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

Issued by the Chief Inspector

Name of designated centre:	A Middle Third
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	28 January 2020
Centre ID:	OSV-0002360
Fieldwork ID:	MON-0025952

About the designated centre

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

A Middle third is a community based home operated by St. Michael's House. The centre provides residential services for five adults both male and female with an intellectual disability. It is situated on the north side of Dublin city close to all the amenities and facilities the city has to offer. The centre is close to public transport links which enable residents to access these amenities and neighbouring areas. The building is a single-storey, five bedroom home with a homely design and layout. Each resident has their own bedroom, one of which is en-suite. There are two shared bathrooms, one with a bath and shower and the other with a shower. The house is fitted with a ceiling hoist to meet residents' needs. The kitchen is accessible and residents are encouraged to get involved with the preparation of meals and snacks. There is a garden to the rear of the property with two sheds for storage. Staff encourage residents to be active members in their communities and to sustain good relationships with their family and friends. The staff team comprises a person in charge, staff nurses, social care staff, direct care support staff and a household staff. Staffing resources are arranged in the centre in line with residents' needs.

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
Tuesday 28 January 2020	09:30hrs to 17:30hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

As part of the inspection, the inspector met with four of the five residents living in the centre. None of these residents were able to tell the inspector their views of the service. They were observed to be overall in good spirits during the course of the inspection. Staff were observed to communicate well with the residents using the individual residents preferred communication method and to respond to non verbal cues. The inspector observed warm interactions between the residents and staff caring for them. The majority of the residents were reported to enjoy music and there was a piano in the centre's sensory room for residents use. A musician also visited the centre on a bi-weekly basis to play music for the residents which it was reported they really enjoyed.

There was evidence that residents and their family representatives were consulted with and communicated with about decisions regarding their care and the running of their 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 to attain their views of the quality and safety of care provided. However, it was reported by staff, that residents' family representatives were generally happy with the care their loved ones received in the centre. A number of compliments from family members were recorded which indicated that family members were generally happy with the care being provided in the centre.

Capacity and capability

There were management systems in place to promote the service provided to be safe, consistent and appropriate to the residents' needs. However, some improvements were required in relation to staffing arrangements.

The centre was managed by a suitably qualified, skilled and experienced person who had a good knowledge of the needs of each of the residents. The person in charge was on planned leave on the day of this inspection but was spoken with, shortly after the inspection, over the phone. Their role as person in charge was a full-time position and they were not responsible for any other centre. While they had recently taken up the position of person in charge, they had previously been the deputy manager for the designated centre for an extended period before her appointment.

The person in charge held a degree in nursing and a certificate in applied

management. They had more than three years management experience and had a sound knowledge of the requirements of the regulations and standards. Staff members spoken with told the inspector that the person in charge supported them in their role and encouraged a culture of openness where the views of all involved in the service were sought and taken into consideration.

There was a clearly defined management structure in place that identified lines of accountability and responsibility which ensured staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the service manager who in turn reported to the director of adult services. There was evidence that the service manager visited the centre at regular intervals. This demonstrated clear lines of reporting and accountability systems for the operational management of the centre.

An annual review of the quality and safety of care had been completed for 2018 and it was reported was being prepared for 2019. Unannounced visits on a six-monthly basis to assess the quality and safety of the service had been completed. There was evidence that actions were taken to address issues identified on these visits. A limited number of other audits had been undertaken and included finance, hygiene, medication and health and safety. A quality enhancement action plan was in place and included actions from various audits and actions proposed. However, it was noted that this had not been reviewed for an extended period. The person in charge completed quality and governance data reports which were submitted to senior management. These reports included data on matters such as incidents, complaints and other operational issues. Although it was proposed that these would be submitted at monthly intervals they had not been completed in the preceding period.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. However, the full complement of staff was not in place at the time of inspection, with three and a half whole-time-equivalent staff vacancies. It was noted that relief and agency staff were used to cover these vacancies and staff leave. This meant that on occasions consistency of care for the residents living in the centre was not always achieved.

