Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	The Beeches
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Announced
Date of inspection:	22 November 2018
Centre ID:	OSV-0002342
Fieldwork ID:	MON-0021656

About the designated centre

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

The centre is operated by St Michael's House and consists of a large two storey detached house located in North Dublin. It is close to local amenities. A service vehicle is available for residents use. The centre currently provides care to seven male and female residents who have an intellectual disability with associated complex needs. There are currently two vacancies in the centre.

The following information outlines some additional data on this centre.

Current registration end date:	09/06/2019
Number of residents on the date of inspection:	7

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
22 November 2018	09:00hrs to 17:55hrs	Amy McGrath	Lead
22 November 2018	13:50hrs to 17:55hrs	Marie Byrne	Support

Views of people who use the service

Inspectors met with six of the seven residents who live in The Beeches. Some residents spoke with inspectors, and others communicated with inspectors with support from staff. Residents spoken with told inspectors they were happy living in their home. Some residents showed inspectors their personal plans, which were available in accessible formats appropriate to residents' needs.

Inspectors observed that residents appeared comfortable in their home throughout the course of the inspection. Interactions between staff and residents were observed to be respectful and considerate. Inspectors found that residents actively participated in the daily running of the centre, and were involved in activities such as grocery shopping and preparing meals.

Capacity and capability

Overall, the governance and management systems in place were effective in ensuring that residents' needs were being met in a safe manner, however there were some concerns regarding the quality of oversight in some areas. The provider had ensured the centre was adequately resourced with sufficient staff who were appropriately trained. Improvements were required in relation to notifications, review of a number of policies, and the statement of purpose.

The centre was managed by a person in charge, who was a clinical nurse manager 2 (CNM 2), who supervised a CNM 1, a team of nurses, social care staff and health care assistants. There was also a part time cleaning staff, and catering staff employed to support residents in these areas. The person in charge was supervised by a service manager, who in turn reported to a director of adult care.

There were sufficient staff available to meet the assessed needs of residents, and this was evident from speaking with staff and residents, and in the quality of the day to day care delivered to residents. Staff had received all mandatory training, and there was a schedule for refresher training in place. The supervision arrangements in place were effective in supporting staff development, and records of supervision meetings showed that supervision occurred regularly, and was of good quality.

The provider had carried out an audit of the centre prior to the inspection, and identified areas for improvement, most of which had been acted upon. Some findings from this audit were issues that had been previously identified through

other mechanisms, such as the provider six-monthly review, and had not been followed up on. For example, it had been recorded, in a number of audits, that the systems in place for managing residents' finances were neither robust or effective. Multiple practices were identified that were outside of the organisation's policy, and the recording systems did not protect residents from the risk of financial abuse. This issue had not been acted upon, despite being identified numerous times.

Furthermore, the inspectors found that the provider's policy on resident's personal property, personal finances and possessions had not been reviewed and updated in accordance with best practice. The procedures in place did not promote residents as being active participants in decisions about their finances. The organisation's policy on safeguarding adults contained information that was contradictory to national policy, and did not guide staff practice. All other policies and procedures as set out in Schedule 5 of the regulations were in place and had been updated within an appropriate scheduled time-frame.

The provider had prepared a statement of purpose, and for the most part, it contained the information required, and accurately reflected the service being provider. Some information was inaccurate, and this was corrected on the day of the inspection. The provider had not notified the Office of the Chief Inspector of all adverse incidents, as set out in the regulations.

Regulation 15: Staffing

There were sufficient staff, with the necessary skills and qualifications to meet the assessed needs of residents. Nursing support was provided in line with residents' needs, and the statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received all mandatory training, and additional training was provided where appropriate. There were robust supervision arrangements in place.

Judgment: Compliant

Regulation 3: Statement of purpose

There were some inaccuracies in the statement of purpose, such as some detail of

the conditions of registration. These were corrected on the day of inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had not notified the Office of the Chief Inspector of all adverse incidents as set out in the regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All policies were reviewed in line with the providers own schedule, however not all policies were updated in accordance with best practice. The policy and procedures in place in relation to safeguarding vulnerable adults, and residents' finances, had not been updated to reflect current policy or legislation, and did not effectively guide staff practice.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements had ensured that the centre was sufficiently resourced to meet the needs of the residents. However, improvements were required to ensure effective oversight of the quality auditing systems, and that actions identified were followed up on.

Judgment: Substantially compliant

Quality and safety

Overall, residents were receiving a service that was of good quality, and person centred, however improvements were required to ensure that the service was safe for all residents. Residents' needs were well assessed and understood by staff. For the most part supports in place were person centred and residents were facilitated to participate in the daily running of their home. While residents were facilitated to

participate in, and make decisions about their care, improvement was required to ensure that this occurred on a wider level and on a more consistent basis.

