



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

## Issued by the Chief Inspector

Name of designated centre:	Ferndale
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Unannounced
Date of inspection:	21 January 2020
Centre ID:	OSV-0003598
Fieldwork ID:	MON-0025440

## About the designated centre

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

Ferndale is a designated centre operated by St Michael's House located in North County Dublin. It provides community residential care for up to seven adults with disabilities. The centre comprises of two houses next door to each other. Both houses are two-storey and share a common driveway and back yard. The first house comprises five bedrooms, sitting room, kitchen/dining room, utility room with laundry facilities, sun room and shared bathrooms. The second house comprises four bedrooms, sitting room, utility room, a kitchen/dining room and shared bathrooms. The centre is staffed by a 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:	7
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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
Tuesday 21 January 2020	10:00hrs to 18:00hrs	Conan O'Hara	Lead

## What residents told us and what inspectors observed

The inspector had the opportunity to meet with the seven people availing of the service at the time of the inspection. The inspector also observed care practices and interactions on the day of inspection. Overall, residents spoke positively about living in the centre and the supports they received. However, one resident informed the inspector that they were not happy living in the centre. The inspector observed a complaint, logged in February 2019, which highlighted that the resident was unhappy in their placement. This was ongoing for a prolonged period of time.

The inspector spent time in the dining room of one of the houses and observed residents as they prepared to engage with their daily activities which included accessing the local community, attending meetings and day services. In addition, the inspector observed residents engaging in various activities in their home such as watching TV, preparing and enjoying meals and spending time with friends. Throughout the day of inspection, the inspector observed positive interactions between staff and residents in both houses.

The inspector observed that the designated centre was decorated in a homely manner. Some residents showed the inspector their bedrooms which were decorated in line with their tastes and preferences. However, some areas of the premises required refurbishment for example, the bathroom in the centre. In addition, one resident noted the lack of storage space in their home for their personal belongings and indicated there had been a delay in installing improved storage space for them.

## Capacity and capability

The provider had governance and management systems in place which effectively and consistently monitored the delivery of care and support to residents. However, improvement was required in relation to the provider's implementation of actions plans to address areas for improvement as identified by their own quality assurance audits. In addition, some improvements were required in the staffing arrangements, the training and development of the staff team and the management of complaints.

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. 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

of action plans being developed.

However, the provider had not ensured that some actions to address areas for improvement had been implemented in a timely manner. For example, some areas of the premises required review in relation to storage space for some residents and refurbishment of bathrooms. This had been self-identified by the provider in their own quality audits and also identified in previous Health Information and Quality Authority (HIQA) inspections in 2016 and 2018. This issue remained ongoing at the time of the inspection and is further outlined under Regulation 17.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of staffing rosters which demonstrated that there were sufficient staff levels to meet the assessed needs of 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.

At the time of the inspection, the centre was operating with 1.41 whole-time-equivalent vacancies. It was noted however, there were efforts, by the provider and person in charge, to ensure continuity of care for residents through the use of regular relief and agency staff. However, a review of the roster demonstrated that at times this was not always possible.

There were systems in place for the training and development of the staff team. The inspector reviewed a sample of staff team training records and found that for the most part, the staff team were up-to-date in mandatory training. However, there were some gaps in training including safeguarding and fire safety management.

There were arrangements in place for the supervision of the staff team. A review of a sample of staff supervision meetings found they had not been completed in line with the time lines as outlined in the provider's supervision policy. For example, some members of the staff team had received two supervision meetings in 2019 while the provider's policy states that supervision meetings should take place quarterly.

On the day of the inspection, the inspector reviewed a sample of recorded complaints and found that the measures in place for responding to complaints in a timely and effective way required improvement. For example, on the day of the inspection, a resident highlighted that they were not happy living in the centre. The resident's representative had submitted a complaint, on their behalf, in February 2019 relating to this. In response, the provider had acknowledged the resident's complaint and had added the resident to an internal transfer list maintained organisationally by the provider. The resident was also supported to meet with an external advocate, this was observed to occur on inspection.

While some measures had been put in place, at the time of inspection the resident's complaint had not been resolved to their satisfaction. In addition, a complaint logged in May 2019 relating to a delay in installing additional storage for a resident, had also not been addressed to the resident's satisfaction and was still ongoing at

the time of inspection.

The person in charge however, did provide assurances to the inspector that additional storage for the resident scheduled to be installed the following week after the inspection. The provider was required to review their complaints management systems to ensure residents complaints were responded to and addressed as much as possible in a manner that was timely and to their satisfaction.

The inspector reviewed a sample of incidents and accidents occurring in the centre and found that all incidents and accidents were notified to the Office of the Chief Inspector as appropriate under Regulation 31.

#### Regulation 14: Persons in charge

The person in charge worked in a full-time post and was appropriately qualified and experienced.

Judgment: Compliant

#### Regulation 15: Staffing

The person in charge maintained a planned and actual roster. There were sufficient staff levels to meet the assessed needs of residents. However, at times, continuity of care was not maintained.

Judgment: Substantially compliant

#### Regulation 16: Training and staff development

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

The provider had systems in place to provide supervision to the staff team however this was not completed in line with the provider's policy.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

All incidents and accidents were reported to the Office of the Chief Inspector as required.

Judgment: Compliant

### Regulation 23: Governance and management

The centre had a clearly defined management structure in place. There were a number of quality assurance audits were in place including the six-monthly provider visit and annual review as required by the regulations.

However, while such audits had occurred and were identifying actions to improve the quality and compliance of the service, the provider had not ensured those required actions from their own internal audits, and some recurring HIQA inspection non-compliances, had been addressed and completed.

