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:	Willowpark
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Announced
Date of inspection:	05 September 2018
Centre ID:	OSV-0002372
Fieldwork ID:	MON-0021671

About the designated centre

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

Willow park is a community house for five adults both male and female with an intellectual disability. It is situated in Co. Dublin on a quiet residential road five minutes walk from local shops, take away restaurants, pub and pharmacy. The area is well serviced by public transport and is close to local amenities such as a swimming pool, and local shopping centres. The house is an extended double fronted single story home comprising of two living rooms, five bedrooms, three bathrooms and a staff office/sleepover room. There is a patio area leading off the living room that can be used for dining and relaxing. The house is staffed by a person in charge and social care workers who are available to support residents on a 24 hour basis. Staff have access to nursing support through a nurse on call service. The house has its own mini bus which is used to support residents to attend day services, appointments and community based activities.

The following information outlines some additional data on this centre.

Current registration end date:	16/12/2018
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
05 September 2018	09:00hrs to 16:30hrs	Marie Byrne	Lead

Views of people who use the service

The inspector had the opportunity to meet and spent some time with all five residents during the inspection. Throughout the inspection residents appeared relaxed and comfortable with the support offered by staff.

As part of the inspection the inspector observed parts of residents' daily lives such as mealtimes and relaxation time. Residents were actively encouraged and supported in all aspects of running the house from preparing meals, shopping and cleaning, to choosing the furnishings and decoration. Residents decided on activities and daily routines. Any residents who required additional support to communicate were provided with pictures or objects as points of reference.

The inspector reviewed satisfaction questionnaires which residents were supported to complete prior to the inspection. Overall, the feedback in these questionnaires was positive and residents were complimentary towards the care and support they received. A number of residents indicated in the questionnaires that they would like more regular staff to facilitate more meaningful activities in the community during the week. The opinion of residents' representatives was sought through questionnaires sent as part of the annual review of care and support. The feedback from these questionnaires was very positive and particularly complimentary towards staff in the centre, how welcome they felt and the open and effective communication in the house.

Capacity and capability

Overall, the inspector found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents. However, staffing vacancies were negatively impacting continuity of care for residents and resulting in a reduction of time available to staff to support residents to engage in meaningful activities.

There were clearly defined management structures which identified the lines of authority and accountability. 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 meeting every six to eight weeks to discuss residents' needs, personal plans, family input, clinical supports, audits, budgets, health and safety, safeguarding, and other issues as they arise. On reviewing the minutes of these meetings the inspector found that they were identifying areas for further development in line with the findings of this inspection.

Overall, the inspector found that the designated centre was well managed and that this was bringing about positive outcomes for residents. However, the person in charge was not being afforded the opportunity to complete sufficient administration hours to consistently and effectively monitor all aspects of care and support for residents.

There was an annual review of the quality and safety of care and six monthly visits by the provider or their representative. The inspectors found that learning and improvements were brought about as a result of the findings of these reviews. There were also audits completed by the person in charge and evidence of follow up on actions from these audits. Staff meetings were held regularly and the agenda items were found to be resident focused.

There were two staffing vacancies at the time of the inspection. There had been three vacancies but the provider had recently redeployed a staff member from another area to fill one of these vacancies. The provider was in the process of recruiting to fill these positions and was attempting to minimise the impact of these vacancies on residents by staff completing additional hours and by using regular relief and agency staff. However, due to the volume of shifts covered by relief staff and agency staff residents were being negatively impacted. Continuity of care was particularly important to a number of residents in line with their changing needs.

The inspector found that residents appeared happy, relaxed and content. Staff members were observed by the inspector to be warm, caring, kind and respectful in all interactions with residents. Each staff member who spoke with the inspector was knowledgeable in relation to their responsibilities and residents' care and support needs. Staff had all completed training and refreshers in line with residents' needs and were in receipt of support and supervision provided by the person in charge and service manager.

Residents were protected by policies and procedures to guide staff in delivering safe and appropriate care and support. The provider had ensured that schedule 5 and other relevant area specific policies and procedures were in place. Residents were also protected by appropriate insurance against risks.

Regulation 15: Staffing

The inspector found that staff were suitably qualified and had the right skills to support residents. However, due to two staff vacancies there were not the right number of staff to ensure continuity of care and support for residents. Planned and actual rosters were maintained by the person in charge.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector found that staff had the required competencies to manage and deliver person-centred, effective and safe care and support for residents. They had access to training and refreshers in line with residents' needs and were in receipt of formal supervision and support from the person in charge and service manager.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was available and contained the information required by the regulations.

Judgment: Compliant

Regulation 22: Insurance

There was written confirmation of insurance cover which included details of insurance against risks in the centre including accidents or injuries to residents.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that there were appropriate governance and management structures in place. However, due to staffing vacancies the required resources were not available to ensure consistent and effective monitoring of care and support for residents. There was an annual review of care and support and six monthly visits by the provider with evidence of follow up on actions from these reviews. The person in charge and service manager were meeting regularly and recognising areas for improvement and putting plans in place to make these required improvements.

