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:	The Laurels
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	21 January 2020
Centre ID:	OSV-0003602
Fieldwork ID:	MON-0025383

About the designated centre

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

The Laurels is a designated centre operated by St Michael's House. The centre which provides a residential service to five adults. The service can accommodate both males and females who have a moderate to profound intellectual disability and who may also have some mental health needs. This is a nurse lead service which can support individuals who have high medical needs such as epilepsy, diabetes and who may also require assistance with catheter care and enteral feeding. Each resident has their own bedroom and there is a suitable equipment such as hoists and hi-low beds to support residents who have increased mobility needs. Residents are supported by a range of nurses, social care workers and health care assistants with their daily needs. Social care is promoted in the centre and residents are supported to attend the community on a regular basis and to choose meaningful goals.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 21 January 2020	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

As part of the inspection, the inspector met with four of the five residents living in the centre. Three of these residents were unable to tell the inspector their views of the service but appeared to be in good spirits. The fourth resident met with the inspector and indicated to her that he was happy living in the centre, enjoyed his day service and that staff were kind to him.

The inspector observed warm interactions between the residents and staff caring for them. Residents had their own bedrooms which had been personalised to their own taste. Each of the residents required a high level of support from staff with their activities of daily living and staff were observed to support residents in a caring and dignified manner.

There was evidence that residents and their family representatives were consulted with and communicated with about decisions regarding the residents care and support, and the running of their house. Residents were actively supported to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspector met with the father of one of the residents and he reported that he and his family were very happy with the level of care and support that their loved one was receiving in the centre.

Capacity and capability

There were effective management systems in place to promote the service provided to be safe, consistent and appropriate to meet residents' assessed needs.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge was absent on the day of this unannounced inspection but was spoken with subsequently over the phone. She had taken up the full-time position within the previous five month period and was responsible for one other centre which was located adjacent to this centre. She was supported by a deputy manager in each of the centres for which she was responsible. The person in charge held a certificate in management and was a registered nurse in intellectual disabilities. She had more than three years management experience. She was found to have a sound knowledge of the requirements of the regulations and standards, and of the care and support needs of each of the residents. Staff members spoken with told the inspector that the person in charge supported them in their role and encouraged a culture of openness where the views of all involved in the service were sought and taken into consideration.

There was a clearly defined management structure in place that identified lines of

accountability and responsibility which ensured staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the service manager who in turn reported to the director of adult services. There was evidence that the service manager visited the centre at regular intervals. This demonstrated clear lines of reporting and accountability systems for the operational management of the centre.

An annual review of the quality and safety of care had been completed for 2018 and was in the process of being completed for 2019. Unannounced visits on a six-monthly basis to assess the quality and safety of the service had been completed. There was evidence that actions were taken to address issues identified on these visits. A limited number of other audits had been undertaken and included finance, medications, personal plans and restrictive practices.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were in place at the time of inspection and the majority of the staff team had been working in the centre for an extended period. This provided consistency of care for the residents in the centre. A number of relief, and on occasions agency staff, covered staff absences.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy, dated March 2018. A training programme was in place which was coordinated by the provider's training department. Training records available on the day of inspection indicated that staff had attended all mandatory training requirements. There were no volunteers working in the centre at the time of inspection.

A directory of residents was maintained in the centre and found to contain all of the information as required by the regulations.

Each of the residents had a contract of care in place which detailed the services to be provided and the fees payable in line with the requirements of the regulations.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team were considered to have the required skills and competencies to

meet the needs of the residents living in the centre. However, the full staff complement was not in place at the time of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was in place and found to contain all of the information required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were contracts of care in place for each of the residents which detailed information on the services provided and the fees payable.

Judgment: Compliant

Quality and safety

The residents living in the centre received care and support which was of a good quality and person centred. However, there were some small areas for improvement in terms of the upkeep and maintenance of the centre.

