compliant	Orange	30/11/2018

	freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/04/2022