Judgment: Not compliant

### Regulation 34: Complaints procedure

The provider was required to review their complaints management systems to ensure residents complaints were responded to and addressed as much as possible in a manner that was timely and to their satisfaction.

Judgment: Substantially compliant

## Quality and safety

Overall, the management systems in place ensured the service was effectively monitored and provided a safe, appropriate care and support to residents. However, improvements were required with regards to premises and aspects of fire safety management.

The inspector completed a walk through of the premises accompanied by the person in charge. The centre comprises of two houses next door to each other and the inspector found that the centre was clean and homely. However, as noted earlier,



some aspects of the centre in relation to storage and modernisation of bathroom required improvements. This was identified on two previous inspections in 2016 and 2019 and self-identified by the provider through internal quality assurance audits. The person in charge noted that the provider's housing association had recently reviewed the premises and plans were in place to address these issues.

The inspector reviewed a sample of residents' personal files and found that overall the residents' well being and welfare were being maintained in the centre. Each resident had an up-to-date assessment of need in place which identified residents' health and social care needs. This, in turn, 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. The residents were supported to manage their health care and had regular access to appropriate allied health professionals. The health care plans were up to date and suitably guided the staff team to support residents with identified health care needs.

There were positive behaviour supports in place for residents to support residents manage their behaviour 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. Residents were supported to enjoy their best possible mental health and, where required, had access to psychiatry and psychology. There were some restrictive practices in use in the designated centre. The restrictions were identified and reviewed by the provider's Positive Approaches Management Group.

There were systems in place to safeguard residents. The inspector reviewed a sample of incidents and accidents in the centre which demonstrated that they were appropriately managed. 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 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 provider's fire safety officer had identified some upgrade works were required to fire and smoke containment measures already in place in the centre. The provider was required to put in place measures to address these identified upgrade works and address them within a suitable time-frame.

## Regulation 12: Personal possessions

Not all residents had adequate space to store and maintain his or her personal property and possessions.

Judgment: Substantially compliant

### Regulation 17: Premises

The centre was found that the centre was clean and homely. However, some aspects of the centre in relation to storage and modernisation required improvement.

Judgment: Substantially 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. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place and centre records demonstrated that fire evacuation drills were completed regularly.

The provider's fire safety officer had identified some upgrade works were required to fire and smoke containment measures already in place in the centre. The provider was required to put in place measures to address these identified upgrade works and address them within a suitable time-frame.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date assessment of need in place which 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

The residents were supported to manage their health care 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 to support residents manage their behaviour where required. The positive behaviour support plans were up to date and guided the staff team.

There were some restrictive practices in use in the designated centre which were suitably identified and reviewed by the provider's Positive Approaches Management Group.

Judgment: Compliant

### Regulation 8: Protection

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.

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
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
<b>Quality and safety</b>	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Ferndale OSV-0003598

Inspection ID: MON-0025440

Date of inspection: 21/01/2020

## 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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:            1 WTE vacancy was filled on 14/02/2020. There is now a WTE of 0.41. Recruitment drive ongoing to fill remaining vacancy. There are 4 days of interviews scheduled for March 2020. The 0.41 vacancy will be covered by permanent staff doing additional hours and also regular relief staff in order to maintain continuity of care for service users.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Fire training.            2 staff members were overdue their Fire safety refresher training. 1 staff member completed training on 3/2/20 and the other is scheduled to complete training on 2/3/20.</p> <p>Safeguarding:            At the time of inspection there was one staff overdue there safeguarding refresher training which was due on 14/01/20. PIC has been in contact with Training dept and the scheduled dates are 18/03/2020</p> <p>Supervision: The PIC will endeavour to schedule and carry out supervision meetings on a quarterly basis, as per SMH Supervision policy. The PIC will take note of any discussions, outside of the SMH Supervision format, with individual staff that supports them to perform their role appropriately .These notes will be kept in individual staff files for examination. This will ensure a record of appropriate supervision is available throughout the year.</p>	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>PIC has met with Housing association representatives and architect on 10/02/2020. Schedule of works being drawn up for kitchen and bathroom upgrade and decoration of unit. Work will be completed by September 2020.</p> <p>Storage solution were installed on the 28/01/2020.</p>	
Regulation 34: Complaints procedure	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>Open complaint in relation to storage in Avondale is resolved as of 29/01/2020</p> <p>Open complaint in relation to service user placement remains open, due to lack of vacancy within SMH to facilitate a move for the service user. The service user will be kept updated on progress of request at regular intervals. The service user has an independent advocate in place to represent them.</p>	
Regulation 12: Personal possessions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 12: Personal possessions:</p> <p>Storage solutions for the residents in Avondale where identified and agreed upon. These storage solutions were installed in Avondale on the 28/01/20 to the satisfaction of all residents.</p>	

Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:  Storage solutions for the residents in Avondale were identified and agreed upon. These storage solutions were installed in Avondale on the 28/01/20 to the satisfaction of all residents.</p> <p>PIC has met with Housing association representatives and architect on 10/02/2020. Schedule of works being drawn up for kitchen and bathroom upgrade and decoration of unit. Work will be completed by September 2020.</p>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:  The Housing Association is starting a roll out program of door closers in 2020 which will address issues referencing fire containment on the means of escape routes. The work is to commence in March 2020 and will be completed in 12 months finishing March 2021.</p>	



## 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 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Substantially Compliant	Yellow	28/01/2020
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/06/2020
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	Substantially Compliant	Yellow	18/03/2020

	development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2020
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	30/09/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2021
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in	Substantially Compliant	Yellow	29/01/2020

	response to a complaint are put in place.			
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