Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Arranmore
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 8
Type of inspection:	Unannounced
Date of inspection:	08 May 2019
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0021801

About the designated centre

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

The designated centre is operated by St. John of God services and is situated on a campus based setting in South Dublin. It is a large one storey property that provides residential services for a maximum of 13 residents. There is one dining area, kitchen, 13 bedrooms, a staff office, a medication room, a family rooms and a TV lounge. There are two accessible bathrooms, 2 shower rooms and 2 toilets. There is a small grassy and paved area to the back of the building where residents, staff and family members can sit. There is also access to a swimming pool, day services, an oratory, gymnasium and multisensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Resident's have access to multidisciplinary supports in the organisation such as; social workers, physiotherapists, occupational therapists, speech and language and psychology, as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 May 2019	09:00hrs to 19:30hrs	Erin Clarke	Lead
08 May 2019	09:00hrs to 19:30hrs	Sarah Mockler	Support

Views of people who use the service

The inspectors had the opportunity to observe five residents on the morning of the inspection. Residents' communication abilities varied and where appropriate, their views where relayed though staff advocating on their behalf and review of relevant documentation in the centre. The inspectors also got the opportunity to speak to family members who could relay their views on the care and support their relatives were receiving in the centre.

During the observation period the residents appeared relaxed and comfortable. All the residents were on their way out to their local day service and this busy time was managed appropriately by staff. Interactions between staff and residents observed during this time were kind and respectful. Staff were very knowledgeable in regards to residents' needs. Family members were complimentary of how staff interacted with their family members.

The annual review process consulted with residents' family representatives for their views, it was reported that families had relayed satisfaction with the care provided to their family members. Any suggestions for improvements of the service had been actioned or were under review. In addition inspectors were informed by families that communication had improved especially in relation to the complaints process.

It was identified by the provider that the premises did not meet the assessed needs for one resident. The resident's independent advocate had written to the Office of the Chief Inspector to make this matter known, this is discussed further in the body of the report.

Capacity and capability

The inspectors found that a series of improvements had been made since the last inspection and this was reflected in a good level of compliance as observed on this inspection. The previous inspection identified that improved managerial oversight was required in a number of areas to ensure that the service was being effectively monitored in all areas of the designated centre. This inspection established that while some areas of non-compliance were identified in fire management, training and personal plans, action had been taken by the provider to address the previous failings.

The management structure was clear as was individual responsibility, reporting relationships and individual accountability for the quality and safety of the service.

The inspector discussed the previous inspection findings and found that the person in charge and persons participating in the management of the centre (PPIM) had a clear understanding of what good governance was, accepted responsibility for the failings previously identified and the requirement for improvement.

A new person in charge had been appointed by the provider in January 2019. This followed a period of substantial management change in the designated centre. Inspectors were assured that there was a clearly defined management system now in place. The person in charge reported to the residential coordinator who in turn reported to the programme manager.

A new person in charge, a clinical nurse manager (CNM2) had been appointed since the previous inspection, and they described how they regularly and consistently participated in the operation and oversight of the service. For instance they worked opposite shifts to the CNM 1 including weekends to ensure consistent oversight of care provision. They were also able to discuss in depth with the inspector any matters queried during the inspection. There were a number of audits completed in the centre demonstrating a commitment to ongoing monitoring and service improvement. From discussions with the persons in charge, family members, minutes of meetings, internal reviews and audits it was evident that any issues identified were adequately responded to and escalated if necessary.

The provider had been carrying out annual reviews and unannounced visits for this designated centre as required by the regulations. The annual review also demonstrated collaboration with family representatives, to further ensure that residents were at the forefront of the service provided. These views formed part of the quality improvement plan for the coming year. Inspectors found that actions generated from these internal audits had been addressed by the person in charge in a prompt manner, which resulted in continuous improvements in the quality of care provided to residents.

The person in charge reported that there were some vacancies in nursing, healthcare assistant and social care worker grades of staff. These positions were undergoing recruitment drives at the time of inspection. On reviewing rosters, inspectors found staffing levels were supplemented by the use of familiar relief and agency staff to ensure continuity of care. The provider had identified in its annual review that there was a requirement for additional drivers to allow for increased activities outside of the designated centre.

There were arrangements in place for annual performance management reviews, in addition to staff supervision meetings. The person in charge had a supervision schedule for the year, this demonstrated that supervision was planned, regular and not in response to adverse incidents. From a review of a sample of supervision records these had occurred in line with the organisations policy. There were systems in place to address staff members' training needs. Inspectors reviewed training records of staff working in the centre; this was maintained by a colour coded system to identify when training was due for renewal. While some gaps were found in refresher training, dates were identified where staff had been booked to complete

the training.

