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:	Landscape
Name of provider:	St Michael's House
Address of centre:	Dublin 14
Type of inspection:	Unannounced
Date of inspection:	20 November 2019
Centre ID:	OSV-0002397
Fieldwork ID:	MON-0026140

About the designated centre

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

Landscape is a designated centre operated by Saint Michael's House located in South County Dublin. It provides a community residential service to six adults with a disability. The centre comprises of two premises which are located in close proximity to each other. The first unit is a two storey house which consists of a five bedrooms, office, sleepover room, two sitting rooms, dining room/kitchen, three bathrooms and utility room. The centre's second premises is a two-storey house which comprised of three bedrooms, sitting room, dining room, kitchen and bathroom. The centre is staffed by a person in charge and social care workers. In addition, the provider has arrangements in place to provide management and nursing support outside of office hours and at weekends 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
20 November 2019	09:30hrs to 16:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with four of the residents on the day of the inspection. One resident was on a planned trip home at the time of the unannounced inspection. The inspector did not meet the other resident in line with their preference and assessed needs. Some residents communicated their thoughts and opinions verbally while others used non-verbal methods to communicate.

Overall, the residents spoke positively about living in the centre and the supports they received. Some residents used non-verbal methods to communicate and were observed appearing content and comfortable in the centre.

The inspector spent time in the kitchen/dining room and one of the sitting rooms and observed residents as they prepared to engage with their daily activities which included accessing the community and day services. The inspector also observed residents engaging in activities of daily living such as enjoying their lunch, watching TV and relaxing. Residents spoken with told the inspector about the things they liked attending clubs, meeting up with family and showed the inspector videos on their tablets. Throughout the day of inspection, the inspector observed positive interactions between staff and residents.

However, the inspector observed a number of complaints in relation to compatibility issues in the resident group which had resulted in some safeguarding concerns which were impacting negatively on residents quality of life and safety of care provided.

Overall, it was observed that the designated centre was decorated in a homely manner. However, some areas of the centre were not kept in a good state of repair. The inspector completed a walk through of the first unit guided by a resident and it consisted of five individual bedrooms which were decorated in line with residents tastes and preferences, office, sleepover room, two communal sitting rooms, dining room/kitchen, three bathrooms and utility room. There was a garden to the rear of the house.

The second house is a two-storey house which comprised of three bedrooms, sitting room, dining room, kitchen and bathroom. On the day of the inspection, the inspector did not visit this house in line with the resident's preference and assessed needs.

Capacity and capability

The governance and management systems in place effectively and consistently

monitored the service to ensure the effective delivery of care and support in line with the assessed needs of residents. However, the staffing arrangements required review.

There was a clearly defined governance and management structure in place. The centre was managed by a full-time person in charge who was also responsible for the management of another designated centre. The person in charge was appropriately qualified and experienced and demonstrated good knowledge of the residents and their assessed needs. There were quality assurance audits in place including six monthly unannounced provider visits and an annual review for 2018 in line with the regulations. In addition, there were specific audits in place which included medication management, health and safety and personal plans. These identified areas for improvement and developed plans to address areas.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of rosters which demonstrated that during the day in the first unit, two staff work in this centre during the day and on weekends there is a third staff on location. At night time, one waking night staff is rostered for this location. The rosters also demonstrated that 1:1 staffing support was provided in the second unit. At the time of the inspection, the centre was operating with two whole time equivalent vacancies (two social care workers). However, continuity of care was maintained by covering shifts with the staff team and a low number of regular relief and agency. The provider was in the process of recruiting to fill these vacancies.

While, there was evidence of increased staffing levels at weekends and a change to waking night staff, the staffing arrangements required further review. For example, the provider could not demonstrate, at the time of the inspection, that there was sufficient staffing levels available to meet all of the assessed needs of residents at times in the designated centre.

There were systems in place for the training and development of the staff team. From a review of the training records, the inspector found that the staff team had up-to-date mandatory refresher training including fire safety, safeguarding and safe administration of medication. In addition, there was evidence of scheduling refresher training to ensure that the staff team had up-to-date skills and knowledge to meet the needs of the residents.

