Office of the Chief Inspector

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

Name of designated centre:	Royal Oak
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	05 February 2019
Centre ID:	OSV-0002361
Fieldwork ID:	MON-0021665

About the designated centre

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

Royal Oak is a designated centre based in a North Dublin suburban area and is operated by St Michael's House. It provides community residential services to three male residents with intellectual disabilities over the age of 18. The designated centre is comprised of two attached houses with an internal door for access. The designated centre consists of five bedrooms, two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. There was a garden to the rear of the centre which contained two small buildings which were used for laundry and storage. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge and social care workers. Staff have access to nursing support through a nurse on call service.

The following information outlines some additional data on this centre.

Current registration end date:	07/06/2019
Number of residents on the date of inspection:	3

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
05 February 2019	10:00hrs to 18:45hrs	Conan O'Hara	Lead

Views of people who use the service

On the day of inspection, the inspector had the opportunity to meet with the three residents who were availing of the services of this designated centre and one family member. The inspector observed care practices and interactions on the day of inspection. In addition, feedback on the quality and safety of the service were taken from a review of questionnaires completed by the residents.

Overall, some people who avail of the service had positive views and communicated that they were satisfied with the care and support received. However, one resident told the inspector that they were unhappy and did not feel comfortable in the service. This dissatisfaction was centred on the compatibility of the residents in the centre, accommodation and access to shared spaces where they could spend time with other residents or visitors.

Capacity and capability

Overall, there was an defined management structure and an established staff team in place to ensure the service provided was safe. However, the systems in place were not effective in ensuring that the service provided was appropriate to all residents' needs. In addition, some improvements were required in staff training, organisational polices.

There was a clearly defined management structure in place. The designated centre was managed by a person in charge who was suitably qualified and experienced and demonstrated good knowledge of the residents. The person in charge was employed on a full time basis, worked directly with the residents and had protected administration time of one day a week. There were a number of quality assurance audits in place to ensure the service provide was safe and effectively monitored. These included a Quality Enhancement Plan, annual reviews and the six monthly unannounced provider visits. Through the quality assurance audits, the provider was aware that a resident was unhappy with the service they were receiving. While the provider had taken some steps to address this, the steps taken were not effective in ensuring that the service provided was appropriate to the resident's needs.

The service being delivered to residents was observed to be in keeping with the centre's current statement of purpose dated February 2019. The statement of purpose contained all of the information as required by Schedule 1 of the regulations.

The person in charge maintained a planned and actual staff roster. The inspector

reviewed a sample of the staff roster and found that, on the day of inspection, there was sufficient staff in place to meet the assessed needs of the residents. Throughout the inspection, the inspector observed staff treating and speaking with residents in a dignified and caring manner.

There were systems for the training and development of staff. The inspector reviewed staff training records and found that not all staff were up-to-date in mandatory training such as safeguarding and positive behavioural support. This meant that not all of the staff team were suitably trained to support all of the assessed needs of the residents. The provider had scheduled training to address this.

The provider had a complaints policy dated February 2018 in place. The inspector reviewed the complaints log and found that complaints were taken seriously, responded to and the outcome of the complaint was recorded.

The inspector reviewed a sample of incidents and accidents in the centre and found that they were notified to the Office of the Chief Inspector as required by the Regulation 31.

On the day of inspection, the inspector found a number of polices required under Schedule 5 of the regulations had not been reviewed, and updated if necessary, at least once every three years or in the time frames outlined as required by the provider.

Regulation 14: Persons in charge

The person in charge was employed on a full time basis, suitably qualified and experienced to manage the centre and demonstrated good knowledge of the residents.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. There was sufficient staff in place to meet the assessed needs of the residents. Throughout the inspection, the inspector observed staff treating and speaking with residents in a dignified and caring manner.

Judgment: Compliant

Regulation 16: Training and staff development

Not all of the staff team were up-to-date in mandatory training including safeguarding and positive behavioral support.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had an insurance policy in place.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure. There were a number of quality assurance audits in place to ensure the service provide was safe and effectively monitored. Through the quality assurance audits, the provider was aware that a resident was unhappy with the service they were receiving. While the provider had taken some steps to address this, the steps taken were not effective in ensuring that the service provided was appropriate to the resident's needs.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose dated February 2019 contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Incident and accidents were reported to the Office of the Chief Inspector as required by Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy dated February 2018 in place. Complaints were taken seriously, responded to and the outcome of the complaint was recorded.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of policies which were found not to have been reviewed and updated if necessary, at least once every three years or in the time frames outlined as required by the provider. These were:

- The management of residents' property and possessions.
- The recruitment, selection and vetting of staff members
- Provision of behavioural support
- The use of restrictive procedure and physical, chemical and environmental restraint.
- The creation of, access to, retention of, maintenance of and destruction of records.

