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:	Fox's Lane
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	15 October 2019
Centre ID:	OSV-0002366
Fieldwork ID:	MON-0025704

About the designated centre

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

The designated centre is a community based home which provides full-time residential care and support to five adults both male and female with varying degrees of intellectual and physical disabilities. The centre consists of a six-bedroom bungalow with two sitting rooms, a kitchen/dining area, shower room and two bathrooms. It is situated in a mature residential cúl-de-sac with coastal views and a variety of local amenities such as shops, churches, restaurants, pubs, beauticians, a medical centre, pharmacies, hairdressers, barbers, banks and local beaches. There is a vehicle to enable residents to access local amenities and leisure facilities in the surrounding areas. Residents in the centre are supported by a staff team comprising of a person in charge and social care workers. Staff support is provided to residents 24 hours a day, seven days a week. Residents' individual needs are continuously changing and staff support is offered in accordance with this.

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
15 October 2019	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 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. The inspector observed that each of the residents had their own bedroom which had been personalised to their individual taste. One of the residents indicated to the inspector that they enjoyed living in the centre and that staff were good to them. However, there was evidence that there were compatibility issues between residents and that the behaviours of two of the residents on occasions had a negative impact on other residents living in the centre.

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 family representatives for any of the residents but it was reported that they were overall 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, due to the compatibility issues for two of the residents, these arrangements were unable to ensure that the service provided was safe and appropriate to meet each of the resident's needs.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge was on planned leave on the day of this unannounced inspection but was interviewed by the inspector, over the phone on their return from leave. It was noted the person in charge had an in-depth knowledge of the needs of each of the residents. The person in charge was in a full-time position and not responsible for any other centre. They were supported by a deputy manager.

The person in charge held a degree in social care and a degree in accountancy and human resource management. They had been working with the provider for more than 13 years and in total had more than five years management experience. They had taken up the role of person in charge in this centre in May 2018. The person in charge was found to have a sound knowledge of the requirements of the regulations and standards. Staff members spoken with told the inspector that he supported them in their role and supported 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 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.

An annual review of the quality and safety of care had been completed. This review referred to consultation with residents and their families as per the requirement of the regulation. The provider had completed six-monthly unannounced visits to assess the quality and safety of the service. There was evidence that actions were taken to address issues identified on these visits but records recording progress were not easy to interpret. The person in charge completed data sheets on a regular basis which were submitted to the service manager. These included matters such as achievements in the previous month, complaints, incident reports and restrictive practices. A number of other audits were completed in the centre. Examples included, medication, health and safety, restrictive practices, hygiene and personal plans.

There were systems in place for the recording and management of all incidents. From a sample of incidents reviewed it appeared that incidents had been appropriately recorded and or notified to the Office of the Chief Inspector of Social Services as per the requirements of the regulations.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. However, at the time of inspection there were 2.5 whole-time-equivalent staff vacancies in the centre. A requirement for one additional staff member had been identified in the preceding period to meet the changing physical and psychological needs of one of the residents. A number of relief staff were used to cover vacancies. Overall, there was evidence that the same core group of staff were used which meant that there was consistency of care for the residents.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. However, at the time of inspection there were a small number of staff overdue to attend some mandatory training. For example, training in the management of challenging behaviour. Dates for this training to be completed had been identified. There was a staff training and development policy, dated March 2018. A training programme was in place which was coordinated by the provider's training department. There were no volunteers working in the centre at the time of inspection.

There were staff supervision arrangements in place. However, it was evident that supervision for some staff members was not being undertaken in line with the frequency proposed in the providers policy. In the absence of the person in charge on the day of this inspection, the inspector did not have an opportunity to review supervision records. However, it was evident from speaking with staff that there were some staff who had not completed formal supervision in an extended period.

