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:	Ratheanna
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Short Notice Announced
Date of inspection:	06 August 2020
Centre ID:	OSV-0002367
Fieldwork ID:	MON-0030129

About the designated centre

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

Ratheanna is a designated centre operated by St Michael's House located in North County Dublin. It provides a community residential service to five adults with a disability. The designated centre is a bungalow which consists of sitting room, a kitchen/dining room, five bedrooms – one of which is a staff office and two shared bathrooms. The centre is staffed by the person in charge and social care workers. Nursing support is provided through the provider's nursing manager on call system.

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
Thursday 6 August 2020	10:00hrs to 16:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the five residents of the designated centre during the inspection. One resident spoken with spoke positively about the staff team in the designated centre but highlighted their wishes about wanting to move to a new designated centre. The inspector also observed elements of their daily lives at different times over the course of the inspection.

Throughout the inspection residents were observed engaging in activities of daily living including having lunch, watching TV, spending time in their bedrooms and accessing the community. The residents appeared happy and comfortable in their home. The inspector also observed positive interactions between residents and the staff team.

The inspector viewed the complaints and compliments folder and found open complaints related to a multiple occupancy room and the general upkeep of the premises. Overall, the house was decorated in a homely manner and some residents gave permission for the inspector to see their rooms which were decorated in line with their tastes and preferences. However areas of the house required upkeep. This is outlined under Regulation 17, premises.

Capacity and capability

Overall, the inspector found that the provider and person in charge were monitoring the quality and safety of the care and support provided to residents. However, improvements were required in relation to the effective governance and management of the designated centre, the provider's response to complaints also required improvement.

There was a clearly defined management structure in place. The centre was managed by a suitably qualified and experienced person in charge. The person in charge reported to the Service Manager, who in turn reported to the Director of Adult Services. There was evidence of regular quality assurance audits taking place including the annual report 2019 and provider unannounced six monthly visits as required by the regulations. The quality assurance audits identified actions to address areas for improvement.

Although the provider was self identifying areas for improvement, the actions identified in the quality assurance audits were not always implemented in a timely and effective manner. For example, it was identified that a bathroom floor was prone to flooding when the shower was in use in August 2018. While there was evidence that this had been escalated to the relevant managers and reviewed,

at the time of inspection it had not been addressed. In addition, in July 2018 a hygiene audit identified areas where wallpaper was peeling and in May 2019 the person in charge identified damaged paint, damaged plaster and peeling wall paper in areas of the designated centre. The actions for these issues also remained outstanding.

In addition, the registration of the designated centre was renewed in 2019 with a condition that the areas of non compliance in premises and resident rights would be addressed by 2022. There was evidence of some progress in addressing these issues including supporting a resident to move to a larger bedroom, securing planning permission for an extension in October 2019 and exploring an alternative placement for one resident. However, on the day of the inspection the inspector was informed that there was no set start date for building works and the plans for the proposed extension were being reviewed by the provider. Overall, it was unclear if the non compliance identified in premises and residents' rights would be addressed in line with the registration condition.

Whilst the provider had a complaints policy and procedure in place improvement was required in progressing complaints in a timely manner and resolving complaints to the complainants' satisfaction. This had been identified at the time of the previous inspection. The inspector reviewed the complaints and compliments folder and found that there were open complaints in relation to the multiple occupancy bedroom since 2018 and one recent open complaint in relation to the upkeep of the premises. There was evidence that the residents of the multiple occupancy bedroom were supported to access advocacy services and one resident had recently been supported to take part in a consultation process to move to another designated centre. However, it was not evident that the measures required for improvement in response to a complaint were put in place in a timely manner and the subject of the complaints remained ongoing and unresolved.

The person in charge maintained a planned and actual roster. From a review of the staff roster, the inspector found that the staffing levels at the designated centre were appropriate to meet the needs of the residents and ensured continuity of care and support to residents. The centre was currently operating with 1.5 whole time equivalent (WTE) vacancies. On the day of the inspection, the inspector was informed that 1.0 WTE vacancy had been filled. At the time of the inspection a number of staff had been redeployed from the provider's day service due to COVID-19 pandemic. Throughout the course of the inspection, positive interactions were observed between residents and the staff team.

