Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Issued by the Chief Inspector

Name of designated centre:	B Canices Road
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	12 February 2020
Centre ID:	OSV-0002333
Fieldwork ID:	MON-0026216

About the designated centre

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

B Canices Road is a designated centre operated by Saint Michael's House located in North County Dublin. It provides community residential services to four adults who have varied support requirements. The centre is a two story house comprising of a kitchen/dining room, a sitting room, a utility room, a staff sleep over room/office, shared bathroom and four bedrooms. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as 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
Wednesday 12 February 2020	10:15hrs to 18:15hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the four people availing of the service. Some residents expressed that they want limited engagement with the inspector and their choice was respected. The inspector observed residents and their interactions with their peers and staff throughout the course of the inspection.

The inspector spent time in the kitchen/dining room of the centre and spoke with residents about what it was like living in the house. Residents spoken with said they were happy with the supports they received and the staff supporting them. Residents told the inspector about their work and others spoke about the day services they attended. Residents also spoke about previous and planned holidays, and activities that they enjoyed including karate and TV programmes they enjoyed.

Some residents showed the inspector photos of their holidays, recent significant birthdays and family events. On the day of the inspection, residents were observed engaging activities of daily living including doing their laundry and preparing meals. In addition, residents were observed accessing the local community and the residents informed the inspector of their plans to go out for dinner that evening in a local restaurant. The inspector observed that residents appeared comfortable in their home and were supported by the staff team in a person centred manner.

The designated centre was decorated in a homely manner. Some residents showed the inspector their bedrooms which were decorated in line with their tastes and preferences. However, some areas of the centre required modernisation for example, a bathroom and bedroom which the provider had also identified in their internal audits.

Capacity and capability

The governance and management systems in place ensured that the service was monitored to ensure the effective delivery of care and support in line with the assessed needs of residents. Residents spoken with told the inspector that they were satisfied with the service they received. However, some improvement was required in relation to the staffing arrangements.

There was a clearly defined management structure in place. The centre was managed by two suitably qualified and experienced people in a job share arrangement. The persons in charge demonstrated good knowledge of the residents and their support needs. There were a number of quality assurance audits in place including six-monthly unannounced provider visits and an annual review for 2018 in

line with the regulations. The annual review for 2019 was in draft at the time of the inspection. In addition, local quality audits were in place including health and safety and medication management. These audits identified areas for improvement and there was evidence of action plans being developed.

The person in charge maintained a planned and actual roster for the designated centre. A review of the roster demonstrated that there was an established staff team in place and continuity of care was maintained. The inspector spoke with a number of staff members who demonstrated a good knowledge of the residents and their needs.

The previous inspection found, based on the findings of the provider's annual review, that additional staffing was required to meet the needs of residents. The provider had made two applications to their funding agency for an increase in staffing resources for the centre. This had yet to be secured at the time of the inspection. There was evidence of the roster being reviewed and a change of shift patterns to best meet the needs of residents. However, on the day of the inspection, it was not demonstrated that the current whole-time-equivalent staffing levels for the centre ensured residents' identified needs could be met at all times.

There were systems in place for the training and development of the staff team. The inspector reviewed a sample of the training files and found that the staff team had up-to-date mandatory training which included the safe administration of mediation, fire safety management and safeguarding. There were also arrangements in place for the supervision of the staff team which discussed areas including roles, responsibilities and well-being. From a sample of supervision records reviewed, the staff team were provided supervision in line with the provider's policy.

The inspector reviewed a sample of adverse incidents and accidents occurring in the centre and found that all incidents were notified to the Office of the Chief Inspector as appropriate under Regulation 31.

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team which ensured that the staff team had up-to-date mandatory training.

There were arrangements in place for the appropriate supervision of the staff team.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance and management structure in place. There were quality assurance audits in place and these audits identified areas for improvement and there was evidence actions plans were being developed and implemented.

Judgment: Compliant

Regulation 31: Notification of incidents

All adverse incidents and accidents occurring in the centre were notified to the Chief Inspector as appropriate.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster for the designated centre. A review of the roster demonstrated that there was an established staff team in place and continuity of care was maintained. However, it was not demonstrated that the current whole-time-equivalent staffing levels ensured that the residents' identified needs could be met at all times.

Judgment: Substantially compliant

Quality and safety

The management systems in place ensured the service was effectively monitored and provided a safe, appropriate care and support to residents. However, some improvement was required personal plans, fire safety and premises.

The inspector reviewed a sample of personal plans and found that an up-to-date assessment of need had been completed for each resident. The assessments identified residents' health and social care needs and informed the resident's personal plan. From a sample reviewed, the personal plans were up to date and guided the staff team to support residents with their identified needs. However, the inspector found that one personal plan for an identified need required review to ensure that arrangements were in place to maximise a resident's personal development in line with their wishes.

There was evidence that residents were supported to manage their healthcare

conditions and had regular access to appropriate allied health professionals. The healthcare plans in place were up to date and suitably guided the staff team to support residents with identified healthcare needs.

