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:	Willowglade
Name of provider:	St Michael's House
Address of centre:	Dublin 14
Type of inspection:	Announced
Date of inspection:	08 January 2020
Centre ID:	OSV-0002400
Fieldwork ID:	MON-0022470

About the designated centre

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

Willowglade is a designated centre operated by St Michael's House located in an urban area in County Dublin. It provides a community residential service for up to six residents at any given time, both male and female, with an intellectual disability. Seven people access the service with two residents availing of the service on a time-share basis. This means only six residents stay in the house at any given time. The designated centre is a dormer bungalow comprising a kitchen/dining room, two sitting rooms, a utility room, six resident bedrooms, a staff sleepover bedroom, office, storage room and a number of shared bathrooms. The centre is staffed by a person in charge, nurses, social care workers, direct care assistants and a domestic staff worker.

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
08 January 2020	09:45hrs to 18:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with six of the residents availing of the service and a family member of one resident at the time of the inspection. The inspector also observed care practices and interactions on the day of inspection. Residents and representatives spoke positively about living in the centre and the supports the residents received. Some residents used non-verbal methods to communicate and were observed appearing content and relaxed in their home.

In addition, feedback of the service was received through questionnaires completed by the residents and or their representatives which reviewed matters such as accommodation, food and mealtime experience, visiting arrangements, residents' rights, activities, staffing and complaints. Overall, the feedback from the questionnaires were positive about the care and support provided in the service.

The inspector spent time in the dining room of the house and observed residents as they prepared to engage with their daily activities which included accessing the local community and day services. In addition, the inspector observed residents engaging in various activities in their home such as watching tv, listening and dancing to music, engaging with sensory equipment and enjoying meals. Throughout the day of inspection, the inspector observed positive interactions between staff and residents in both locations which included staff discussing plans for the day.

The inspector observed that the designated centre was decorated in a homely manner with pictures of the residents throughout the house. One resident proudly showed the inspector their bedroom which were decorated in line with their tastes and preferences. However, some areas of the centre required upkeep for example, the kitchen in the centre required updating. This is outlined under Regulation 17.

Capacity and capability

The governance and management systems in place ensured that the service provided was effectively and consistently monitored to ensure the effective delivery of care and support in line with the assessed needs of residents. However, some improvement was required in staffing arrangements, the training and development of the staff team and ensuring that the service was adequately resourced.

There was a clearly defined governance and management structure in place. The centre was managed by a full-time person in charge who was appropriately qualified and experienced and demonstrated good knowledge of the residents and their assessed needs. The person in charge worked directly with the residents and

had eight hours protected management time a week. The person in charge was supported in their role by an experienced Clinical Nurse Manager 1 (CNM1). There were quality assurance audits in place including six monthly unannounced provider visits and an annual review for 2018 in line with the regulations. There was evidence that the annual review for 2019 was in draft at the time of the inspection. In addition, there were regular service audits in place including audits on medication management, fire safety and health and safety. These audits identified areas for improvement and there was evidence actions plans were being developed and implemented. However, the resources allocated to the centre required review. A number of quality improvement audits identified the lack of an allocated transport vehicle to the service as having a negative impact for the residents in the centre. This was discussed with the provider at the feedback meeting and the provider outlined that funding options are being explored.

The person in charge maintained a planned and actual roster. The previous inspection identified that staffing levels at times were not sufficient to meet the needs of residents. The provider had completed a roster review in 2019 and on the week of the inspection increased staffing levels in the centre. While the provider had increased staffing support and informed the inspector of future plans to review the staffing the arrangements, on the day of the inspection it was not demonstrable that the increased staffing levels would ensure that the residents' needs would be met at all times. At the time of the inspection, the centre was operating with 2.5 whole time equivalent vacancies. However, there was evidence that the provider had ensured continuity of care as any gaps in the roster were covered by the current staff team, regular relief staff and block booked agency staff.

