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:	Garvagh House
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	23 April 2019
Centre ID:	OSV-0002348
Fieldwork ID:	MON-0021659

About the designated centre

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

The centre comprises of a six bedroomed house which is located in a suburb of Dublin. There are five residents bedrooms, one staff sleepover room, a sensory room, quiet room, sitting room and kitchen come dining room. It is within walking distance of public transport and a range of local amenities which residents frequently use. The centre provides residential care for six residents over the age of 18 years with physical and intellectual disabilities. It is a fully wheelchair accessible house. There is a well proportioned private garden to the rear of the centre for residents to enjoy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
23 April 2019	10:00hrs to 18:00hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with four of the five residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. The inspector observed warm interactions between the residents and staff caring for them. None of the resident were able to tell the inspector their view of the service but they were observed to be in high spirits. The inspector observed the bedrooms for three of the residents which had been personalised to their own taste.

There was evidence that residents and their family representatives were consulted with and communicated with, about decisions regarding their care and the running of the house. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspector did not have an opportunity to meet with the relatives of any of the residents it was reported that they were happy with the care and support their loved ones were receiving. A relative of one of the residents completed an office of the chief inspector questionnaire and this indicated that the relative was very happy with the care that their loved one was receiving.

Capacity and capability

There were suitable management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge was on leave at the time of this unannounced inspection but was contacted after the inspection and interviewed over the phone. She was found to have an in-depth knowledge of the needs of each of the residents, and of the requirements of the regulations and standards. The person in charge had taken up the position in January 2017. She held a diploma in social care practice, a degree in social studies and a certificate in management. She was in a full-time position and was not responsible for any other centre. Staff members spoken with, told the inspector the person in charge supported them in their role and promoted a person-centred approach to the delivery of care. The person in charge reported that she felt supported in her role and had regular formal and informal contact with her manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. A deputy manager was in place

to support the person in charge. The person in charge reported to the service manager who in turn reported to the director of service. There was evidence that the service manager visited the centre at regular intervals. The person in charge and service manager held formal meetings on a regular basis.

The provider had completed an annual review of the quality and safety of services and unannounced visits to assess the quality and safety of the service as required by the regulations. A quality enhancement plan was in place which was informed by audits undertaken and was subject to regular review. There was evidence that actions were taken to address issues identified. The person in charge collected a range of data on a monthly basis in relation to the quality of the service which was submitted to the service manager. There was evidence that issues identified were actioned and addressed.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were not in place with two and a half whole-time equivalent staff vacancies. These vacancies were being covered by a a small relief panel of staff. Generally, there was consistency of care for the residents from care givers.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the providers training department. Training records showed that the majority of staff were up to date with mandatory training requirements. However, two relatively new staff members required training in positive behaviour support. Dates for same had been scheduled. There were no volunteers working in the centre at the time of inspection.

As the person in charge was not on duty on the day of inspection, the inspector was unable to access supervision records for staff. However, staff reported that they had regular supervision which they reported helped them to perform their duties.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

The staff team were considered to have the required skills and competencies to

meet the needs of the residents living in the centre. However, the full complement of staff were not in place with two and a half whole time equivalent staff vacancies.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, two relatively new staff members required training in positive behaviour support.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained on the centre and contained all of the information required in the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Quality and safety

The residents living in the centre received care and support which was of a good quality, person centred and promoted their rights. However, areas for improvements in relation to fire safety were identified.

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Care plans and personal support plans reflected the assessed needs of the individual resident and outlined the support required to maximise their personal development in accordance with their individual health,

personal, communication and social needs and choices. Well being reviews had been completed in the last year with the involvement of members of the multidisciplinary team for the majority of residents. However, a review had not been completed for one of the residents. For some residents there was limited evidence that their family representatives were involved or that the effectiveness of the personal plan was reviewed as per the requirement of the regulations. Goals set for some residents were identified not to be specific or measurable.

Residents were supported to engage in meaningful activities in the centre and within the community. Four of the residents attended a day service located nearby whilst a fifth resident had an individualised day service which was operated from the centre. Activities residents enjoyed included, trips to a local castle, salt therapy facility, swimming, horse riding, shopping, cinema and dinners out. There were some arts and crafts materials in the centre for residents use.

The centre was homely, accessible and laid out to meet the aims and objectives of the service. Overall, it was in a good state of repair although some chipped paint was observed on walls and woodwork in a number of areas. Each of the residents had their own bedroom which had been personalised to their tastes and choices. There was adequate communal spaces available for residents with a sensory room, family room and large sitting room. This promoted the resident's independence, dignity and respect. There was a well proportioned garden to the rear of the centre which included a seating area, goal posts and a basket ball hoop.

The residents were provided with a nutritious, appetising and varied diet. The timing of meals and snacks throughout the day were planned to fit around the needs of the residents. Meals were agreed with each of the residents on a weekly basis and it was noted that a healthy eating programme was promoted.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. A local risk register was maintained as a 'living' document in the centre. These outlined appropriate measures in place to control and manage the risks identified. An analysis of all incident was undertaken on a regular basis to identify trends and learning for the staff team in order to prevent re-occurrences. There was evidence that incident reviews were undertaken following all serious incidents.

Arrangements in place for the containment of fire had been identified by the provider to require improvement. There was evidence of plans to address the deficits on a planned basis. Overall, there were adequate means of escape and a fire assembly point was identified in an area to the front of the centre. However, it was identified that keys to open side gates, along the identified escape route were not readily available.