The inspector reviewed a sample of incidents and accidents occurring in the centre and found that the Office of the Chief Inspector was notified as required in Regulation 31.

Regulation 14: Persons in charge

The centre was managed by a suitably qualified and experienced person in charge.

The person in charge demonstrated a good knowledge of the residents and their support needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. At the time of the inspection, the staffing levels at the designated centre were appropriate to meet the needs of the residents and ensured continuity of care and support to residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. There was evidence of regular quality assurance audits taking place which identified actions to address areas for improvement. However, the actions identified in these audits were not always implemented in a timely and effective manner.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Office of the Chief Inspector was notified of incidents and accidents as required in Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

There were complaints polices and procedures in place and residents were supported to access advocacy services. However, it was not evident that the measures required for improvement in response to a complaint were put in place in a timely and effective manner.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that there were systems in place to ensure that residents received a safe service. However, significant improvement was required in relation to the premises and residents' rights. In addition, some improvements were also required regarding fire safety and risk management.

The inspector completed a walk through of the premises accompanied by the person in charge. The centre consisted of a sitting room, a kitchen/dining room, five bedrooms (one of which is a staff sleepover room) and two shared bathrooms. Overall, the centre was decorated in a homely manner. However, the general upkeep and maintenance of the premises required attention. For example, there were areas in the centre with wallpaper peeling, damaged plaster and damaged paint. In addition, improvement was required in upkeep and accessibility of some of the bathrooms. In August 2018, one shared bathroom had been identified by the provider as posing a high risk due to flooding when the shower was in use. This bathroom was also assessed by an Occupational Therapist in 2019 who made recommendations to alter the layout of the bathroom to meet a resident's needs. While there was evidence of some review of the flooding concern, these issues remained ongoing at the time of the inspection. In addition, the inspector was informed a shower in an en suite bedroom that was not accessible to the resident due to their mobility needs.

The previous inspection identified that the premises of the designated centre did not meet the number or needs of residents. Since the last inspection, a resident who was not happy with the size of their bedroom, due to their assessed needs, had been supported to move to a bigger bedroom. However, in line with the previous inspection, there remained insufficient private and communal space to meet the number and needs of residents. For example, there was no private space to welcome visitors and two residents shared a bedroom which impacted on their privacy and dignity. The provider recognised that the premises was not suitable to meet the residents' needs and there was evidence of plans to address the premises issues. However, this issue remained ongoing.

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. Each resident had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting residents to evacuate. There was evidence of regular fire evacuation drills which identified areas for improvement. For example, a recent night time fire drill identified that one resident chose not to engage in the evacuation of the centre. While this had been reviewed by the person in charge with the provider's fire safety officer, some improvement was required to ensure that all persons evacuate the designated centre in the event of a fire. In a fire safety report prepared by the

provider's fire safety officer, it was identified that improvements were required in the arrangements for the containment and detection of fire. The provider had a organisation wide plan to address these areas for improvement.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre specific and individual risks and the measures in place to mitigate the identified risks. However, the controls identified to mitigate identified risks were not always put in place in a timely manner. For example, the bathroom flooding was identified as a high risk and the identified control measures had not been implemented in a timely manner to address this issue.

The inspector reviewed a sample of personal plans and found them to be person centred. Each resident had an up-to-date assessment of need which identified residents' health and social care needs and informed the residents' personal support plans. In addition, there was evidence that residents' health care needs were appropriately managed. Residents were supported to access allied health professionals as required including General Practitioners (GP), Dentist, Psychology and Psychiatry. The healthcare plans were up to date and suitably guided the staff team to support residents with identified healthcare needs. Nursing support was also available through an on-call system and from centres located near by if required.

Residents were supported to manage their behaviours and there were positive behaviour support plans in place as required. 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 was one identified restrictive practice in use in the centre which was regularly reviewed by the provider's Positive Approaches Monitoring Group.