Judgment: Not compliant

Quality and safety

Overall, the residents living in the centre received care and support which was person centred. However, on the day of inspection a resident highlighted that they were unhappy and did not feel comfortable in the service. The arrangements in place did not meet some of the needs and the will and preference of the resident involved. In addition, improvements were required in a health care plan, safeguarding and protection, fire containment and medication management.

On the day of the inspection, one resident told the inspector that they were unhappy with the service they received. The resident told the inspector that this was due to the compatibility of the residents in the centre and access to shared spaces where they could spend time with other residents or visitors. This was also identified at the time of the last inspection in 2016. The provider informed the inspector that the resident had been offered an alternative placement which was declined and the

resident was currently on the provider's internal transfer list. The inspector found that the arrangements in place did not meet some of the needs and the will and preference of the resident involved.

The inspector reviewed residents' files and found that there was an up-to-date assessment of need in place. Residents' social care and health care needs were appropriately assessed and care plans were available to guide the staff team. While the plans were reviewed quarterly, it was not evident that the annual review of the personal plan assessed the effectiveness of the plans.

The inspector found that the residents were supported to enjoy best possible health. Residents had access to a range of allied health professionals and to nursing support through a nurse on call service if required. However, some improvement was required in the detail of one health care plan as it did not guide appropriately guide staff on the arrangements and supports in place to support a resident with an identified health care need.

There were positive behavioural supports in place for residents as appropriate. The inspector reviewed the positive behaviour support plans and found that they were up-to-date and guided staff in supporting residents manage their behaviour.

There were systems in place to safeguard residents from abuse. Staff spoken with were clear in what constituted abuse and what to do in the event of an allegation or concern. However, the inspector identified one incident of concern which was reported internally by the person in charge. While the incident was reviewed by the principle social worker and designated officer, a formal preliminary screening was not carried out and notified to the Safeguarding and Protection Team in line with the national policy 'Safeguarding Vulnerable Persons at Risk of Abuse'.

There were arrangements in place for the assessment, management and ongoing review of risk. The provider maintained a risk register which was up-to-date and outlined individual and service risks and the controls in place to manage these risks.

In relation to medication management, there were established systems in place. A sample of prescription and administration sheets were viewed and were found to contain appropriate information. Residents were supported to take responsibility over their own medication and had an capacity assessment and risk assessment in place. However, some areas of risk were identified in relation to the safe storage of medication. The inspector observed the key for the medication press stored in an accessible place in the staff office. In addition, guidelines were not in place for the administration of a number of as required (PRN) medications.

The inspector completed a walk through of the centre, accompanied by the person in charge, and in general found that the house was decorated in a homely way. The house consisted of five bedrooms, two kitchen come dining rooms, two sitting rooms, an office, two bathrooms and two toilets. One of the bathrooms was found to be in contrast with the rest of the house as it was clinical in nature. There were areas for improvement which included the upkeep of paint in some areas of the centre and a broken locking mechanism on a door. The inspector

acknowledges that both of these areas were in the process of being addressed at the time of the inspection.

There were systems in place for fire safety management. The centre had suitable fire safety equipment including emergency lighting, fire alarm and extinguishers which were serviced as required. Centre records demonstrated the fire drills were carried out regularly. Each resident had a personal emergency evacuation plan in place which outlined the supports for each resident to evacuate the designated centre. However, improvements were required in relation to containment of fire. For example, the provider had self identified the need for cold smoke seals on all fire doors and ventilation grilles above doors to be fire rated. The provider was taking measures as part of a service wide improvement plan to ensure that suitable fire containment measures would be in place.

Regulation 17: Premises

The house was decorated in a homely way. There were areas for improvement which included the upkeep of paint in some areas of the centre and a broken locking mechanism on a door.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were arrangements in place for the assessment, management and ongoing review of risk. The provider maintained a risk register which was up-to-date and outlined individual and service risks and the controls in place to manage these risks.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required in relation to containment of fire. For example, the provider had self identified the need for cold smoke seals on all fire doors and ventilation grilles above doors to be fire rated. The provider was taking measures as part of a service wide improvement plan to ensure that suitable fire containment measures would be in place.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was a medication management system in place. Improvements were required in the safe storage of medication as the key for the medication press was stored in an accessible place in the office. In addition, guidelines were not in place for the administration of a number of as required (PRN) medication.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

One resident was not happy with the service they were receiving. While some steps had been taken by the provider, the arrangements in place did not meet some of the assessed needs and will and preference of the resident involved.