Inspectors found that safeguarding arrangements did not ensure that areas of concern were consistently identified, and therefore not all safeguarding concerns had been responded to appropriately. A number of safeguarding incidents had been identified retrospectively, and therefore had not been addressed promptly. Where safeguarding plans were in place, these contained generic information, and did not include specific safeguarding measures necessary to keep residents safe.

The inspectors found that the premises was well designed and laid out and provided plenty of private and communal space for residents. The house was found to be clean throughout and well maintained. There was adequate space and storage facilities available for residents personal use. Works had been completed prior to ensure the premises was fully accessible for all including the installation of a lift from the first to second floor. Each resident had their own bedroom and access to the necessary equipment to support them such as ceiling hoists, which were installed in key areas of their home.

Residents' health care needs were appropriately assessed and care plans were developed in line with these assessed needs. Care plans in place clearly outlined what supports residents required. Each resident had access to appropriate allied health professionals in line with these assessed needs. Staff who spoke with the inspectors were knowledgeable in relation to residents' health care needs. Meal times were observed to be a positive and social event.

Residents' positive behaviour support plans clearly guided staff practice to support them. There was evidence that they were reviewed and updated regularly in line with residents' changing needs. Residents had access to the support of relevant allied health professionals to help them to manage their behaviour. There were a number of restrictive practices in place and evidence that these were regularly reviewed by the multidisciplinary team to ensure the least restrictive measures were used for the least amount of time. Staff who spoke with the inspectors were knowledgeable in relation to the implementation of residents' positive behaviour support plans.

Inspectors found that residents were supported by staff to exercise choice and control in their daily lives, in areas such as meal planning, choosing activities, and planning holidays and trips. However, improvement was required to ensure that residents fully participated in, and consented to decisions about their care and supports. For example, while residents could decide how to spend their own money on a day to day basis, the arrangements in the centre for spending larger sums of money did not identify or include the resident as the decision maker. The procedures in place were not effective in determining if residents' finances were being managed in line with their will and preference, and did not adequately protect residents from risk of financial abuse. Furthermore, some residents were in receipt of medication that had been recorded as being consented to by a third party. The resident was not fully aware of the purpose or effects of this medicine, and had not

been given sufficient opportunity to give informed consent.

Residents were protected by appropriate risk management policies, procedures and practices. There was a system for keeping residents safe while responding to emergencies. There was a local risk register in place and the person in charge and person participating in the management of the centre were meeting regularly to review this. General and individual risk assessments were developed as required and there was evidence that these were reviewed and updated regularly. A new system was in place for incident review and tracking.

There were appropriate policies and practices in place in relation to the ordering, receipt, storage and disposal of medicines. There were appropriate procedures in place for the handling and disposal of unused and out of date medicines. Medication audits were being completed regularly. Any medication errors and incidents were recorded, reported and followed up on in line with the organisations' policy.

The provider had ensured there were sufficient arrangements in place for detecting, containing and extinguishing fires, and regular checks were carried out to ensure that these were maintained. Residents took part in fire drills, and there were detailed personal evacuation plans in place for each resident. While there was an adequate number of fire exits in the centre, one exit route from the kitchen was blocked with cleaning supplies on the day of inspection.

Regulation 12: Personal possessions

The person in charge had not ensured that residents retained control of their personal property and finances, and received support appropriate to their needs. The arrangements for the management of residents' finances were not robust, and did not effectively protect residents from the risk of financial abuse.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of the centre was in line with the statement of purpose and meeting the number and needs of residents. There was adequate private and communal space for residents and the physical environment was clean.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management polices, procedures and practices. General and individual risk assessments and a local risk register were in place and reviewed regularly.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had taken adequate precautions against the risk of fire, and staff were appropriately trained in fire safety. There were sufficient arrangements in place for safe evacuation although one exit was blocked with cleaning equipment on the day of inspection.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

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

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need undertaken in respect of each resident, and support plans were present which contained sufficient information to guide staff practice.

Judgment: Compliant

Regulation 6: Health care

Residents were being supported to enjoy best possible health. Healthcare

assessments and support plans were in place and residents had access to allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place for residents who required them, which outlined proactive and reactive strategies. Where restrictive practice was utilised, there was evidence that these were reviewed regularly with the relevant members of the multidisciplinary team.

Judgment: Compliant

Regulation 8: Protection

All staff had received appropriate training in safeguarding and protection, however not all safeguarding incidents were being recognised and managed as they occurred. Where safeguarding plans were in place, these did not contain sufficient detail, and were not overseen in line with national policy.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors found that residents were not supported to participate in, and consent to decisions about their care and support on a consistent basis. In some case, residents were not facilitated to exercise their legal rights, or to access independent advocacy services.