There was a fire safety policy, dated January 2019. Fire drills had been undertaken and indicated an appropriate time taken to evacuate the centre. However, the last fire drill involving residents undertaken was in August 2018 so not in line with

frequency proposed in the providers policy. A fire risk assessment had been completed. There was documentary evidence that fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. The staff team had received appropriate training.

There were measures in place to protect residents from abuse and residents were provided with appropriate emotional and behavioural support. However, the individual behaviours of a number of the residents were on occasions difficult for staff to manage in group living environment. This had the potential to have a negative impact on the other residents despite safeguarding measures which had been put in place.

Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual resident. There was evidence that plans in place were regularly reviewed by the provider's psychologist. Staff had received training to assist them in meeting residents behavioural support needs.

There were systems in place to ensure the safe management and administration of medications. The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. A medication management policy was in place, dated February 2018. There was a secure cupboard for the storage of all medicines. Staff had received appropriate training in the safe administration of medications. Individual medication management plans were in place. There were some systems in place to review and monitor safe medication management practices which included a count undertaken by staff on receipt of medications from the pharmacy and thereafter on a weekly basis. There was evidence that where deficits were identified these were then investigated by the person in charge.

Regulation 10: Communication

The residents' communication needs were met. Residents communication needs had been appropriately assessed and guidance had been put in place to support staff in meeting residents' communication needs.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre was homely and fit for purpose and reflected the layout as described in the centre's statement of purpose.

Judgment: Compliant

Regulation 18: Food and nutrition

The residents were provided with a nutritious, appetizing and varied diet.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management polices, procedures and practices. General and individual risk assessments and the local risk register were reviewed regularly in line with residents' changing needs.

Judgment: Compliant

Regulation 28: Fire precautions

Arrangements in place for the containment of fire had been identified by the provider to require improvement. There was evidence of plans to address the deficits on a planned basis. It was identified that keys to open side gates, along the identified escape route were not readily available. The last fire drill involving residents undertaken in the centre was in August 2018 which was not in line with frequency proposed in the provider's fire safety policy.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Overall, residents' well-being and welfare was maintained by a good standard of evidence-based care and support. However, a review had not been completed for one of the residents as required by the regulations. For some residents there was limited evidence that their family representatives were involved or that the effectiveness of the personal plan was reviewed. Goals set for some residents were identified not to be specific or measurable.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' health-care needs were being met in line with their personal plans and assessments. Specific health plans were in place for residents who required same. Each of the residents had their own general practitioner (GP). Residents attended regular reviews with their GP. A log was maintained of all GP and other professionals contacts.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from abuse and residents were provided with appropriate emotional and behavioural support. However, the individual behaviours of a number of the residents were, on occasions, difficult for staff to manage in group living environment. This had the potential to have a negative impact on the other residents despite safeguarding measures which had been put in place.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	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	Substantially compliant

Compliance Plan for Garvagh House OSV-0002348

Inspection ID: MON-0021659

Date of inspection: 23/04/2019

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 Organization has in place a procedure to ensure that the recruitment of staff is appropriate to the number and assessed needs of the residents in the designated centre. • The PIC ensures that a monthly staff roster is in place and this reflects the needs of the residents. • All documents specified in Schedule 2 are maintained by the HR department and are available for review. In response to the area of non-compliance found under regulation 15; • At present there is an ongoing recruitment campaign. Service provider continues to, whenever practicable; employ familiar relief staff to provide as much continuity for residents as possible. • One new full time staff member will commence in the Designated Centre on the 1st July 2019.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff in St Michael House have access to appropriate training, relevant to their position. In response to the area of non-compliance found under regulation 16;	

• Positive Behavior Support training has been scheduled for two staff on the following dates 03/09/19 and 22/10/19

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The organization will ensure that effective fire safety management systems are in place to provide adequate precautions against the risk of fire in the Designated Centre.

In response to the area of non-compliance found under regulation 28;
• Additional fire containment measures that are required in the designated centre form part of the SMH Fire Safety Plan for 2019 and will be completed in order of priority in 2019
• Self closing devices fitted on 03/05/19
• Keys are present at emergency exits
• Fire Drill for 2019 completed 09/06/2019

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The PIC will continue the review of all residents' personal plans within the designated centre to assess the effectiveness of each plan.
• Within this review the personal plan will be evaluated to ensure the plan was developed arising from the resident's goals and wishes.
• Each resident living in the designated centre has comprehensive assessment of need, this is reviewed annually or as required with multi disciplinary input as appropriate.
• An assessable format of each resident's personal plan is now available to each resident ,and where appropriate their representative, in a format that is meaningful to the individual.

In response to the area of non-compliance found under regulation 5;

• Review for all resident to be completed 03/07/19.
• All personal plans to be reviewed for the effectiveness of the plan.
• While reviews are being completed, evidence of family representatives to be recorded, to ensure measures of their involvement.
• Goals to be reviewed with resident to ensure that they are specific and measurable.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• St Michael's House has a policy in place for safeguarding vulnerable adults..
• Safeguarding training for all staff has been completed.
• Each resident is supported to develop skills so that they have knowledge and skills to promote their protection.
• All incidents of a safeguarding nature will be notified in line with regulatory requirements.

In response to the area of non-compliance found under regulation 8;

• Staff will continue to support and monitor all residents to ensure the protection of all.
• Staffing levels in place to ensure the safety of all residents.

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	31/12/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	03/12/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape,	Not Compliant	Orange	25/04/2019

	including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/04/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	09/06/2019
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's	Substantially Compliant	Yellow	15/07/2019

	wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/08/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2019