There were systems in place for the training and development of the staff team. From a sample of training reviewed, in the most part the staff team had up-to-date mandatory training which included the safe administration of mediation, people handling and de-escalation and intervention techniques. However, there were gaps in some training including safeguarding training for one staff member. This had been identified by the person in charge and refresher training had been scheduled to address this. In addition, there were arrangements in place for the supervision of the staff team which discussed areas including roles, responsibilities and well being. From a sample of supervision records reviewed, the inspector found that the timeliness of the supervision meetings required improvement to be in line with the provider's supervision policy.

The previous inspection found that not all incidents had been notified to the Chief Inspector of Social Services in line with Regulation 31. The provider addressed this by completing a retrospective review of incidents and submitting the incidents as required. On the day of the inspection, the inspector reviewed a sample of adverse incidents and accidents occurring in the centre and found that all incidents were notified as appropriate.

Regulation 14: Persons in charge

The person in charge worked in a full-time post. The person in charge was appropriately qualified and experienced to mange the service and demonstrated good knowledge of the residents and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster. While it was evident that the provider increased staffing levels on the week of the inspection, it was not demonstrable that this increase would ensure that the needs of residents were met at all times. At the time of the inspection, the centre was operating with 2.5 whole time equivalent vacancies and there was evidence that the provider had ensured continuity of care.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. For the most part the staff team had up-to-date mandatory training. However, there were gaps in some training including safeguarding training for one staff member.

There was arrangements in place for the supervision of the staff team. However, the timeliness of the supervision meeting required improvement.

Judgment: Substantially compliant

Regulation 22: Insurance

There was evidence that the centre had an insurance policy in place which insured against the risk of injury to residents.

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 audits identified areas for improvement and there was evidence actions plans were being developed and implemented. However, the resources allocated to the centre required review as a number of quality improvement audits identified the lack of an allocated transport vehicle to the service as having a negative impact for the residents in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre's statement of purpose dated January 2020 included all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All adverse incidents and accidents occurring in the centre were notified to the Chief Inspector as appropriate.

Judgment: Compliant

Quality and safety

The management systems in place ensured the service was effectively monitored and provided a safe, appropriate care and support to residents. Staff were observed to support residents in a person-centred manner at all times over the course of this inspection and residents appeared content and comfortable in their home. Some improvements were required with regards to aspects of fire safety management procedures, risk management and premises.

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 resident's personal plan. From a sample of plans reviewed, the inspector found that the plans in place were up to date and guided the staff team to support residents

with identified needs.

Residents' health care needs were managed to an adequate standard. All residents were supported to manage their health care conditions and had regular access to appropriate allied health professionals including General Practitioners, Chiropody, Physiotherapy, Occupational Therapy. 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 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 and psychology. There were a number of restrictive practices in use in the designated centre. The restrictions were identified and recorded on a restrictive practice register. From a review of the register, it was evident that restrictive practices were reviewed by the provider's Positive Approaches Management Group and efforts had been made to reduce or remove some restrictive practices where appropriate.

There were systems in place to safeguard residents. There was evidence of safeguarding measures in place to manage identified safeguarding concerns. Staff spoken with were clear in what constituted abuse and what to do in the event of an allegation or concern. The inspector observed that residents appeared comfortable in their home and in the presence of staff and management.

There were systems in place to identify, assess and review risk and the person in charge maintained a risk register which outlined general risk and individual risks. In the most part, the inspector found that risk was well managed in the designated centre. The provider was in the process of moving to a new risk management system. The inspector noted however, that risk assessment documentation in the centre did not accurately reflect the controls in place to manage some identified risks.

The inspector completed a walk though of the designated centre accompanied by the person in charge. Overall, the designated centre was decorated in a homely manner. The previous inspection identified that the kitchen in the centre required review as the laminate on the outside of presses and drawers was in disrepair. This had been self-identified by the provider as an infection control risk. The provider informed the inspector of plans in place to update the kitchen by June 2020.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Centre records demonstrated that fire evacuation drills were completed regularly and there was evidence of learning from fire drills. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place which outlined the supports for each resident to evacuate the designated centre. The systems in place for the containment of fire required review. This was self identified by the provider in an internal audit in of fire safety systems which

identified a number of areas for improvement including upgrading the fire alarm system and containment of fire.

