Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	A Bettystown Ave
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	06 February 2020
Centre ID:	OSV-0002365
Fieldwork ID:	MON-0025441

About the designated centre

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

A Bettystown Ave is a designated centre operated by Saint Michael's House located in North County Dublin. It provides a community residential service to six adults with a disability. The centre is a two-storey house in a residential area and comprises of two sitting rooms, a kitchen/diner, utility room and seven bedrooms, of which six are used by residents and a number of shared bathrooms. The centre further provides a patio area to the rear of the house and a garden to the side which are both accessible to residents. The centre is staffed by a person in charge and social care workers. In addition, the provider's has arrangements in place outside of office hours and at weekends to provide management and nursing support if required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Thursday 6 February 2020	10:30hrs to 18:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to met with the six people availing of the service on the day of the inspection. Some residents communicated their thoughts and opinions verbally while others used non-verbal methods to communicate. In addition, the inspector also observed residents and their interactions with their peers and staff throughout the day of the inspection.

The inspector observed residents as they engaged with their daily activities which included accessing the community, attending work and day services, receiving visitors, enjoying meals and relaxing in their home. On the day of the inspection, residents had planned to go out for dinner to celebrate a birthday. The inspector spent time in the kitchen/dining room and spoke with residents about work, plans for holidays and the upcoming general election. Overall, residents spoken with said they were happy in the house and the inspector observed that residents appeared content in their home. However, one resident spoken with highlighted access to a transport vehicle as an area for improvement. The inspector followed this up with the person in charge who noted that the provider had recently developed arrangements to improve the centre's access to a transport vehicle for residents.

Overall, it was observed that the designated centre was decorated in a homely manner. Some residents showed the inspector their bedrooms which were decorated in line with their tastes and preferences. However, some areas of the centre required upkeep for example, the kitchen in the centre required updating.

Capacity and capability

The governance and management arrangements in place ensured that the service provided was effectively monitoring and in line with the support needs of residents. However, improvements were required in staffing arrangements and training and development of the staff team.

There was a clearly defined governance and management structure in place. The centre was managed by a suitably qualified and experienced person in charge who demonstrated good knowledge of the residents and their support needs. The person in charge was responsible for another designated centre and was supported in their role by a social care worker. There were a number of quality assurance audits in place including six-monthly unannounced provider visits and an annual review for 2019 in line with the regulations. These audits identified areas for improvement and there was evidence of action plans being developed. For example, the annual review 2019 identified the lack of an allocated transport vehicle to the centre as an area for improvement. The person in charge informed the inspector that the

provider had developed arrangements to improve the centre's access to a transport vehicle for residents.

The person in charge maintained a planned and actual roster for the designated centre. In 2019, the provider self-identified the requirement for additional staffing to meet the identified needs of residents. A review of the roster demonstrated that the provider had resourced the centre with additional staffing however, the provider relied on a number of relief and agency staff to manage the additional staffing requirements.

While, there were efforts, by the provider and person in charge, to ensure continuity of care was in place for residents by using the same agency and relief workers as much as possible, a review of the roster demonstrated at times this was not always possible. During the course of the inspection staff were observed to support residents in a person-centred manner at all times and residents appeared content and comfortable in their home.

There were systems in place for the training and development of the staff team. The inspector reviewed a sample of staff team training records and found that staff team were up-to-date in mandatory training requirements. In addition, there were arrangements in place for the supervision of the staff team.

A review of a sample of staff supervision meetings found that supervision meetings had not been completed in line with time-lines set out in the provider's supervision policy. For example, the supervision records reviewed demonstrated that staff had received two supervision in 2019 while the provider's policy outlines that supervision meetings should take place quarterly. The inspector was shown evidence of planning for the upcoming year to ensure all staff received quarterly supervision meetings.

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

Regulation 14: Persons in charge

The person in charge worked in a full-time post and was appropriately qualified and experienced. The person in charge demonstrated good knowledge of the residents and their support needs. The person in charge was responsible for another designated centre and was supported in their role by a social care worker.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster for the designated centre. There were sufficient staff levels to meet the assessed needs of residents. A review of the roster demonstrated that at times continuity of care was not always ensured.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The inspector reviewed a sample of staff team training records and found that staff team were up to date in mandatory training. There was arrangements in place for the supervision of the staff team. However, the timeliness of the supervision meeting required improvement.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined governance and management structure in place. The centre was managed by a suitably qualified and experienced person in charge. There were a number of quality assurance audits in place including six-monthly unannounced provider visits and an annual review for 2019 in line with the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents and accidents were notified to the Office of the Chief Inspector as required under Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the governance and management systems in place ensured that the service provided was safe and in line with residents needs. However, some improvement was required in the premises and fire safety management.