The inspector reviewed a sample of adverse incidents and accidents and found that adverse incidents were notified to the Office of the Chief Inspector of Social Services in line with Regulation 31.

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. At the time of the inspection, the centre was operating with two whole-time-equivalent vacancies (two social care workers). Continuity of care was maintained overall, however, the

staffing arrangements required ongoing review.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The staff team had up-to-date mandatory refresher training including fire safety, safeguarding and safe administration of medication.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance and management structure in place. There were quality assurance audits in place including six-monthly unannounced provider visits and an annual review for 2018 in line with the regulations.
These identified areas for improvement and developed plans to address areas.

Judgment: Compliant

Regulation 31: Notification of incidents

All adverse incidents and accidents were notified to the Office of the Chief Inspector of Social Services in line with Regulation 31.

Judgment: Compliant

Quality and safety

While on the day of the inspection residents appeared content and comfortable in their home, ongoing compatibility issues in the resident group had resulted in some safeguarding concerns which were impacting negatively on residents' quality of life and safety of care provided. In addition, some improvements were required in personal plans, fire safety, medication management and premises.

Residents told the inspector that they were happy in the centre and were observed

to appear comfortable in their home. However, the systems in place for safeguarding residents required improvement as the systems in place to safeguard residents were not effective at all times. From a review of recorded adverse incidents, which had occurred in the centre, it was noted that some adverse incidents impacted on residents' quality of life and the safety of care provided. On the day of the inspection, there was evidence that the provider had put safeguarding plans in place to help address some of these issues and reviewed the compatibility of residents. In addition, the provider noted that they had reviewed a number of adverse incidents, identified a trend and had developed a plan. However, at the time of this inspection, the inspector found that ongoing adverse incidents meant that at times, residents were not adequately safeguarded in the centre.

The inspector reviewed a sample of residents' personal files and found that an up-to-date assessment of need had been completed for each resident. The assessments 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. Some personal plans required review to ensure they appropriately guided staff team. For example, one care plan reviewed did not include or refer to the allied health professionals guidelines. This had also been self-identified by the provider through an audit of personal plans.

There were positive behaviour supports in place for residents where required. The inspector reviewed a sample of the positive behaviour support plans and found that they were up-to-date and guided the staff team in supporting residents to manage their behaviour. Residents were supported to enjoy their best possible mental health and, where required, had access to psychiatry. There was a small number of restrictive practices in use in the designated centre, and there was evidence that the restrictions were reviewed by the provider's Positive Approaches Management Committee in a timely manner. In addition, any PRN (as required) medication prescribed to support residents was regularly reviewed by the psychiatrist.

The inspector completed a walk though of the designated centre. Overall, the designated centre was decorated in a homely manner. However, some areas of the centre were not kept in a good state of repair. The previous inspection identified some furniture in disrepair and some areas of paint and plaster requiring repair. While, the furniture had been replaced, the paint and plaster remained in disrepair. In addition, the inspector observed that the floorboards in one of the rooms were uneven and required review.

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 risks including lone working, medication and fire safety. In addition, individual risk assessments were in place for risks including behaviour and safeguarding.

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 outlined the supports for each resident to evacuate the designated centre if required. While, there was evidence of fire drills and regular discussions with residents regarding fire safety, improvements were required to ensure the safe and timely evacuation of all persons in the designated centre in the event of a fire. For example, it was not evident that the provider had assessed the effectiveness of their night time evacuation procedures for each residential unit that made up the designated centre, for example by way of a night time drill.

The inspector reviewed the medication management practices within the centre. There were suitable practices in place for the ordering, receipt, disposal and administration of medication. The inspector reviewed a sample of medication administration sheets and found that medication was administered as prescribed. However, the storage arrangements in place required some minor improvement as not all medications (creams and liquids) had opening dates recorded.