There was a complaints log in place with a record of any complaints. Any complaints made by residents or their advocates were addressed in a serious and timely manner by the person in charge or persons participating in management. Where a concern was raised and the person did not want to engage in the complaints process, the grievance policy was enacted. Inspectors reviewed actions from the complaints and grievance log and were satisfied that any concerns raised were being addressed.

Registration Regulation 7: Changes to information supplied for registration purposes

Inspectors identified that some outstanding information required from the provider for the change of person in charge and PPIM in line with registration requirements had not been submitted in a timely manner.

Judgment: Not compliant

Regulation 14: Persons in charge

A suitable person in charge had recently been appointed in January 2019. The person in charge was appropriately qualified and experienced and had a good understanding of the residents' care needs. The person in charge had responded to actions plans generated from internal reviews which ensured that the quality and safety of the service was maintained to a good standard.

Judgment: Compliant

Regulation 15: Staffing

An appropriate skill mix of consistent staff was provided to support residents. Nursing staff was available in line with the provider's statement of purpose while planned and actual rosters were maintained. The person in charge had ensured a continuity of care was delivered when staff vacancies arose through the use of familiar and regular relief and agency staff.

Judgment: Compliant

Regulation 16: Training and staff development

Arrangements were in place for staff to received both formal and informal supervision. There was also a day-to-day management presence in the centre which ensured that staff practice could also be supervised. Training was provided in a range of areas but some refresher training was overdue in areas such as feeding , eating and drinking, epilepsy and manual handling.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had made improvements to the management arrangements to ensure that there were robust governance and management structures in place to oversee the operational management of the service and to provide appropriate oversight of the quality of care provided.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre had a publicly available statement of purpose, dated January 2019, that accurately and clearly described the services provided. However amendments were required to reflect changes in the organisational structure. The admission policy and criteria outlined in the statement of purpose stated that admissions to the designated were planned and did provide information in the event of an unplanned admission.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A complaints log was maintained in the centre which outlined the nature of the complaints made and any actions taken in response. Family members of service users indicated that they were aware of how to make a complaint if they needed to.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider and person in charge were endeavouring to ensure that the quality of the service provided for residents was good. There were systems in place to keep the residents safe. There had been a number of changes to the person appointed in charge of the centre over recent years, however this had settled following the appointment of the current person in charge. This person was driving quality improvement across the service and this work was evident on the day of inspection.

The premises was a very large bungalow located within the St. John of God service. The registered provider had ensured best practice in achieving and promoting accessibility due to the assessed needs of the residents. Some residents' bedrooms were viewed by inspectors and found to be spacious and personalised. The premises was clean. Paintwork was required throughout the premises and this had commenced prior to the inspection, and was ongoing during the inspection. The person in charge spoke about their plans in relation to promoting a more homely feel in the large premises and there was evidence of this work on the day of inspection.

A sample of residents' personal plans were reviewed. There were assessments in place that identified the individual health, personal and social care needs of the resident with an associated plan of care. There was evidence of a multidisciplinary review of the personal plan. The personal plans reviewed had evidence of meaningful activities as part of the residents social goals. Residents had access to a keyworker who worked together with the resident and their representative to complete the planning process of the goals. Elements of the personal plan were made available such as visual formats of the residents daily routine that were displayed in the residents' rooms. However the person in charge had recognised that the accessible format of the plan was an area of development for the service and spoke about future plans in relation to this. In addition it was identified that additional drivers were required to improve residents' access to the community and engage in individual activities.

The residents' had appropriate supports in place in relation to positive behaviour support plans and access to relevant allied professionals. A sample of plans were reviewed. The plans were informed by function based assessments and an effort was made to identify the possible antecedents conditions that may have elicited the behaviour. Staff were knowledgeable around the details of the plan. Where chemicals were used as a form of restraint, staff were very clear why such medicines were prescribed and administered. A restrictive register was in place. Any restrictive practices used were reviewed on a regular basis and in recent months they had been referred to the rights committee. Recently two restrictive practices had been reviewed and removed as they were no longer deemed necessary.

Overall, the rights of residents were protected and promoted, and residents were

treated in a manner that maximised their privacy and dignity. All residents had their own bedrooms and had facilities for the secure storage of their personal belongings and valuables. The provider's practices ensured that residents' well-being was promoted at all times and that they were kept safe. However, at the time of inspection, inspectors observed the use of viewing panels on bedrooms to facilitate the practice of hourly night time rounds. This practice was not reviewed in line with residents assessed needs.