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 4: Written policies and procedures

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

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents lived in a warm, comfortable and relaxed home. The existing staff team were attempting to support residents to engage in meaningful activities and to live a life of their choosing. However, due to staffing vacancies residents were not getting and opportunity to engage in as many community based activities as they would like to.

The premises was found to be clean, spacious, well designed, homely and meeting residents' specific care and support needs. Each resident had their own bedroom which was decorated in line with their wishes and preferences. Residents had plenty of storage for their personal items and to display their pictures. There was a private space available for residents to meet their visitors if they so wished. There were areas in need of maintenance and repair such as painting and repair following removal of a press in the kitchen and following works completed to an external door. The flooring in the main bathroom was worn and in need of replacement.

The inspector reviewed a number of residents' personal plans and found them to be person-centred. Each resident had access to a keyworker to support them and had an assessment of need which outlined which care and support plans they required. The inspector reviewed a number of residents' personal plans and found that care plans were in place in line with residents' assessed needs. However, improvement was required in relation to recording residents' social goals and in relation to consistency across documentation in some residents' personal plans. In addition improvement was required in relation to reviewing residents' support plans to ensure they were effective. In line with the findings of this inspection the provider had recognised the need for staffing resources to support residents to engage in meaningful activities. From discussions with residents and the staff it was evident

that residents were attending events and concerts. However, there were limited opportunities for residents to engage in community based activities during the week due to residents' changing needs and current staffing levels.

Residents' healthcare needs were appropriately assessed and support plans were in line with these assessed needs. Each resident had access to appropriate allied health professionals in line with their assessed needs. Meal times were observed to be a positive and social event.

The inspector found that the provider and person in charge were promoting a positive approach to responding to behaviours that challenge. Residents' positive behaviour support plans clearly guided staff practice in supporting residents to manage their behaviour and they were reviewed regularly. Staff who spoke with the inspector were knowledgeable in relation to residents' behaviour support needs in line with their positive behaviour support plans. The inspector found that there were no restrictive practices on the day of inspection.

The provider and person in charge had systems to keep residents in the centre safe. There were policies and procedures in place and safeguarding plans were developed as necessary in conjunction with the designated officer. Staff were found to be knowledgeable in relation to keeping residents safe and reporting allegations of abuse. The inspector reviewed a number of residents' intimate care plans and found they were detailed and guiding staff practice in supporting residents. However, one intimate care plan required review to ensure that it clearly guided staff practice in relation to one residents' wishes and preferences.

Residents were protected by policies, procedures and practices relating to health and safety and risk management. There was a system for keeping residents safe while responding to emergencies. There was a risk register which was reviewed regularly by the person in charge and service manager. General and individual risk assessments were developed and there was evidence that they were reviewed regularly and amended as necessary. There were also systems to identify, record, investigate and learn from adverse events in the centre.

There were suitable arrangements to detect, contain and extinguish fires in the centre. Works had been completed in relation to fire containment since the last inspection. Suitable equipment was available and there was evidence that it maintained and regularly serviced. Each resident had a personal emergency evacuation procedure. Fire procedures were available in an accessible format and on display. Staff had completed fire training and fire drills and fire walks were occurring.

There were policies and procedures in relation to medicines management and suitable practices in relation ordering, receipt, storage, and disposal of medicines. However, on reviewing a number of medication prescriptions and administration records the inspector found that one residents' eye medication was not being administered as prescribed. In addition, the inspector found a number of documentation errors which had not been recognised or reported. The inspector reviewed these errors with the person in charge during the inspection and

assurances were provided that the errors did not reach the residents involved and were in fact documentation errors. Audits were completed regularly and there was evidence of review of these incidents including discussions relating to learning following incidents at staff meetings. However, these audits were not picking up on documentation errors in the centre.

Regulation 17: Premises

Overall, the inspector found that there was adequate private and communal space for residents and that the physical environment was clean. However, there were a number of areas in need of maintenance and repair as outlined in the body of the report.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The safety of residents was promoted through appropriate risk assessment and the implementation of the centres' risk management and emergency planning policies and procedures. There was evidence of incident review in the centre and learning from adverse incidents.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements to detect, contain and extinguish fires in the centre. Works had been completed in relation to fire containment in the centre since the last inspection. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Staff had appropriate training and fire drills were held regularly. Residents' personal evacuation plans were reviewed regularly.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate policies, procedures and practices relating to the ordering,

receipt, prescribing, storage and disposal of medicines. Audits were completed regularly in the centre. However, there were a number of documentation errors which were not being picked up on and one resident was not receiving one medicine as prescribed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans were found to be person-centred and each resident had access to a keyworker to support them with their personal plan. There was an assessment of need in place for residents which were reviewed in line with residents' changing needs. Support plans and risk assessments were developed in line with residents' assessed needs. However, improvement was required to documenting residents' social goals, to ensuring information was consistent across all documentation in residents' personal plans and in reviewing support plans to ensure they were effective.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had appropriate assessments completed and were given appropriate support to enjoy best possible health. Residents' changing needs were recognised and appropriate assessments and supports put in place. Residents had access relevant allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider and person in charge promoted a positive approach in responding to behaviours that challenge. Residents had positive behaviour support plans which clearly guided staff to support them to manage their behaviour. Staff who spoke with the inspector were found to have the up-to-date knowledge and skills to support residents to manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