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, dated May 2019. A training programme was in place which was coordinated by the provider's training department. Training records available on the day of inspection indicated that the majority of staff had attended mandatory training requirements. There were no volunteers working in the centre at the time of inspection.

A directory of residents was maintained in the centre and found to contain all of the information required by the Regulations.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre.

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 staff complement was not in place at the time of inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was in place and found to contain all of the information required by 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

Regulation 24: Admissions and contract for the provision of services

Each of the residents had a contract of care in place which detailed the services provided and the fees payable.

Judgment: Compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality and person centred. However, some improvements were required in relation to medication management, safeguarding and personal plan review arrangements.

Overall, residents' well-being and welfare was maintained by a good standard of evidence-based care and support. However, a number of the residents personal plans had not been reviewed in in an extended period in line with the requirements of the regulations. Residents' care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal, communication and social needs and choices. A number of residents personal plans were overdue for review, whilst some reviews undertaken did not review the effectiveness of the plans on place. A number of the residents had goals set but progress in achieving goals were not always clearly recorded.

Residents living in the centre required a high level of care and support from the staff team. There was a registered staff nurse on duty at all times to meet the needs of the residents living in the centre. Each of the residents attended a formal day service which it was reported they individually enjoyed. Residents were supported to engage in meaningful activities in the centre and within their local community. Activities residents enjoyed included, cinema, shopping, overnight hotel stays and day trips, concerts, shows, walks and meals out. One resident was engaged in an art class within the community and a good supply of arts and crafts material were available for residents use in the centre.

Residents' communication needs were met. There was a policy on communication. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. Communication passports were on file for residents who required same. There were communication tools for residents, such as picture exchange and object of interest in place to assist residents to choose diet, activities, daily routines and journey destinations. A number of residents also used some sign language.

The centre was found to be accessible, comfortable and homely. However, some worn paint was observed on a number of walls, the grouting in a small area in the bathroom was observed to be stained, the flooring in the staff office was broken and a number of kitchen units were observed to be worn. Each of the residents had their

own bedroom which had been personalised to their tastes and
choices. This promoted residents' independence, dignity and recognised their individuality and personal preferences. There was adequate private and communal space for residents and the physical environment appeared clean.

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. These outlined appropriate measures in place to control and manage the risks identified. A risk register was in place and maintained as a contemporaneous document. It was noted that risk was a standing agenda item at all staff meetings.

Overall, suitable arrangements were found to be in place for the management of fire. There was documentary evidence that the fire alarm system, emergency lighting and fire fighting equipment was serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. A fire risk assessment had been completed. There was a fire safety management policy also in place.

Adequate means of escape were observed throughout the premises and a fire assembly point was identified in an area to the front of the centre. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident.

Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training. Fire doors were in place as part of the centre's overall fire safety containment measures. Fire drills were undertaken at regular intervals involving residents. It was noted that the time taken to evacuate residents was greater then that recommended by the provider but the person in charge reported that this was being reviewed by the provider's fire officer.

There were safeguarding measures in place to protect residents from suffering from abuse. However, at the time of inspection the behaviour of one of the residents, particularly at night, was difficult for staff to manage in a group living environment. This was considered to have a negative impact on some of the other residents living in the centre. A formal impact assessment for the other residents had not been completed. Safeguarding plans were in place for residents identified to require same.

Overall, residents were provided with appropriate emotional and behavioural support. However, behaviour support plans were not found to be in place for two residents identified to require same. Other behaviour support plans in place were found to contain a good level of detail to guide staff in meeting the needs of the individual resident.

The systems in place to ensure the safe management and administration of medications were not found to be fully effective at the time of this inspection. The inspector reviewed a sample of medication prescription charts and administration sheets, and found a number of discrepancies which were not in line with the

providers policy or best practice in this area. These included that a medication was being recorded as administered to a resident but a record of the doctors prescription sheet was not available. A number of other prescribed medications were not being administered to a resident but had not been documented as discontinued on the prescription chart. It was noted that the time indicated on the prescription sheet for some medications to be administered was not clear.

There was a secure cupboard for the storage of all medicines. This was a nurse led service so a registered staff nurse was responsible for the administration of all medications. Other staff had received appropriate training in the safe administration of medications. There were some systems in place to review and monitor safe medication management practices which included medication audits and counts.

