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:	The Maples
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	31 July 2018
Centre ID:	OSV-0003601
Fieldwork ID:	MON-0021804

About the designated centre

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

The Maples is a designated centre which provides a residential service to five adults. The service can accommodate both males and females who have a moderate to profound intellectual disability and who may also have some mental health needs. This is a nurse led service and it can support individuals who have high medical needs such as epilepsy or diabetes, and who may also require positive behaviour support. Each resident has their own bedroom and there is suitable equipment such as hoists and hi-low beds to support residents who have increased mobility needs. Residents are supported by a range of nurses, social care workers and health care assistants with their daily needs. Social care is promoted in the centre and residents are supported to attend the community on a regular basis and to choose meaningful goals.

The following information outlines some additional data on this centre.

Current registration end date:	17/12/2018
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
31 July 2018	09:00hrs to 17:00hrs	Amy McGrath	Lead

Views of people who use the service

The inspector met with the five residents who live in the centre. Residents were supported by staff to engage with the inspector according to their preference and ability. Residents were observed in their home throughout the course of the inspection. The inspector observed residents going to their day services, and coming home from activities, at various times throughout the day. Residents appeared very comfortable in their homes. The inspector engaged with residents at meal times, and found that they were a pleasant experience. Residents were encouraged and supported to make decisions regarding their daily lives.

Residents views were also elicited from four resident questionnaires received, which were completed by residents with support of a family member. For the most part, residents were satisfied with the service provided. It was noted that residents were happy with the food in the centre, the activities and opportunities offered by the centre, and the level of support received. One resident commented that they particularly liked the garden in the centre. One resident's family member commented that the activities facilitated in the centre were limited due to staffing levels, although the resident did enjoy the activities they engaged in.

The inspector also spoke with a family member of one resident, who had concerns that this resident's full support needs were not being adequately met in this centre. While the family member felt that this resident was safe in their current home, they felt that it was not the most suitable placement to meet the resident's social care needs. The provider acknowledged that this resident was awaiting a vacancy in a centre that was more preferable to them and their family.

Capacity and capability

Overall, the inspector found that the governance and management arrangements in the centre supported the delivery of safe and quality care to residents. The provider had ensured that all actions required from a previous inspection had been addressed. The inspector found that there were some improvements required following this inspection, however, these issues were not having an impact on the care provided to residents. There were some improvements required to ensure that the statement of purpose contained all of the information required by the regulations. The arrangements for protected time for the person in charge to fulfil administration responsibilities also required review.

The centre had a clearly defined management structure, which identified lines of authority and accountability. There were reporting mechanisms in place, and staff

spoken with were aware of how to raise any concerns. The provider had carried out an annual review of the quality and safety of the service, and had conducted unannounced audits on a six monthly basis. These audits informed a quality enhancement plan overseen by the person in charge, and were found to affect positive change in the centre.

The provider had ensured that the centre was managed by a suitably skilled and qualified person in charge. The post of person in charge was full time, however, the person in charge was responsible for two designated centres, and the inspector found that the protected time available for the person in charge was not sufficient to ensure consistent oversight of the operational management and administration of both designated centres.

The person in charge was supported in their role by two clinical nurse managers (CNM1). The centre had twenty-eight hours per week as protected management time, between all three managers, and the remainder of managers hours were worked in a front-line capacity. The inspector was informed that the rosters in the centre were planned to ensure that there is a manager present at all times. A review of rosters found that for a period of twenty-eight days prior to the inspection, there was a manager present for seven days. As stated previously, the arrangements for protected time for managers was insufficient to ensure effective oversight of the centre.

The centre was staffed by a mixture of nurses, social care workers and care staff. The centre maintained a planned and actual roster, and the inspector found that there was sufficient staff to meet the assessed needs of residents. Staff had engaged in a programme of training and had received all mandatory training as set out in the regulations, including safeguarding adults, fire safety and positive behaviour support. The inspector reviewed the supervision arrangements in the centre, and found that there was a formal supervision process for staff and management. The person in charge was supervised by the service manager, and also received supervision from the director of nursing. Supervision records documented planned actions and included a review of progress of previous actions.

The centre had a complaints policy, and accessible procedures in place. Staff, residents and family members were encouraged to use the complaints process, and on review of the centre's complaints log, the inspector found that complaints were managed promptly, with the complainants satisfaction level recorded.

The centre was adequately insured against risk of accident or injury to residents. A statement of purpose was in place, that contained most of the information set out in Schedule 1 of the regulations. The information in the statement of purpose did not accurately reflect the management arrangements of the centre, and required review.

Regulation 14: Persons in charge

The person in charge was suitably skilled and experienced, and had ensured effective oversight of the centre. However, there was evidence that the level of oversight of the two centres that the person in charge was responsible for, could not be maintained within the protected hours of the person in charge.

Judgment: Substantially compliant

Regulation 15: Staffing

Sufficient numbers of suitably qualified and experienced staff members were available to meet the assessed needs of residents. There was a planned and actual roster, and arrangements were in place to cover staff leave whilst ensuring continuity of care.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff had received mandatory training, and there was a schedule of refresher training in place.