There were appropriate arrangements in place for the admission and discharge of residents to and from the centre. Each resident had a written agreement in place which outlined the terms on which the resident would reside in the centre. However, in one of the resident's files reviewed, the fees to be charged were not clearly stated as 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, at the time of inspection there were two and a half whole-time-equivalent staff vacancies in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, a small number of staff were overdue to attend mandatory training. Formal staff supervision for some staff had not been undertaken in line with the frequency proposed in the providers policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service. However, due to the incompatibility of residents, these arrangements were unable to ensure that the service provided was safe and

appropriate to meet each of the residents needs.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had a written agreement in place which outlined the terms on which the resident would reside in the centre. However, in one of the resident's files reviewed, the fees to be charged were not clearly stated as required by the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

There were systems in place for the recording and management of all incidents. Incidents had been appropriately recorded and or notified to the chief inspector as per the requirements of the regulations.

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, the changing physical and psychological needs of one resident was difficult for staff to manage in a group living environment and negatively impacted on the residents.

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Care plans, personal support plans and 'all about me' documents were in place. These 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. Goals for individual residents had been established and progress in achieving goals set were monitored and recorded on goal update and tracker sheets. Personal support plans were reviewed at regular intervals with the involvement of the resident's multidisciplinary team, the resident and family representatives at well being review meetings.

The residents were each supported to engage in meaningful activities in the centre

and within the community. Each of the residents were engaged in a formal day programme. Activities residents enjoyed included, trips to theatres, shows and matches, shopping, cinema, dinners out and beautician treatments. It was noted that some residents enjoyed going on hotel breaks or short breaks to the provider's holiday home located a distance away from the centre. A number of the residents went to their family homes for overnight stays on a regular basis. A record was maintained of activities residents engaged in.

The communication needs of residents had been assessed and were being met. Individual communication guidelines and communication support plans were in place and provided a good level of detail to guide staff. There were communication tools, such as picture exchange and object of interest in place, to assist this resident to choose diet, activities, daily routines and journey destinations.

The centre was found to be accessible, comfortable and homely. However, maintenance and upkeep was required in a number of areas. For example, a number of areas required repainting and the surface of presses and work tops in the kitchen were broken and required replacement. This meant that it would be difficult to clean these areas which in turn had an impact on the effectiveness of infection control measures being implemented.. Each of the residents had their own bedroom which had been personalised to their tastes and choices. This promoted the resident's independence, dignity and respect. Plans were in place to update the garden to the front of the centre.

The residents were provided with a nutritious, appetizing and varied diet. The timing of meals and snacks throughout the day were planned to fit around the needs of the residents. A weekly menu was agreed with residents 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. These outlined appropriate measures in place to control and manage the risks identified. The provider's quality and standards manager provided support to the person in charge where required. Monthly health and safety audits were completed in the centre. A local risk register was maintained in the centre. There were systems in place for the reporting and management of incidents and accidents. Local incident review reports were completed and incident and accident trackers were maintained. This promoted opportunities for learning to improve services and prevent incidences.

Overall, suitable arrangements were in place for the management of fire. However, at the time of inspection it was identified that the fire alarm system was overdue for servicing. In addition, the provider had identified a small number of fire safety works for completion, required for the containment of fire. There was a plan in place for the completion of same. There was an internal emergency response plan and a fire safety management policy, dated March 2019. A fire risk assessment had been completed. There was documentary evidence that fire fighting equipment was serviced at regular intervals by an external company and checked regularly as part

of internal checks in the centre. There were adequate means of escape 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 emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Fire drills involving residents were undertaken at regular intervals. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training.

There were some measures in place to protect residents from suffering abuse and residents were provided with appropriate emotional and behavioural support. However, the behaviours of two of the residents were difficult for staff to manage in a group living environment. There was evidence that this was having a negative impact on other residents living in the centre. From a review of incidents and other records held in the centre it was evident that the behaviour of one of the residents in particular had, on occasions, a negative impact on other residents living in the centre. It was noted that this had been identified by the provider and that an alternative residential placement was being sought for the resident.

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. Safeguarding plans were also in place.

Regulation 10: Communication

The communication needs of residents had been assessed and were being met.

Judgment: Compliant

Regulation 17: Premises

The centre was homely and accessible. However, maintenance and upkeep was required in a number of areas. For example, a number of areas required repainting and the surface of presses and work tops in the kitchen were broken and required replacement.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a nutritious, appetizing and varied diet.

Judgment: 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

Overall suitable arrangements were in place for the management of fire. However, at the time of inspection it was identified that the fire alarm system was overdue for servicing. In addition, the provider had identified a small number of fire safety works for completion, required for the containment of fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support.

