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:	49 Rathbeale Road
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	20 August 2020
Centre ID:	OSV-0002393
Fieldwork ID:	MON-0030223

About the designated centre

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

49 Rathbeale Road 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 detached dormer bungalow which consisted of two sitting rooms, a kitchen, five bedrooms, staff sleepover room, spare room, two shared bathrooms and a utility room. The centre is staffed by the person in charge and social care workers.

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 20 August 2020	11:00hrs to 17:00hrs	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. Residents spoken with said they liked living in the house. Some residents used non-verbal methods to communicate and appeared comfortable in their home and in the presence of staff. The inspector also had the opportunity to speak with two family members who spoke positively about the care and support provided in the designated centre.

The inspector also observed elements of residents' 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, listening to music, spending time in their bedrooms and accessing the community. Overall, the residents appeared happy and comfortable in their home. The inspector also observed positive interactions between residents and the staff team.

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 governance and management, staffing and staff training.

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. The quality assurance audits identified actions to address areas for improvement. However, improvement was required in the timeliness of completing the provider's unannounced six monthly visits as required by the regulations. For example, the last two six monthly visits were carried out May 2020 and June 2019.

The person in charge maintained a planned and actual roster. From a review of the staff roster, the inspector found that on the day of the inspection staffing levels at the designated centre were appropriate to meet the needs of the residents and ensured continuity of care and support to residents. However, at the time of the inspection a number of staff had been redeployed from the provider's day service due to COVID-19 pandemic. While the current staffing levels were appropriate, it was not clear that plans were in place to ensure continuity of appropriate staffing levels in line with the residents' changing needs when redeployed staff returned to work in the day services. Throughout the course of the inspection, positive

interactions were observed between residents and the staff team.

There were systems in place for the training and development of the staff team. From a review of a sample of staff training, the inspector found that the records did not demonstrate that some of the staff team had up-to-date mandatory training in areas including hand hygiene, food hygiene, safe administration of medication and safeguarding vulnerable persons. While, the person in charge noted that some refresher training had been completed on-line, it was not clear from training records that the staff team had up-to-date skills and knowledge to meet the needs of the residents.

The previous inspection identified that improvement was required in the directory of residents. From a review of a sample of the directory, this had been addressed and included all information as specified by Regulation 19.

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 person in charge worked full time and was suitably qualified and experienced to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual staff roster. At the time of the inspection, staffing arrangements at the centre were appropriate to meet the needs of the residents and ensured continuity of care and support to residents. However, it was not clear that plans were in place to ensure continuity of appropriate staffing levels in line with the residents' needs when redeployed staff returned to work in the day services.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. However, it was not clear from training records that the staff team had up-to-

date skills and knowledge to meet the needs of the residents.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents contained all of the information as specified by Regulation 19.

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. However, improvement was required in the timeliness of completing the provider's unannounced six monthly visits.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

There were systems in place for the recording and management of all incidents. All adverse incidents were notified as appropriate to the Office of the Chief Inspector in line with Regulation 31.

Judgment: Compliant

Quality and safety

The management systems in place ensured the service was monitored and provided a safe, appropriate care and support to residents. However, improvement was required in fire safety, upkeep of premises, personal plans and risk assessments.

The inspector completed a walk through of the premises accompanied by the person in charge. The designated centre is a detached dormer bungalow comprising of two sitting rooms, a kitchen, five bedrooms, staff sleepover room, spare room, two shared bathrooms and a utility room. Overall, the designated centre was decorated

in a homely manner. Some residents showed the inspector their rooms which were decorated in line with their tastes. The previous inspection found that the premises was not laid out to meet the number of residents. This had been addressed as the provider had supported one resident to move to alternative accommodation in line with their needs and reduced the total number of residents living in the designated centre. However, there were areas of the premises which required attention including areas of paint, flooring in areas of the house and the kickboards in the kitchen. These were self-identified by the provider in a hygiene audit.

The inspector reviewed a sample of personal plans and found that each resident had an up-to-date assessment of need in place. This assessment informed the residents' personal plans which were found to be up-to-date and appropriately guided the staff team in supporting residents with identified health and social care needs. However, some improvement was required to ensure the assessment of need captured each identified need and a personal plan is in place in order to guide the staff team in supporting residents. For example, the inspector identified that one assessment of need did not appropriately identify all health care needs for one resident. However, there was evidence that the resident was supported with this need. The assessment of need and plans required review to ensure residents were appropriately supported.

Residents' health care needs were managed to an adequate standard. Residents were supported to manage their health care conditions and had regular access to allied health professionals including General Practitioners (GP), Speech and Language Therapists and Physiotherapists.The healthcare plans were up to date and suitably guided the staff team to support residents with identified healthcare needs.

There were positive behaviour supports in place to support residents to manage their behaviour where required. The inspector reviewed a sample of positive behaviour support plans and found that they were up to date and appropriately guided the staff team. There was one restrictive practice in use in the designated centre which was identified and reviewed regularly by the Provider's Positive Approaches Management Group.

There were systems in place to safeguard residents. The previous inspection identified that the behaviours of a resident were difficult for staff to manage in group living environment and there was evidence that this was having a negative impact on other residents. This had been addressed as the provider had supported a resident to move to alternative accommodation in line with their needs. The inspector reviewed a sample of incidents occurring in the centre which demonstrated that incidents were appropriately managed and responded to. There was evidence that identified safeguarding concerns were identified, responded to and appropriately reported on. Residents were observed to appear comfortable and content in the service throughout the inspection and some residents spoke positively about living in the designated centre.

