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:	Glenmalure
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	16 August 2018
Centre ID:	OSV-0002386
Fieldwork ID:	MON-0021679

About the designated centre

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

Glenmalure is a designated centre, located in a campus setting, that provides residential support and care to up to six adults with an intellectual disability. Glenmalure can also support residents with additional healthcare, mental health or behaviour support needs. Glenmalure is fully wheelchair accessible and can provide support to residents with mobility needs. The service provided is nurse led; and a team of nurses, social care workers, and healthcare assistants provide full time care and support to residents. Glenmalure can provide day service support for residents where required. It is located in close proximity to a busy North Dublin suburb, and there are a range of amenities in the locality for residents to utilise.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
16 August 2018	10:05hrs to 17:30hrs	Amy McGrath	Lead

Views of people who use the service

The inspector met with four of the six residents who live in the centre. Some residents spoke to the inspector, and others were supported by staff to engage with inspectors in a manner that suited them.

Residents were observed to be comfortable in their homes, and engaged in the daily running of the centre. Some residents were at home at the time of inspection, as they had personalised day programmes to meet their individual needs. Residents spoken with said that they liked living in the centre, and that they liked the staff that worked there. Residents told the inspector that they felt their needs were being met, and that they felt safe. Residents told the inspector that they enjoyed going out in their local community, and discussed recent trips and holidays they had been on. Residents were satisfied with the food provided, and felt there was sufficient choice offered to them.

Capacity and capability

Overall, the governance and management arrangements ensured that a safe and good quality service was delivered to residents. The provider had adequately addressed all actions from the previous inspection. There were improvements required to the statement of purpose, to ensure that that it contained accurate information. Staff supervision arrangements required review, and there were some improvements required to ensure that the annual review sufficiently evaluated the quality and safety of the centre.

A statement of purpose was available which was reviewed at regular intervals. While it contained most of the information required by Schedule 1 of the regulations, some of the information was not accurate and required review. For example, the information regarding the whole time equivalent staffing complement and named management roles within the organisational structure were not accurate, and the description of the premises was found not to accurately reflect the facilities provided. These issues were addressed on the day of inspection.

There was a well defined management structure, and clear lines of accountability and authority. Staff spoken with were knowledgeable of their role and responsibilities, and were confident that they could raise any concerns regarding the quality or safety of the service.

The service was managed by a person in charge, who was supported in her role by a clinical nurse manager (CNM) 1. The person in charge managed a team of nurses, social care workers, and health care assistants. The inspector found that the person

in charge had the appropriate skills, experience and qualifications to manage the service.

There were sufficient staff present to ensure that the needs of residents were met, including additional staff to support residents day programmes. The skill mix and qualifications of staff were found to be sufficient to meet the assessed needs of residents. There was a well maintained planned and actual roster, and there were arrangements in place to ensure continuity of care for residents during periods of staff absence. A review of staff records found that the information required by Schedule 2 of the regulations had been obtained for staff.

Staff had received all mandatory training, such as safeguarding adults, and fire safety, and there was a schedule of refresher training in place. While staff received informal supervision on a regular basis, the formal supervision arrangements required improvement. The frequency and quality of supervision varied significantly amongst staff members. In once case, a staff member had attended two meetings this year, and the majority of fields on the recording form were blank. Improvements were required to ensure that the supervision mechanisms were effective inappropriately supervising staff.

The provider had carried out unannounced audits on a six monthly basis, and had conducted an annual review of the quality and safety of the centre. The inspector found that the annual review did not contain sufficient detail to effectively evaluate the service, and for the most part was a reiterance of some findings from other internal and external audits. While there were some actions identified following the review, it was unclear as to how they had been derived, or what plans were in place to address the identified deficits. The quality of the annual review did not have a direct impact on the quality and safety of care received by residents, as there were a suite of other audits and reviews carried out at local level that identified and addressed deficits; however the annual review required improvement to ensure that it accurately and comprehensively evaluated the quality and safety of the service.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced to manage the centre.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staff, with the appropriate skill mix, to meet the assessed needs of residents. A review of a sample of staff files found that the records required

under Schedule 2 of the regulations had been obtained.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records found that all staff had received mandatory training, such as safeguarding adults, and fire safety. Refresher training was facilitated where necessary. While there was a schedule of supervision in place, and evidence that staff received supervision, the quality and frequency of formal supervision for staff members varied significantly and required review.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the governance and management arrangements ensured that residents received a high quality, safe service. The provider had carried out an annual review of the quality and safety of the service, however this did not contain sufficient detail to effectively evaluate the quality or safety of the service.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre had a statement of purpose in place which was reviewed at regular intervals, however it did not contain all of the information required as set out in Schedule 1 of the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A complaints policy, and an accessible complaints procedure was available. Complaints were managed promptly, and a detailed record of all complaints was maintained.