Although the provider was meeting the assessed needs of the residents in terms of assessments and supports, the environment was not also suitable for some of the residents due to the size and number of residents in the designated centre. The centre was home for 12 residents and due to this it was busy and at times a noisy environment. The needs of the residents that required a low arousal approach were not being met. This had been recognised by the provider and the residents' family. While this was included in the centres quality improvement plan and was referred to the admissions, discharge and transition committee there was no time bound plan in place to address this. The residents independent advocate who had been appointed in 2016 had highlighted concerns in relation to the current living environment. The resident had been discharged from the advocacy service in 2018 due to the absence of an agreed plan to address the longstanding issues from the provider.

A sample of healthcare assessments and associated plan of cares were reviewed. Residents were receiving appropriate support in line with their assessed needs. Some residents had very complex needs in relation to this and were supported appropriately by the nursing staff employed in the centre. There was evidence that residents were being supported to access the National Screening program. The person in charge had provided access to allied professionals for residents and there was an appointment log and notes on outcome of appointment kept the relevant residents' file.

Suitable fire equipment was provided and there was adequate means of escape, including emergency lighting. The escape routes were free from obstruction and sufficiently wide to enable evacuation. There was appropriate storage of equipment such as medical gases and combustible material. This storage system had just been updated is recent months. The building was adequately subdivided with fire resistant construction such as fire doors as appropriate. Staff members spoken with were knowledgeable about the horizontal evacuation procedures.There was a fire escape door off one of the living rooms in the house that could be locked using a key. The key was in the door during inspection. However there was no systems in place to open this door if the key went missing.

Regulation 17: Premises

Inspectors identified that due to the size and number and residents in the designated centre, it did not meet the assessed needs of one resident.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided. There was appropriate storage of equipment such as medical gases and combustible material. A fire escape door could be locked using a key, however there was no systems in place for this door during an emergency if the key went missing.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was an assessment in place for each resident that identified the individual health, personal and social care needs of each resident. The personal plan was made available to the resident but not in an accessible format that could be easily understood by the resident. Due to the size and number of residents living in the centre, residents needs that indicated a low arousal approach were not being met. Residents transport requirements required the use of additional drivers.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate healthcare was made available for each resident having regard to their personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where restrictive procedures such as physical, chemical or environmental restraint were used, such procedures were applied in accordance with national policy and evidence-based practice.

Judgment: Compliant

Regulation 8: Protection

There were appropriate measures in place to keep residents safe and to protect them from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Two practices observed in the designated centre did not promote the privacy and dignity of the resident.

Judgment: Substantially 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
Views of people who use the service	
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially 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
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0021801

Date of inspection: 08/05/2019

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: All documents have been forwarded to HIQA registration department	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All training that is due for renewal / refresher is scheduled for future dates	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of purpose will be amended to include information set out in schedule 1	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As discussed during feedback, all options have been considered in relation to the resident in question. Supports and relevant documentation available for inspection and viewed on the day reflected the residents needs had been identified and supports such as care interventions and therapies promoting a low stimulating environment were in place.

The provider nominee has submitted a proposal to the HSE outlining the resource requirements for the resident. The resident is on the ADT waiting list and this position is discussed on a monthly basis with the committee. The provider nominee will gain a response from the HSE by December 30th 2020 regarding regulation 17.

During this time, the resident has care support interventions in place to meet his identified needs for a low stimulating environment. Both the resident and family are content with the current residential placement which is evidenced by the family at MDT meetings. The resident's personal space is located away from the main house and the resident can choose to stay in his own personal space for relaxation or to access the main house. There is a separate entrance to the resident's accommodation, where he chooses to come and go as he wants. The resident has staffing support on a 1:1 basis during the day. The residents accommodation has been re-designed to further enhance a low stimulating environment. The plan on view on inspection for this re-design has now been completed in line with the residents identified support needs.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In relation to the fire door that is locked with a key, a key will be stored in the vicinity of the door for emergency use.

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:

All Su have circle of support and individual planning meetings. All personal plans are discussed with residents and families at circle of support meetings and individually with residents. Residents can avail of assistive technology and this will be expanded further over the coming months. The service will continue to link with OT and SLT departments to ensure the most appropriate communication methods are being used for each individual. All transport needs are met through staff drivers or paid taxis.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The current situation will be referred to the Human Rights committee and subsequent recommendations considered

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
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Orange	20/06/2019
Registration Regulation 7(3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the designated centre) within 28 days of the change	Not Compliant	Orange	20/06/2019

	and supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person participating in the management of the designated centre.			
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	30/08/2019
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	31/10/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/07/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set	Substantially Compliant	Yellow	30/06/2019

	out in Schedule 1.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/10/2019
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	
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.	Substantially Compliant	Yellow	30/10/2019