Judgment: Compliant

Regulation 22: Insurance

There was appropriate insurance in place against risks in the centre.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the governance and management systems had ensured that the service provided was safe and of good quality. There were some improvements required to

ensure that the service was effectively monitored.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained most of the information as set out in the associated Schedule. The information in the statement of purpose regarding staffing and management complements was not reflective of the actual arrangements.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had ensured that there was an effective complaints procedure in place. There was a nominated complaints officer, and the centre maintained a log of any complaints made.

Judgment: Compliant

Quality and safety

Overall, the care and support provided to residents was of good quality and was delivered in a safe and effective manner. The centre had risk management systems in place that protected residents from harm and promoted positive risk taking. Residents were engaged in the running of the centre, in accordance with their needs and wants, and were supported to maintain good health.

The person in charge reviewed accidents and incidents in the centre, and maintained oversight of risk. Risks were reviewed on an ongoing basis by the person in charge, and also on a quarterly basis with the service manager. The risk management system was effective in identifying emergent risks, and implementing appropriate control measures.

There were measures in place to safeguard residents, and all staff had received training in safeguarding adults. There was a designated officer in place, and concerns relating to safeguarding were escalated appropriately. Residents had safeguarding plans in place where necessary, and these were reviewed at clinic meetings. Each resident had an intimate care plan in place that detailed the level of

support required according to the residents needs and preferences.

Where required, residents had positive behavioural support plans in place, and these were reviewed by a multi-disciplinary team. Staff had received appropriate training to enable them to support residents who had needs in this area. There were a number of restrictive procedures in use and each of these had an associated risk assessment and support plan in place to guide effective use. The inspector found that these had been appropriately reviewed, and that efforts had been made to ensure that the least restrictive measure was utilised, for the shortest time.

Each resident had an assessment of need carried out on admission, and reviewed at least annually. These assessments identified support needs in a range of areas such as communication, social supports, and community participation. There were associated support plans in place for any assessed need identified, and these were sufficiently detailed to guide staff in meeting residents' needs.

Health-care needs were identified as part of the assessment of need process, and there was evidence that residents were supported to maintain good health. Residents had access to a general practitioner (GP) of their choice, for example, one resident attended a GP near their family home. Residents had access to a range of multi-disciplinary supports, such as physiotherapy and psychology. There was evidence that recommendations from health professionals were facilitated in the centre. For example, the inspector observed residents being supported to eat meals that were prepared in accordance with recommendations from a speech and language therapist or dietician.

The inspector reviewed the medication arrangements and found that there were appropriate arrangements for the ordering, storage, and administration of medicines. A stock check of PRN (medicine to be take as the need arises) medication found that the correct stock levels were in place. There were protocols in place to guide the use of PRN medicines for each resident.

Measures were in place to protect residents from the risk of fire. There were adequate measures for detecting and extinguishing fires, as well as sufficient containment measures. All staff had suitable training in fire prevention and emergency procedures. Residents took place in regular fire drills, and there were personal evacuation plans in place for each resident which were reflective of residents' support needs.

Regulation 26: Risk management procedures

Effective risk management arrangements were in place. The person in charge actively monitored and regularly reviewed the risks and a formal review of risk was conducted with the service manager on a quarterly basis.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had arrangements in place to ensure safe evacuation in the event of a fire. All staff had received training in fire safety.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents had a pharmacist available to them, and practices in relation to the ordering; receipt; storing; and administration of medicines were found to be appropriate.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were assessments of need completed for each resident, and personal plans in place that supported residents to maximise their personal development.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to maintain best health, and had access to allied health professionals in accordance with their individual needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, residents had comprehensive behaviour support plans in place. Restrictive measures were used where necessary, and in line with evidence based

practice.

Judgment: Compliant

Regulation 8: Protection

There were effective measures in place to safeguard residents, and all staff had training in safeguarding adults. Staff spoken with were aware of their responsibilities in relation to safeguarding residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially 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	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
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 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Maples OSV-0003601

Inspection ID: MON-0021804

Date of inspection: 31/07/2018

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • There is a full time Person in Charge in the designated Centre with the required experience and qualifications. **In response to the area of non-compliance found under regulation 14:(4)** • The person in charge shall ensure that sufficient protective hours will be allocated to ensure effective oversight of the centre. This will be reflected within the roster.	
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 available in the centre 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.

- All policies and procedures referred to in schedule 5 are updated and available within the centre.

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

- The PIC shall ensure that there will be sufficient protected hours allocated to ensure that the service is effectively monitored based on the needs of the service.

- Management of the roster is ultimately the responsibility of the Person in Charge (PIC). Rosters must be sent to the Service Manager for approval before being issued to staff and is completed 3 weeks in advance of the roster start date.

- A shift leader is identified on each shift to co-ordinate with the effective delivery of service.

Regulation 3: Statement of purpose	Substantially Compliant

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

- The registered provider has prepared in writing a Statement of Purpose for the designated centre and this is available to residents and their representatives .

- The statement of Purpose has been reviewed on an annual basis

In response to the area of non-compliance found under regulation 3 (1):

- The Statement of Purpose has been reviewed and now contains the information set out in Schedule 1, including the actual staffing and management compliments within the designated centre.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	19/08/2018
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	19/08/2018
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	28/09/2018