Judgment: Compliant

Regulation 8: Protection

There were some measures in place to protect residents from being harmed or suffering from abuse. However, the behaviours of two of the residents were difficult for staff to manage in group living environment and there was evidence that this was having a negative impact on other residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
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	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Fox's Lane OSV-0002366

Inspection ID: MON-0025704

Date of inspection: 15/10/2019

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: In response to the area of non-compliance found under regulation 15; • At present there is an ongoing recruitment campaign to replace Staff vacancies. 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 has been identified for one WTE position and will commence in the Designated Centre on the 13/1/2019	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to the area of non-compliance found under regulation 16; • Positive Behavior Support training: One staff has commenced on the 5th Nov 2019 and two staff scheduled for the next PBS on the 4th Jan 2020. • Hand Hygeine: 6th Dec 2019 • Food safety: Completed on the 26th Nov 2019 • Therapeutic intervention Promoting Safety training for 3 staff is scheduled for 6th Dec 2019. One additional staff will be scheduled for next available slot early 2020 • First Aid Training: Scheduled for one staff on the 9th Jan 2020, one additional staff scheduled for refresher FA on the 14th Jan 2020. • Staff supervision scheduled and completed for all staff by 2nd Dec 2019. • PIC to ensure supervision meetings for all staff are scheduled tri monthly to comply with SMH supervision policy	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to the area of non-compliance found under regulation 23;

• Review of all residents compelted and relevant information forwarded to residential waitlist for consideration of Residential setting more suited to their support needs.
• External advocate has been sourced and actively links with residents within the centre.
• Links with Mental Health ID service within SMH to best support residents
• ICM for one resident on the 26th Nov 2019 and recommendations re; specific support needs.
• Psychology input, re; behavioural strategies to address behaviours that challenge
• Each resident is informed of their safeguarding support plans at weekly house meetings and keyworker/ keyclient meetings. Minutes of same are captured in Significant Conversation Meetings.
• Easy read complaint procedure in place and residents have been supported to make a complaint .
• All incidents of a safeguarding nature will be notified in line with regulatory requirements and acted on within SMH Safeguarding of Adults Policy

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
In response to the area of non-compliance found under regulation 24;

• Contract of care for one resident has been updated on the 1st Nov 2019 and now reflects the weekly fees to be charged under regulatory requirements

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to the area of non-compliance found under regulation 17:

• Replacement of the veneer on the door of kitchen presses, handles, shelves and Kitchen top; To be completed by 31 /3/2020
• Painting and redecorating of the DC addressing previous issues: To be completed by: 28/2/2020
• Completion of repair works carried out in 2019; To be completed by 31/1/2020

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to the area of non-compliance found under regulation 28;
• The fire alarm had been serviced on the 14th Oct 2019 but Documentation had not been on site for review on date of inspection. Subsequent to this service record acquired on the 22nd Oct 2019 and available on site for review.
• TSD re: Alcatrave in one residents room had not been finished adequately to ensure fire containment will be completed by 6th Dec 2019

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In response to the area of non-compliance found under regulation 8;
• A meeting was held with the Lead Social Worker of the National Safeguarding Office on 10th October 2019. This meeting was attended by the Designated Officer / Service Manager, PIC and Director of Adult Services. Follow up meeting will take place in Jan 2020
• Staff will continue to support and monitor all residents to ensure the protection of all.
• Where an identified risk relates to a safeguarding issue there will be consultation with the Principal Social Worker and Designated Officer and an associated safeguarding processes will be implemented
• Ongoing Safeguarding plans revised to reflect the dynamics within the centre. Behaviors that challenge, their impact and identified controls reviewed in order to ensure the safety of all the residents. These plans will be reviewed by the PIC / Service Manager on a tri monthly basis
• Recruitment of staff ongoing to ensure consistent approach to service delivery. One Vacancy to be filled by 13th Jan 2020
• Ongoing recruitment to replace additional 1.5 vacant position

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	13/01/2020
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	13/01/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2020

Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2019
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	01/11/2019
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services,	Substantially Compliant	Yellow	06/12/2019

	bedding and furnishings.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/11/2019