Regulation 10: Communication

The residents' communication needs were being met.

Judgment: Compliant

Regulation 17: Premises

The centre was found to be accessible, comfortable and homely. However, some worn paint was observed on a number of walls, the grouting in a small area in the bathroom was observed to be stained, the flooring in the staff office was broken and a number of kitchen units were observed to be worn.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable arrangements were found to be in place for the management of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The systems in place to ensure the safe management and administration of medications were not found to be fully effective at the time of this inspection. It was found that a medication was being recorded as administered to a resident but a record of the doctors prescription sheet was not available. A number of other prescribed medications were not being administered to a resident but had not been documented as discontinued by the residents general practitioner. It was noted that the time indicated on the prescription sheet for some medications to be administered was not clear.

Judgment: Not 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 number of the residents personal plans had not been reviewed in in an extended period in line with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Overall, residents were provided with appropriate emotional and behavioural support. However, behaviour support plans were not found to be in place for two residents identified to require same.

Judgment: Substantially compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. However, at the time of inspection the behaviour of one of the residents, particularly at night, was difficult for staff to manage in a group living

environment.
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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for A Middle Third OSV-0002360

Inspection ID: MON-0025952

Date of inspection: 28/01/2020

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
.
• 1 X Fulltime Clinical Nurse manager 1 has been recruited to fill one vacancy. This person will be available to start on the 14th April 2020
• 1 X Fulltime Direct Support Worker will transfer from another location on 7th April 2020
• On–going Nurse recruitment is in place to fill the outstanding 1.5 WTE nurse vacancy.
• As suitable candidates are recruited these positions will be filled.</td></tr>
<tr><td>Regulation 17: Premises</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 17: Premises:
• The Technical Service Department have been contacted in regard to outstanding work required;
1. Some wall areas in the centre require re painting and a freshen up.
2. A request has been submitted to get the flooring in the Office replaced.
3. A request has been submitted for the kitchen area to be reviewed and worn areas to be replaced.
• The grouting in the Bathroom has been deep cleaned and on-going cleaning of this will be included in the centre's overall cleaning schedule.</td></tr>
</table>

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• All Medication administration sheets and Medication recording sheets have been reviewed by the PIC to ensure they are fit for purpose and fully in date.
• Going forward Medication prescription sheets will be amended in a timely manner following all changes. In the interim time a copy of the original prescription of the change will be held with the current medication administration sheet in order to clearly guide medication administration practices.
• All medication administration sheets have been reviewed by the PIC to ensure administration times are correct and in line with the residents current needs.
• Internal audits will be completed as per policy by the PIC in regard to medication management to ensure best practice at all times.

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:
• Each resident has a personal plan which details their needs and outlines the supports required to maximize their personal development and quality of life in accordance with their changing needs.

• All current personal plans are being reviewed by the PIC and updated by key workers in consultation with relevant members of the allied healthcare team, to reflect the changing needs of each individual resident.

All assessments of need and personal plans will be reviewed quarterly by key workers at a minimum. A full review of all Person Centered Planning will be conducted through each individuals My-Life meeting held within a 12month perio

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• All residents have been reviewed by the Senior Psychologist with the staff team on

19/02/2020.
• All residents who require them have Positive Behavioral Support Plans in place, which are currently in date and will be reviewed regularly.
• Future / emerging behavioral support needs required for residents will be identified and managed through the Individual Co-ordination meeting structure.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All safeguarding concerns are managed in line with Organizational policy.
• Identified concerns regarding the impact of certain behaviors on residents has been identified and discussed with the staff team and relevant members of the allied Healthcare Team on 19/02/2020.
• Positive Behavioral Supports are in place for residents who require them and are reviewed regularly.
• Relevant notifications regarding the safeguarding of residents are made as required.

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	14/09/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2020
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable	Not Compliant	Orange	25/02/2020

	practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 05(6)(a)	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 multidisciplinary.	Substantially Compliant	Yellow	30/03/2020
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	25/02/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	25/02/2020