Judgment: Compliant

Quality and safety

Residents received care and support that was person centred and of good quality. Residents' safety was maintained, although there was some improvement required in this area in relation to documentation. Overall, risk was well managed, and residents enjoyed engaging in activities both within their home and in the community. Staff spoken with had good knowledge of residents' needs, and supported them to realise self-led goals and aspirations. There were some issues identified in relation to fire safety, however these had been identified by the provider and plans in place to address areas of concern were implemented shortly after the inspection.

The design and layout of the premises was suitable in meeting the needs of residents. The provider had ensured that the premises was accessible to all residents, and where required, residents had access to assistive aids and devices. Although the centre was well maintained and clean, there was improvement required in some areas of the premises to ensure it was appropriately decorated in a homely manner.

The risk management practices had ensured that risk was managed appropriately. Residents were supported to take positive risk, and there were supports in place to maximise independence and minimise risk. The person in charge regularly reviewed records of incidents and accidents, and emergent risks were identified on an ongoing basis. There was a live risk register, which was reviewed by a senior manager on a quarterly basis. The inspector found that the arrangements in place were effective in identifying, assessing, and managing risk. There was a risk management policy that contained the prescribed information as set out in the regulations.

The inspector reviewed the positive behaviours supports, and found that residents who had needs in this area were supported appropriately. Staff had received training in positive behaviour support, and support plans were informed by an appropriate allied health professional. There were some restrictive practices in use, and these were utilised with informed consent from residents, and reviewed regularly. The inspector found that where restrictive procedures were utilised, there had been efforts to identify and alleviate contributing factors to residents behaviour support needs, and alternative measures had been utilised prior to a restrictive procedure being used.

The needs of residents were comprehensively assessed prior to admission, and on an on-going basis. There were support plans for any identified need, in areas such as health-care, communication, and community participation. Residents contributed to the development of their personal plans, and identified goals that maximised self-development according to their needs and preferences. There were accessible

versions of personal plans available for residents. For example, the personal plan for one resident with a visual impairment was recorded and available in audio format.

The communication needs of residents were assessed on an annual basis, and there were support plans to guide staff in supporting residents appropriately. Each resident had a communication passport, which outlined the residents preferred methods of communication, and level of support required. These plans were developed with input from a speech and language therapist.

The inspector found that residents' privacy and dignity was maintained and respected in the centre. Residents participated in the daily running of the centre, and there were weekly residents meetings where residents discussed plans for the week ahead and decided on preferred meals. Residents were involved in purchasing and preparing food. Residents were supported to exercise choice and autonomy, and had access to information regarding advocacy services.

There were systems to safeguard residents; all staff had received training in safeguarding adults, and staff spoken with were aware of their responsibilities and roles in relation to safeguarding residents. The centre had a named designated officer, and safeguarding concerns were escalated and managed appropriately as per national policy. Where safeguarding concerns had been identified, residents had safeguarding plans. However the inspector found that these did not contain sufficient detail of the measures to protect residents, and did not adequately guide staff in this area. Residents were supported to develop the knowledge and self awareness for self care and protection.

There were fire safety management systems, including regular reviews of fire safety. Residents took part in fire drills, and there were personal emergency evacuation plans for residents that accurately reflected their support needs. All staff had received fire safety training. There were arrangements for detecting and containing fire, and while the inspector found some deficits in this area, the provider had identified them previously as part of their fire safety review systems, and there were plans to address these issues; works were carried out and completed in the days following the inspection. The interim fire safety measures were adequate in ensuring that residents were safe.

Regulation 10: Communication

The actions required from a previous inspection had been satisfactorily implemented. The inspector found that communication needs were supported appropriately, and in a person centred way. Residents had communication passports in place, and efforts were made in the centre to ensure that information was available to residents in a format that they could understand.

Judgment: Compliant

Regulation 17: Premises

For the most part, the design and layout of the centre was suitable in meeting the assessed needs of residents. There were some improvements required in the general maintenance of the centre, and some rooms required further attention as they were not homely or suitably decorated.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The risk management practices in the centre were effective in identifying, addressing and monitoring risk.