Overall, residents reported that they were happy with the service provided and appeared content in their home. However, ongoing compatibility issues had resulted in some safeguarding concerns which were impacting negatively on residents quality of life and safety of care provided. In addition, some improvements were required in personal plans, fire safety, medication management and premises.

Regulation 17: Premises

The designated centre was decorated in a homely manner. However, some areas of the centre were not kept in a good state of repair. Some areas of the paint and plaster required repair and upkeep. In addition, the floorboards in one of the rooms were uneven and required review.

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.

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 emergency lighting, a fire alarm and fire extinguishers which were serviced as required. While, there was evidence of fire drills, improvements were required to ensure the safe and timely evacuation of all persons in the designated centre in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable practices in place for the ordering, receipt, disposal and administration of medication. The inspector reviewed a sample of medication administration sheets and found that medication was administered as prescribed. However, the storage arrangements in place required some minor improvement as not all medications (creams and liquids) had opening dates recorded.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date comprehensive assessment of need in place for each resident. The personal plans were up-to-date and guided the staff team in supporting residents with their assessed needs. Some personal plans required review to ensure they appropriately guided staff team.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were positive behaviour supports in place for residents where required. The plans were up-to-date and guided the staff team in supporting residents to manage their behaviour. Residents were supported to access psychiatry where required.

There were restrictive practices in use in the designated centre, and there was evidence that the restrictions were reviewed by the provider's Positive Approaches Management Committee in a timely manner.

Judgment: Compliant

Regulation 8: Protection

The systems in place for safeguarding residents required review as ongoing adverse incidents meant that at times, residents were not adequately safeguarded in the centre.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	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 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Landscape OSV-0002397

Inspection ID: MON-0026140

Date of inspection: 20/11/2019

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: • St Michaels House HR Manager, Administration Manager, Service Manager and the Person in Charge of the centre have completed a roster review in order to identify the staffing levels that are required in meeting the assessed needs of the residents in the designated centre. It will be reviewed again in March 2020 to ensure that we are meeting the needs of the residents in the designated centre. • The unfunded DSAMT will be implemented from 2020 • Recent recruitment campaign was successful in back filling two SCW posts and unfunded DSAMT post. • Interim measure is that day service hours will be extended for one resident to meet their specific support needs	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The Register Provider will ensure that the furniture is fit for purpose and in good repair. • The CEO of St Michael's Housing Association will ensure that the walls are painted and plaster where required.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • PIC will ensure that all residents part take in fire drills and this is reflected on eforms and Personal evacuation plans.	

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: PIC will ensure that all medicines such as creams and liquids are labeled with date of opening.	
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: • The Person in charge will ensure the individual assessment and personal plan documentation is reviewed annually or more frequently if there is a change in need or circumstances.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • All safeguarding concerns will continue to be reported to the Principle Social Worker, Designated Officer, Service Manager, HIQA and the HSE Safeguarding Team where appropriate – Ongoing • Additional staff were allocated to the day service to extend the hours up to 5pm and additional staff were allocated for night duty and at weekends to manage the situation - Ongoing • Staff are present at all times and support all residents in their daily routines and intervene when and where an issue arises - Ongoing • All staff have completed Safeguarding Training- Completed • Good contact and communication is maintained with Families in relation to all issues affecting their family members - Ongoing • All safeguarding plans will be reviewed and updated for each resident in the centre - Ongoing • Individual clinical support has been provided to Residents to help them and assess the impact of issues on their lives - Ongoing • The Registered Provider has commissioned a Multi Element team to review the current safeguarding measures and to provide recommendations – 30/04/2020 • The issue has been highlighted with the HSE and a DSMAT has been sent for additional	

funding in meeting the changing needs of one the residents. The unfunded DSMAT will be implemented from 01/01/2020.

The Registered Provider will continue to explore all internal options to resolve the compatibility issues in the centre – 31/12/2020

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(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	30/04/2020
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	30/06/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	20/12/2019

	suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	20/12/2019
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,	Substantially Compliant	Yellow	31/03/2020

	as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2020