The inspector completed a walk through of the premises accompanied by the person in charge. The centre was clean and decorated in a homely manner. The centre was a two-storey house in a residential area and comprises of two sitting rooms, a kitchen/diner, utility room and seven bedrooms, of which six are used by residents and a number of shared bathrooms. However, the kitchen required updating as the veneer on the outside of the presses was in disrepair. This was self-identified as an infection control risk and an area for improvement by the provider.

The inspector reviewed a sample of residents' personal files and found that each resident had an up to date assessment of need. The assessment of need identified residents' health and social care needs and informed the residents' personal plan. The personal plans reviewed were up-to-date and guided the staff team in supporting residents with their assessed needs. Residents were supported to manage their health care needs and there was evidence of regular access to appropriate allied health professionals. The health care plans in place were up to date and suitably guided the staff team in supporting residents manage their health care. In addition, the provider had completed a nursing needs assessment to ensure that health care needs of residents were being met appropriately in the centre.

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The inspector reviewed a sample of behaviour support plans and found that they were up-to-date and contained appropriate information to guide the staff team. On the day of the inspection, there were some restrictive practices were in use in the centre. The restrictions had been identified by the person in charge and reviewed by the provider's Positive Approaches Management Group.

There were systems in place to safeguard residents. The inspector reviewed a sample of incidents occurring in the centre and there was evidence of safeguarding measures in place to manage identified safeguarding concerns. Residents informed inspectors that they felt safe and were observed to appear comfortable and content in their home throughout the inspection.

There were systems in place to assessment, management and review of risk. The person in charge maintained a risk register. The risk register outlined general risks and individual risks and the controls measures in place to reduce risk. There was also evidence of a positive approach to risk taking which included residents staying at home alone for periods of time and travelling independently.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire

extinguishers which were serviced as required. Centre records demonstrated that fire evacuation drills were completed regularly. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place which outlined the supports for each resident to evacuate the designated centre.

However, one PEEP required updating as the supports outlined did not suitably guide staff. This was reviewed by the person in charge and the fire safety officer and addressed shortly after the inspection. The provider's fire safety officer had identified some upgrade works were required to fire detection and containment measures already in place in the centre. The provider was taking measures as part of a service wide improvement plan to upgrade fire identification and containment measures.

Regulation 17: Premises

The designated centre was decorated in a homely manner and well maintained. However, the kitchen in the centre required updating as the veneer on the outside of presses was in disrepair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to identify, assess and review risk and the person in charge maintained a risk register which outlined general risk and individual risks.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management including suitable fire safety equipment and regular fire drills. Some upgrade work, as identified by the provider's fire safety engineer, were required to enhance the current fire safety arrangements in place for the detection and containment of fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up to date assessment of need in place which identified residents' health and social care needs and informed the residents' personal plan. The personal plans were up-to-date and guided the staff team in supporting residents with their assessed needs.

Judgment: Compliant

Regulation 6: Health care

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

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The plans were up to date and contained appropriate information to guide the staff team.

There were some restrictive practices being utilised in the centre. The restrictions had been identified by the person in charge and reviewed by the provider's Positive Approaches Management Group.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and manage safeguarding concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for A Bettystown Ave OSV-0002365

Inspection ID: MON-0025441

Date of inspection: 06/02/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • 1 WTE has been assigned to current vacancy • 1 WTE staff has been assigned to designated centre and a relief staff has been also assigned on fulltime hours to ensure continuity of care. • Efforts will continue to be made to ensure experienced staff familiar with the centre are utilized to ensure continuity of care.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Staff supervision schedule in place for 2020. • Three supervision meetings completed so far. Remaining first quarter meetings scheduled to be completed by end of March 2020. • Supervision meeting records on file in centre.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Housing Association contacted to seek upgrade of kitchen on 03.03.2020.

• Housing Association Manager visited premises 10.03.2020 and completed a detailed inspection of work required. Housing Association confirmed work will be completed by quarter 4 of 2020.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• St. Michaels House Housing Association is commencing a door closer role out programme opening onto means of escape corridors in centre's, this is due to commence in March 2020

• The attic space between 1A & 1 (B) Bettystown has been compartmentalized, this was completed in November 2019.

• A work schedule has been developed by SMH Fire Officer and it is expected that all works will be completed by end 2020.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	29/02/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	29/02/2020
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	31/12/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	31/12/2020

	detecting, containing and extinguishing fires.			