The inspector reviewed the medication management practices within the centre. There were suitable practices in place for the ordering, receipt, storage disposal and administration of medication. The inspector reviewed a sample of medication administration sheets and found that medication was administered as prescribed. The person in charge completed a medication audit which identified areas for improvement and there was evidence of action plans being developed and implemented.

Regulation 17: Premises

The designated centre was decorated in a homely manner and well maintained. However, the kitchen in the centre required review as the laminate on the outside of presses and drawers was in disrepair. This had been self-identified by the provider as an infection control risk.

Judgment: Substantially compliant

Regulation 20: Information for residents

The provider prepared a residents guide which contained all of the information as required under Regulation 20.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to identify, assess and review risk and the person in charge maintained a risk register which outlined general risk and individual risks. However, the risk assessment documentation did not accurately reflect the controls in place to manage identified risks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management including suitable fire safety equipment and regular fire drills. However, the arrangements in place for the containment of fire required review.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable practices in place for the ordering, receipt, storage disposal and administration of medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need in place for each resident. The assessments identified residents' health and social care needs and informed the resident's personal plan. The plans in place were up to date and guided the staff team to support residents with identified needs.

Judgment: Compliant

Regulation 6: Health care

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

Judgment: Compliant

Regulation 7: Positive behavioural support

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

There were a number of restrictive practices in use in the designated centre. The restrictions were regularly reviewed by the provider's Positive Approaches

Management Group and there was evidence of efforts to reduce some restrictive practices.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to manage safeguarding concerns. There was evidence of safeguarding measures in place to manage identified safeguarding concerns.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Willowglade OSV-0002400

Inspection ID: MON-0022470

Date of inspection: 08/01/2020

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: St Michael's House are currently actively recruiting for the 2.5 vacancies in Willowglade. A specific advertisement was published for Willowglade and there are dates scheduled for interviews in February and March 2020.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The staff member who requiring safeguarding training has a date for training on 05/02/2020. Person in charge along with Clinical Nurse Manager 1 will put together a schedule to ensure supervision/support meetings are carried out with staff ensuring they have protective time for this. This will be carried out every 6 months as local policy deems due to large size of the team. As part of the schedule there will be 2 support meetings carried out per month, thereby ensuring that at the end of the year all staff will have received the required number of meetings.	
Regulation 23: Governance and	Substantially Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Currently arrangements are in place to try to negate the lack of a unit bus:

1. Borrowing a bus from a neighbouring St Michael's House unit
2. Using Acts taxi's which are a wheelchair bus taxi firm.
3. Plans to research the cost and availability of suitable vehicles from GoCar.
4. Fundraising will continue
5. Search any grants available from Dunlaoghaire and Rathdown County Council/Lottery funding or other sources.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As stated from QEP and 6 monthly report, the kitchen will be completed by June 2020. Have received all three quotes.

1. PIC will submit the three quotes to St Michael's House Housing Association
2. Agree which company will install kitchen
3. To arrange for installation of kitchen

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All high risks have been reviewed and updated. High risks will be reviewed every 3 months in line with the overall risk register review that is completed for the unit.
All other risk assessments will be updated and in line with the new risk assessment form by 28/02/2020

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The unit has been identified as requiring a fire alarm system upgrade, this is due to age of system (no issues with current operation of the system). A meeting will be held in February between SMH Fire Officer and the SMH Housing Association to agree a roll out program in 2020. The SMH Fire Officer has identified an organisational list of units that require a similar upgrade. Work will be completed by year end 2020. Remaining 2 fire alarm deficits noted in the internal fire report relating to the fire alarm system will be addressed as part of this upgrade.

The Housing Association is starting a roll out program of door closers in 2020 which will address issues ref fire containment on the means of escape routes. The work should be completed by year end 2020.

Remaining actions identified in the providers internal fire report are on a schedule for completion this year. Completion of the works required is being managed by the SMH Fire Officer.

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	31/05/2020
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.	Substantially Compliant	Yellow	05/02/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2020

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/12/2020
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	28/02/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2020