Judgment: Not 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
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially 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	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for The Beeches OSV-0002342

Inspection ID: MON-0021656

Date of inspection: 22/11/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 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 containing information in Schedule 1 of the regulations , this is available to residents and their representatives . • Statement of purpose available to the Inspector on the 22nd November but did not reflect the conditions of registration re; capacity and was amended on that date. Copy given to the inspector on 22nd November	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • A full review of all incidents in the Designated Centre was completed • Outstanding notification of safeguarding concerns were submitted to the authority retrospectively by the 27th November 2018 • The PIC will ensure that all required notifications will be sent to the authority in the required time frame.	

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The registered provider has prepared and implemented policies and procedures on the matters set out in Schedule 5 of the regulations.
• All policies and procedures as appropriate are in line with and under pinned by HSE policies and procedures. These are available in the designated centre to all staff.
• SMH have established a Working group to review Service users monies policy in line with Legislative changes and Asssisted Decision Making, first draft available by 30/06/2019
• SMH Safeguarding policy will be updated by 31/05/2019
• Assisted Decision Making Group has convened and will issue first draft by 31/12/2109

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The Organization has effective leadership, governance and management arrangements in place and clear lines of accountability and responsibility.
• Management systems are in place to ensure that the service provided is safe, appropriate to residents needs, consistent and effectively monitored.
• An annual review of quality & safety of the centre was completed for Jan - Dec 2018, this is available for review. All areas for improvement were highlighted and now appear as part of plan for 2019
• Two six monthly unannounced visits were completed for the centre in 2018, actions identified and previously unaddressed within a 28 day period will now form part of an action plan for the 1st Quarter of 2019, through the HIQA framework Audit tool. 30/4/2019
• Review of all service users finances was carried out on the 23rd November 2018
• Meeting with residents families, SMH Accounts manager, Principal social worker, Service Manager and PIC carried out on the 19th December to discuss St Michaels house Service User Monies policy and Residents Rights re; administration of their own finances.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal

possessions:
• Monthly audits completed by Keyworkers and reviewed by PIC at end of each month. Reconciliation of these monies with bank statements in line with SMH policy on the management of service users monies.
• Referral to Advocacy services on the 22/11/2018, advocate met with staff 22/1/2019. Residents access to finance has been addressed in the interim.
• Review of all service users finances was carried out by Accounts Manager on the 26/11/2018
• Briefing of staff on service users money management policy by Accounts Manager on the 4/12/2018
• Meeting with residents families, SMH Accounts manager, Principal social worker, Service Manager and PIC carried out on the 19th December to discuss St Michaels House Service User Monies policy and Residents Rights re; administration of their own finances.
• Further review by Accounts on 17/1/2019 and recommendations re: residents finances.
• SMH have established a Working group to review Service users monies policy in line with Legislative changes and Asssisted Decision Making, first draft available on 30/06/2019/

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All staff have received training in relation to fire prevention, safety and evacuation.
• There are accessible fire action notices in the centre to support staff and residents in the event a fire evacuation is required.
• St Michaels house will continue to ensure that effective fire safety management systems are in place, review of all fire safety procedures by SMH Fire officer with staff team on the 13/2/2019

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• St Michael's House Policy and procedure for the Protection of Adults from Abuse and Neglect is available in the designated centre.
• This policy is currently under review and will be updated by 31/05/2019.
• All staff have received appropriate training in safeguarding and protection. Incidents of concern had been escalated in line with SMH procedures re; Safeguarding.
• All staff have completed online Children's First safeguarding training.

• All allegations of abuse will be reported and screened as per St Michael's house and National safeguarding policy.
• Each resident is supported to develop skills so that they have knowledge and skills to promote their personal self care and protection.
• Outstanding notification of safeguarding concerns were submitted to the authority retrospectively by the 27th November 2018
• Review of all safeguarding plans to reflect specific concerns and how this concern may impact on each resident individually 31/1/2019

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Residents in receipt of medications consented to by third party had commenced an appropriate assessment in relation to the self administration and understanding of medication on the 7/11/2018. Further supports and review with residents will take place by 31/3/2019
• The residents medication plan will be revewed by the appropriate Clinician on the 8/2/2019 to confirm understanding of their medications.
• Staff have supported resident to make a referral to Advocacy services on the 22/11/2018 in relation to finances.
• Advocate met with staff for information gathering on 22/1/2019. A further meeting to be scheduled.
• Residents access to their finances has been addressed in the interim

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/06/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2019
Regulation 28(2)(b)(i)	The registered provider shall	Substantially Compliant	Yellow	13/02/2019

	make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
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	22/11/2018
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	27/11/2018
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/12/2019
Regulation 08(1)	The registered provider shall ensure that each resident is assisted	Not Compliant	Orange	31/01/2019

	and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/01/2019
Regulation 08(3)	The person in 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.	Not Compliant	Orange	26/11/2018
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	31/03/2019
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Not Compliant	Orange	31/03/2019

	of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Not Compliant	Orange	31/03/2019