There was an up-to-date assessment of need in place for each resident. The assessment of need inform care plans which were reviewed quarterly. However, it was not evident that the annual review of the plan assessed the effectiveness of the plans.

One health-care plan reviewed did not appropriately guide staff on the arrangements and supports in place to support a resident with an identified health care need.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. Residents had access to a range of allied health professionals and to nursing support through a nurse on call service if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behavioural supports in place for residents as appropriate which

were up-to-date and guided staff in supporting residents manage their behaviour.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents from abuse. Staff spoken with were clear in what constituted abuse and what to do in the event of an allegation or concern. One incident of concern which was reported internally by the person in charge. While the incident was reviewed by the principle social worker and designated officer, a formal preliminary screening was not carried out and notified to the Safeguarding and Protection Team in line with the national policy 'Safeguarding Vulnerable Persons at Risk of Abuse'

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Royal Oak OSV-0002361

Inspection ID: MON-0021665

Date of inspection: 05/02/2019

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 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 to their position. In response to the area of non-compliance found under regulation 16; • Safeguarding training completed 13/03/2019 • Positive Behavior Support training assignment submitted 14/03/2019	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The designated centre is resourced to ensure all residents care and support needs are met. • There is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability. • There are management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. • Annual reviews of the quality and safety of care and support are completed in consultation with the resident and their representatives • A copy of the annual review is available to residents and is held in the centre. In response to the area of non-compliance found under regulation 23; The organization will continue to keep under review the service provided and alternative service's to ensure the service is appropriate to the residents needs.	

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, adopted and implemented policies and procedures as set out in Schedule 5.
• All the policies and procedures referred to in schedule 5 are now available to all staff in the designated centre.
• The organization currently adopts the HSE Vetting Policy in line with the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016, and are now fully compliant in this regard.

In response to the area of non-compliance found under regulation 4;
• The management of residents' property and possessions - local policy to support each residents personal possessions record is now in place.
• The recruitment, selection and vetting of staff members - the SMH HR folder which contains these policies is in place.
• Provision of behavioural support - currently under review and will be completed by June 2019.
• The use of restrictive procedure and physical, chemical and environmental. Currently under review with first draft to be completed August 2019.
• The creation of, access to , retention of, maintenance of and destruction of records. Currently under review with first draft to be completed August 2019.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The register provider will ensure the premises are laid out to meet the aims and objectives of the service and the number and needs of resident.
• The designated centre is of sound construction and in good state of repair.
• The designated centre is clean and suitably decorated

In response to the area of non-compliance found under regulation 15;
• Painting has been completed throughout the centre by 16/02/2019
• The locking mechanism on the door was repaired on 21/02/2019

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.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The PIC shall ensure that the designated centre has appropriate and suitable practices relation to the ordering, receipt, prescribing , storing, disposal and administration of medicines to ensure that all medicines are kept securely.
• The Organisation has a policy & procedure in place for the Safe administration of Medication, which is underpinned by national policy. This policy guides practices relating to the management of medication: ordering/ receipt/ prescribing/ storing/disposal and administration of medication is in line with best practice.
• The Organisation ensures that all staff receive training in the safe administration of medication.
• All residents in the designated centre have access to a pharmacist of their choice.
• There is a system of recording for each resident of prescribed and administered medication and these are kept in a secure location within the designated centre.

In response to the area of non-compliance found under regulation 29;
• Keys for the medicine press are now kept in a locked key box.
• Administration guidelines are in place for all as required medication (PRN)

Regulation 5: Individual assessment and personal plan	Not 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 residents 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 residents 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;
• Presently the Organization is reviewing the placement and the assessed needs of the current residents in the Designated Centre to ensure all supports are in place to support the compatibility of all.
• A referral has been made to the organization residential waitlist committee in regard to future placements options.

• Health care plans have been reviewed and updated to ensure that staff are appropriately guided, to support the resident with an identified health care need.	
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 which is currently under review. • 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; • Where there are any incidents, allegations or suspicion of abuse, the PIC will ensure this is reported to the Designated Officer and notifications are made as appropriate. In line with Saint Michaels House and the National Safeguarding Policy notifications will be sent to the authority in the appropriate timeframe.	

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 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	14/03/2019
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	21/02/2019
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	21/02/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2019
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal	Not Compliant	Orange	21/02/2019

	and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable 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.	Not Compliant	Orange	21/02/2019
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		30/09/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	01/04/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	21/02/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review,	Not Compliant	Orange	21/02/2019

	carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
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.	Substantially Compliant	Yellow	21/02/2019