There were policies and procedures to keep residents safe. Staff had completed training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff who spoke with the inspector were knowledgeable in relation to recognising and reporting suspicions or allegations of abuse.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Willowpark OSV-0002372

Inspection ID: MON-0021671

Date of inspection: 05/09/2018

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

- The Person in Charge will continue to ensure that there is a planned and actual roster in place in the designated centre, clearly identifying the day and night duty shifts.
- Relevant and up to date documentation in line with schedule 2 on all staff is kept within the HR department and available to review on request

In response to the area of non-compliance found under regulation 15 (1):

The Registered Provider will recruit appropriately qualified and experienced staff members to the two staff vacancies in the Centre, to ensure that the assessed needs of the residents are met, in line with the Centre's statement of purpose.

In response to the area of non-compliance found under regulation 15 (3):

The Person in Charge, Service Manger and HR will complete a roster review to ensure residents receive continuity of care and support, particularly where staff are employed on a less than full time basis

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- There is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability

- 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.

- The Person in Charge will continue to have regular staff meetings and discuss areas of quality and safety improvement for the residents of the centre

In response to the area of non-compliance found under regulation 23 (1)) (a):

- The Registered Provider will recruit appropriately qualified and experienced staff members to the two vacancies in the Centre, to afford the person in charge adequate rostered management time, to ensure consistent and effective monitoring of care and support for residents in the centre.

In response to the area of non-compliance found under regulation 23 (1) (c):

- A Quality Enhancement Plan (QEP) will be 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.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

- The premises is designed and laid out to meet the current residents' needs and decorated in a manner of their choosing.

- The Person in Charge will continue to ensure the centre is clean and suitably decorated to the residents' needs and requests.

- The registered provider will continue to ensure provisions relating to schedule 6 are maintained for the centre

In response to the area of non-compliance found under regulation 17(b):

The Person in charge has contacted the Technical Services Department to request that the required painting be carried out in the Kitchen \ dining area, and that the bathroom and hall flooring be replaced.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- The registered provider and the Person in Charge will continue to ensure all residents in the designated centre have access to a pharmacist of their choice in the local community.

- The Person in Charge has a system for the recording for each resident prescribed and administered medication and these are kept in a secure location within the designated centre.

- The Organisation has a policy & procedure in place for the Safe administration of Medication, which is underpinned by national policy. This policy guides practices relating to the management of medication: ordering/ receipt/ prescribing/ storing/disposal and administration of medication is in line with best practice.

- The Person in Charge will continue to ensure that all staff receive training in the safe administration of medication.

In response to the area of non-compliance found under regulation 29(4)(b):

- The Person in Charge will review the centre's systems and practices, relating to the ordering, receipt, prescribing, storage, disposal and audit of medication, to ensure that they comply with the Provider's policies and procedures.

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 all residents in the centre have comprehensive personal plans in place outlining their needs and supports in accordance with their wishes.

- The Person in Charge will continue to ensure that the designated centre is suitable for the purpose of meeting each residents support needs.

- The Person in Charge will continue to ensure that personal plans are available to the resident and their representative in an accessible format meaningful to them as an individual.

- The Person in Charge will continue to ensure that all residents are involved in the person centered planning process and an annual outcome review meeting takes place with the involvement of MDT team as appropriate. The resident is supported to attend this meeting and any changes in meeting the needs of the resident will be documented, clearly identifying the person responsible for meeting the agreed objectives and within the agreed timescale

In response to the area of non-compliance found under regulation 05(6)(c):

- The Person in charge will ensure that the progression of social goals is clearly documented to reflect the most up to date information, to outline the resident's experience, and to demonstrate the effectiveness of each goal.

In response to the area of non-compliance found under regulation 05(6)(d):

- The Person in Charge will monitor the progress of goals and related documentation, at bi-monthly supervision and support meetings with each key-worker.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- The organization has a policy in place for the Protection of Adults from Abuse and Neglect this reflective of National Safeguarding Vulnerable Persons at Risk of Abuse Policy.

- Through residents meetings, each resident is supported to develop skills so that they have knowledge and skills to promote their personal self care and protection.

- Where there are any incidents, allegations or suspicion of abuse, the PIC will ensure this is reported to the Designated Officer and notifications are made to the authority.

- Safeguarding training for all staff has been completed.

In response to the area of non-compliance found under Regulation 08(6):

The Person in charge will ensure that intimate care plans for all residents, are clear, comprehensive, up to date, and reflective of the needs, wishes and preferences of each resident, so as to clearly guide staff practice.

The PIC will further ensure, that safeguarding measures are in place in the centre to ensure that staff providing intimate care to residents, do so in a manner which respects each resident's dignity and bodily integrity.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2018
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/10/2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/10/2018
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/12/2018

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	31/10/18
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	14/09/2018
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/10/2018
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/10/2018
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	31/10/2018