There were systems in place for the assessment, management and ongoing review of risk. The person in charge maintained a risk register which outlined general risks

in the centre and individual risks. The risk assessments outlined the control measures in place to manage and reduce the risk in the designated centre. However, some improvement required to ensure that all identified risks had a risk assessment in place. For example, there was identified risk for one resident in relation to eating and drinking. While there were appropriate controls in place including allied health professional input and guidance, it was not evident a risk assessment had been carried out.

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 service user had a personal evacuation plan in place. Centre records demonstrated that fire evacuation drills were completed. However, improvement was required in the arrangements in place to ensure all persons could be evacuated and bringing them to safe locations. For example, the centre has been categorised as high fire evacuation risk due to the needs of the residents and evidence from fire drills. A fire drill carried out in July 2019 identified that one resident would not evacuate. There was evidence of review in 2019 and a role play evacuation in September 2019. However, a fire drill in January 2020 identified that a number of residents would not evacuate. While this was escalated to the Fire Safety Officer, the issue remained ongoing at the time of 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. There was a folder with information about COVID-19 and infection control guidance and protocols for staff to implement while working in the centre. The inspector observed that personal protective equipment including hand sanitizers and face masks were available and in use in the centre.

The previous inspection identified that assessments had not been completed to determine if any of the individual residents had the ability to self manage and administer their own medications as required by the regulations. This had been addressed and the provider had completed this assessment with each resident.

Regulation 17: Premises

The centre was well maintained and decorated in a homely manner. However, there were areas of painting, flooring and kitchen kick boards in need of maintenance and repair.

Judgment: Substantially 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, some improvement was required to ensure all identified risk had a risk assessment in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and control of 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 which were serviced as required. However, improvement was required in the arrangements for reviewing fire precautions as outlined in the report.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The action from the previous inspection was addressed and assessments had been completed to determine if any of the individual residents had the ability to self manage and administer their own medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an assessment of need in place for residents which were reviewed regularly. Support plans were developed in line with residents' assessed needs. However, there was some improvement required to ensure the assessment of need captured each identified need and a personal plan is in place in order to guide the

staff team in supporting residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had support plans in place to guide staff on how to support the residents to enjoy the best possible health. Residents had access relevant allied health professionals in line with their assessed 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 were identified and reviewed regularly by the Provider's Positive Approaches Management Group.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence that identified safeguarding concerns were identified, responded to and appropriately reported on. Residents were observed to appear comfortable and content in the service throughout the inspection.

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	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for 49 Rathbeale Road OSV-0002393

Inspection ID: MON-0030223

Date of inspection: 20/08/2020

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:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In response to Regulation 15 (1) and the need for plans to be in place to ensure continuity of appropriate staffing levels in line with Residents' needs the Provider has: • Already increased the staffing levels from 6 WTE posts to 7.4 WTE to address changing needs • Changed the sleepover shift to a live night shift for greater supervision • The PIC + Service Manager have attended Roster Reviews and a further Roster Review will be arranged • Consultation with Residents has begun to identify what Service they would like, how often etc when Day Service resumes for people living in Residential Houses • The PIC has identified the need for 2 additional staff to remain supporting Residents until the resumption of Day Service in the absence of redeployed Day Service Staff • The Registered Provider in consultation with the PIC has identified the need for 2 additional staff to remain in the centre to support residents who aren't in receipt of Day Service Provision. A Business Case has been submitted to the HSE in relation to this	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to Regulation 16 (1) (a) the PIC will: • Ensure that the Staff Training Records are up to date to include all the recent on-line training completed • The PIC will develop a local system to ensure up to date Training Records are kept	

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 Regulation 23 (2) (a):
• The Service Manager will ensure that 2 x 6 Monthly Audits are carried out in a timely manner annually
• A second 6 Monthly Audit will be scheduled for Nov 2020

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to Regulation 17 (1) (b):
• The PIC has contacted the Maintenance Dept identifying the outstanding works to be completed including painting, flooring and kitchen kick boards and agree a time frame for completion
• The Maintenance Dept have completed a site visit and have measured up the kick boards in the kitchen
• A quote has been submitted for the painting
• Any works needed will be put on the schedule of work for the organisation

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In response to Regulation 26 (2):
• The PIC will review all the risks identified and ensure that there is a risk assessment in place for each one.
• The PIC will complete a risk assessment in relation to eating and drinking to support all the controls and guidance already in place for one Resident

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to Regulation 28 (3) (d):

• All staff members have completed on-line Refresher Fire Safety Training between March – June 2020
• The PIC has completed on-line Frontline Manager Fire Safety Training in April 2020
• The PIC will arrange for the Staff Training records to reflect the training completed
• The PIC has discussed fire safety and evacuation procedures with staff members at the unit staff meeting on 9th Sept 20
• Following this the PIC and Fire Officer will forward recommendations to the Service Manager + Director of Adult Services
• The PIC will furnish the report to the Organisational Fire Officer and any works will be put on the schedule of work for the organisation
• The PIC will arrange for a further Fire Drill to be completed in line with the organizational policy and procedure

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
In response to Regulation 5 (4) (a):
• The PIC will arrange to review the Assessments of Need and Support Plans with each Key Worker
• The PIC and Key Workers will ensure that all health care needs are appropriately identified in the Assessment of Need documents

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	31/01/2021
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.	Not Compliant	Orange	30/09/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/03/2021

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/12/2021
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	30/09/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	31/03/2021

	evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2020