There were systems in place to safeguard residents. The inspector reviewed incidents and found that they were appropriately managed and responded to. Residents were observed to appear comfortable and content in their home throughout the inspection.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment including hand sanitizers and masks were available and were observed in use in the centre on the day of the inspection.

Regulation 17: Premises

The design and layout of the designated centre did not meet the number and needs of residents. For example, there was a multiple occupancy bedroom and

there was insufficient private and communal space to meet the number and needs of residents. In addition, the general upkeep and maintenance of the premises required attention as outlined in the report.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. However, the controls
identified to mitigate identified risks were not always put in place in a timely manner.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with infection.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including which were serviced as required. There was evidence of regular fire evacuation drills taking place. Each resident had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting residents to evacuate. However, improvements were required in evacuating all persons in the designated centre in the event of a fire and the arrangements for the containment and detection of fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date assessment of need which informed the residents' personal support plans. Personal support plans were found to be person centred, up

to date and provided appropriate guidance to the staff team.

Judgment: Compliant

Regulation 6: Health care

Residents health care needs were appropriately managed. Residents were supported to access allied health professionals as required. The healthcare plans were up to date and suitably guided the staff team to support residents with identified healthcare needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and there were positive behaviour support plans in place as required.

Restrictive practices in use in the centre were identified and were regularly reviewed by the provider's Positive Approaches Monitoring Group.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to access advocacy services. However, improvement was required in relation to protecting residents' privacy and dignity due to a multiple occupancy bedroom.

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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	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
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ratheanna OSV-0002367

Inspection ID: MON-0030129

Date of inspection: 06/08/2020

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 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Director of Adult Services had a meeting with the CEO of St Michael's Housing Association and the Director of Operations on the 1st September 2020. Agreement made to proceed with the planned extension as listed in the planning permission dated 24th October 2019.</td></tr>
<tr><td>Regulation 34: Complaints procedure</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Each resident is supported by an independent advocate to assist their participation in the complaint process. Each of these complaints has been escalated to the organisations Complaints Officer who has corresponded and met with both residents on the 28th February 2020.
• All complaints have been followed up and the provider has engaged in the process with the residents and advocate to address the complaints in relation to the shared bedroom and the premises.
• At a meeting with the St Michaels Housing Association on the 1st of September 2020 it was agreed that all remedial and interior decorating works would be completed by the 30th September 2020.
• Consultation processes for one resident recommenced on the 25th August and continues.
• Works on upgrading the main bathroom to commence 21st September 2020.</td></tr>
</table>

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Director of Adult Services had a meeting with the CEO of St Michael's Housing Association and the Director of Operations on the 1st September 2020. Agreement to proceed with the planned extension as listed in the planning permission dated 24th October 2019.
• A schedule of works and costing is to be developed and completed by 30th September 2020.
• At a meeting with the St Michaels Housing Association on the 1st of September 2020 it was agreed that all remedial and interior decorating works would be completed by the 30th September 2020.
• In relation to the shared bedroom, the consultation process recommenced on the 25th August.
• Works on upgrading the main bathroom to commence 21st Spetember 2020.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Shower room upgrade to meet changing needs of residents – CEO of SMH Housing Association to instruct SMH TSD to get Quotations from 3 Contractors by 2nd September 2020.
• Shower room upgrade to meet changing needs of residents - Works to commence 21st September 2020.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A further fire evacuation will take place by 6th September.
• The resident's PEP has been updated.
• Director of Adult Services had a meeting with the CEO of St Michael's Housing Association and the Director of Operations on the 1st September 2020. Agreement to

proceed with the planned extension as listed in the planning permission dated 24th October 2019.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Consultation prosess recommenced on the 25th August and continues. • Director of Adult Services had a meeting with the CEO of St Michael's Housing Association and the Director of Operations on the 1st September 2020. Agreement to proceed with the planned extension as listed in the planning permission dated 24th October 2019.	

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	28/02/2021
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.	Not Compliant	Orange	28/02/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	28/02/2021
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	28/02/2021

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	21/10/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	28/02/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	28/02/2021
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put	Not Compliant	Orange	21/10/2020

	in place.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	28/02/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	28/02/2021