There were positive behavior planning in place to support residents manage their behaviour where required. The previous inspection identified that the dignity and rights of one resident was not upheld in the use of a strategy for the management of behaviour of distress. This had been addressed by the provider by supporting the resident to access an external advocate and reviewing the strategy with appropriate allied health professionals. The centre promoted an environment free from restraint and the inspector found good practices in place to identify and review possible restrictive practices. In addition, there was evidence that residents were supported to develop the skills and knowledge to remove/reduce an identified restriction.

There were systems in place to safeguard residents. The inspector reviewed a sample of incidents and found that they were being reviewed by the person in charge and managed appropriately. There was evidence of safeguarding measures in place to manage identified safeguarding concerns. For example, each resident had a safeguarding plan in place. Staff spoken with were clear in what constituted abuse and what to do in the event of an allegation or concern. The residents spoken with said they were happy in the house and were observed to be comfortable in their home.

There were systems in place for the assessment, management and ongoing review of risk. The person in charge maintained a risk register which identified general risks and the controls in place to mitigate or remove the risk. In addition, individual risk assessments were in place which included risk of choking, falls and behaviour that challenges. The inspector found that overall risk was well managed in the designated centre.

The inspector completed a walk through of the premises and found that the centre was decorated in a homely manner. However, as noted above, some areas of the centre required modernisation including a resident's en-suite shower and painting in one bedroom. This had been identified by the provider through their own audits and plans were in place to address this.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Centre records demonstrated that fire evacuation drills were completed regularly. Each resident had an up-to-date Personal Emergency Evacuation Plan (PEEP) in place which outlined the plan in place to evacuate the designated centre.

However, the plans in place to evacuate residents required review as some personal evacuation plans did not appropriately guide the staff team to support all residents to evacuate. For example, one plan stated that a resident, with a bedroom upstairs, would go to another bedroom and await fire services in the event of an fire. The inspector was informed that this was also the plan for the two other residents with

bedrooms upstairs however, this was not outlined in their plans.

In addition, the utility room in the designated centre had the potential of impacting on the evacuation route from the centre should a fire start in this location. While, there was evidence of nightly checks to ensure the equipment stored in this room was switched off and fire doors were in place to provide containment of fire and smoke, it was not evident, on the day of inspection, that containment measures were in place for all aspects of the utility room space to prevent the spread of fire and smoke.

Following the inspection, HIQA wrote to the provider and requested a review, by an appropriately qualified fire safety engineer, of the evacuation plan(s) for the centre and an assurance regarding the containment measures of the utility space. Following this review, the provider would be required to address fire safety improvement measures, if any, on foot of the fire safety engineer's assessment.

The inspector reviewed a sample medication management practices which were identified as requiring improvement in the previous inspection. The medication was stored securely and a new combination lock had been installed for the secure storage of keys to the medication press. The inspector reviewed a sample of medication administration sheets and found that maximum dosages were listed for PRN medications. Also, self-administration of medication assessments had been completed with each resident. However, some improvement was required in supporting residents to take control of their own medication in accordance with their wishes. This is referred to under Regulation 5,

Regulation 17: Premises

The designated centre was decorated in a homely manner and well maintained. However, some areas of the centre required modernisation.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to assessment, management and ongoing review of risk.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management including suitable fire safety equipment and regular fire evacuation drills. However, the plans in place to evacuate the designated centre in the event of a fire required review. In addition, it was not evident that containment measures were in place for all aspects of the utility room space to prevent the spread of fire and smoke.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was appropriate and suitable practices for the ordering, receipt, prescribing, storage, disposal and administration of medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need had been completed for each resident. The assessments identified residents' health and social care needs and informed the resident's personal plan which were up to date and guided the staff team. However, a personal plan required review to ensure that arrangements were in place to maximise a resident's personal development in line with their wishes.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were managed to an adequate standard. Residents were supported to manage their healthcare conditions and had regular access to appropriate allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behavior supports in place to support residents manage their

behaviour where required.

The centre promoted an environment free from restraint. Possible restrictive practices were suitably identified and reviewed.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence of safeguarding measures in place to manage identified safeguarding concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 15: Staffing	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for B Canices Road OSV-0002333

Inspection ID: MON-0026216

Date of inspection: 12/02/2020

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider and the PIC with review the roster to ensure the needs of the resident's is met.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider and the PIC will complete a schedule of works to upgrade the premises.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(3)(a) The Registered Provider Fire Prevention officer has provided the inspectorate with assurances in relation to concerns outlined in the report. Regulation 28(3)(d) The PIC has reviewed the PEEPS with the staff team and Fire Prevention Officer and updated as appropriate	

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: Regulation 05(4)(b) The PIC and key-worker will review the resident's personal plan to ensure that his preferences to develop his skills is maximised	

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.	Substantially Compliant	Yellow	31/12/2020
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.	Substantially Compliant	Yellow	31/07/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	27/02/2020

	containing and extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	11/03/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/03/2020