Judgment: Compliant

Regulation 28: Fire precautions

There were fire safety management systems in place, and precautions had been taken against the risk of fire. There were some issues identified on the day of inspection that the provider had identified, and there was a plan of works in place. These issues were addressed in the days following the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment of need carried out prior to admission, and on an annual basis. There were personal plans in place for identified needs, that were sufficiently detailed to guide staff. Residents' personal plans were available in an accessible format according to their abilities and preferences.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff were trained in positive behaviour support and there were support plans for residents who had needs in this area. While there were some restrictive practices utilised, these were reviewed regularly as part of the personal planning process, and were implemented with the informed consent of residents.

Judgment: Compliant

Regulation 8: Protection

There were systems in place in the centre to safeguard residents. All staff had received training in safeguarding adults. Where necessary, there were safeguarding plans in place for residents, however they did not contain sufficient detail to effectively inform staff of the measures in place to protect residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The centre was operated in a manner that respected the rights of residents. Residents participated in, and consented to decisions about their care and support.

Judgment: 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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glenmalure OSV-0002386

Inspection ID: MON-0021679

Date of inspection: 16/08/2018

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge will continue to ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme. • Staff are informed of the Act and any regulation and standards made under it • Regulation 16(1) (b): The PIC will establish a Supervision system for all staff to receive formal support in line with SMH Supervision policy, same will be available in designated centre's diary to assure the supervision and support meetings are completed within the timeframe of 12 weeks, in line with the registered provider's 'Staff's Supervision and Support Policy' . • The PIC and staff member will complete in full all sections of the "Staff Support and Support Discussion Form" and the "SMH Supervision and Support Template", ensuring staff are supported in all areas of supervision. • The PIC and Service Manager will review supervision at their regular management meetings	
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 in accordance with the statement of purpose.

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

- Management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to the residents' needs, consistent and effectively monitored.

- Regulation 23 (1) (d) there is an annual review of quality and safety of care and support in the designated centre and that such care and support is in accordance with standards The Annual Review 2017 of the designated centre will be amended in the section of 'review of quality and safety'. More detail will be added in regards to findings of local audits and reviews, including smart action plans to ensure full compliance with Regulation 23. The Annual Review will be made available in the designated centre for review by the Authority. These amendments will be reflected in all Annual reviews.

- The Annual review will be prepared in consultation with residents and their representatives.

- The Annual review shall be made available to residents and available for review by the Authority.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

- The register provider has prepared in writing a statement of purpose containing the information set out in Schedule 1

- The statement of purpose is reviewed at intervals of not less than one year.

- The Statement of purpose is available to residents and their representatives.

- Regulation 3 (1). Amendments have been made within the Statement of Purpose regarding the following Schedule 1, Information required:

  2.(a) the specific care and support needs that the designated centre is intended to meet

  2.(b) the facilities which are to be provided by the registered provider to meet those care and support needs
  2.(c) the services which are to be provided by the registered provider to meet those care and support needs

  3. The number, age range and gender of the residents for whom it is intended

that accommodation should be provided.

6. The total staffing compliment, in full-time equivalents, for the designated centre with the management and staffing compliments as required in Regulations 14 and 15.

- The updated Statement of Purpose has been sent to the Inspector.

Regulation 17: Premises	Substantially Compliant

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

- The designated centre is laid out to meet the aims and objectives of the service and the number of residents.

- The premises is of sound construction and kept in a good state of repair externally and internally

- Regulation 17(1) (c): The centre is clean and well maintained and a cleaning roster is in place.

- Two missing lampshades have been installed and both shower curtains in bathrooms have been replaced.

- The PIC will liaise with residents and staff in relation to any suggestions they may have in relation to décor of the designated centre.

Regulation 8: Protection	Substantially Compliant

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

- Each resident is assisted and supported to develop the knowledge, self awareness and skills needed for self – care and protection.

  The register provider protects all residents from all forms of abuse, All staff have completed training in Safeguarding for adults, this is a fixed item on the staff meeting agenda. Safeguarding refresher is available as required to all staff.

  All staff faithfully follow the safeguarding policy, where there is an allegation or suspicion of abuse all staff will take appropriate action in line with the Safeguarding policy.

- Regulation 8(3): The PIC in consultation with the Service Manager and the Senior Social Worker will review all Safeguarding support plans which will be amended appropriately. More detail will be added, including Risk Assessments and preventative measures to support staff in providing a safe environment to all

residents of the designated centre at all times.

- PIC will continue to ensure regular reviews of incidents and clinical input from multidisciplinary team.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2018
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	25/08/2018
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/09/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	25/08/2018
Regulation 08(3)	The person in	Substantially	Yellow	10/10/2018

	charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Compliant		