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Comprehensive assessments of needs had been completed for each of the residents. Care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal, communication and social needs and choices. Each of the personal plans had been reviewed with the involvement of the resident's family representatives and key workers within the last year. Specific goals for individual residents had been identified. There was evidence that progress in achieving goals set were monitored and recorded in goal update and tracker sheets for individual residents.

Each of the residents required a high level of care and support from the staff team. The centre had a nurse-led service with a staff nurse on duty at all times to meet the assessed nursing care needs of the residents. Each of the residents had their own general practitioner (GP) whom they were seen by at regular intervals. In addition residents attended a day service which was suitable to meet their needs. Residents were each supported to engage in meaningful activities in the centre and within their local community. Activities some residents enjoyed included, walks, drives, cinema, overnight stays and visits to their family homes, and swimming. A record was maintained of activities residents engaged in.

Residents' communication needs were met. There was a policy on communication. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. Communication passports were on file for residents who required same. The majority of the residents were non-verbal. There were communication tools, such as picture exchange and object of interest in place, to assist this resident to choose diet, activities, daily routines and journey destinations.

Overall the centre was found to be in a good state of repair. However, some staining of tile grouting in main shower room was observed and the patio area to the rear of the centre required some upkeep. Each of the residents had their own bedroom which had been personalised to their tastes and choices. This promoted residents' independence, dignity and recognised their individuality and personal preferences. The centre was found to be comfortable and homely. The person in charge reported that new soft furnishings were in the process of being attained for a number of areas which would enhance the residents comfort in their home.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified. A local risk register was maintained in the centre. A log was maintained of all accidents and incidents occurring in the centre, including details of actions taken to reduce or mitigate the likelihood of incidents occurring. Overall,

there were a relatively small number of incidents recorded.

Suitable arrangements were found to be in place for the management of fire. A fire risk assessment had been completed. There was documentary evidence that fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified in an area to the front of the centre. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Fire drills involving residents were undertaken at suitable intervals and indicated that residents could be evacuated in a timely fashion in the event of fire. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training.

There were safeguarding measures in place to protect residents from suffering from abuse and residents were provided with appropriate emotional and behavioural support. Although the behaviour of a small number of the residents were on occasions difficult for staff to manage in a group living environment, there did not appear to be a negative impact on the other residents living in the centre. Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual resident. There was evidence that plans in place were regularly reviewed by the provider's psychologist.

A log was maintained of restrictive practices in use in the centre. Each of these had initially been approved by the provider's 'Positive Approach Monitoring Group'. However, a number of restrictive practices in place were overdue for review so as to ensure that they were assessed as being required and that the least restrictive procedure, for the shortest duration necessary, was used.

There were systems in place to ensure the safe management and administration of medications. As this is a nurse led service, a registered staff nurse was responsible for the administration of all medications. However, the majority of the care staff team had received appropriate training in the safe administration of medication so that they could administer medications when required if residents were away from the centre. The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. Protocols were in place to guide staff in the administration of 'PRN' or as required medications. A medication management policy was in place.

There was a secure cupboard for the storage of all medicines. Individual medication management plans were in place. There were some systems in place to review and monitor safe medication management practices which included medication audits. An assessment had been completed with each of the residents for the self administration of medications but had found that each of the residents did not have capacity for the self administration of their own medication at that time.

Regulation 10: Communication

Residents' communication needs were met.

Judgment: Compliant

Regulation 17: Premises

Overall the centre was found to be in a good state of repair. However, some staining of tile grouting in main shower room was observed and the patio area to the rear of the centre required some upkeep.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable arrangements were found to be in place for the management of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, residents were provided with appropriate emotional and behavioural support. However, a number of restrictive practices in place were overdue for review by the provider's 'Positive Approaches Monitoring Group' so as to ensure that they were assessed as being required and that the least restrictive procedure, for the shortest duration necessary, was used.

Judgment: Substantially compliant

Regulation 8: Protection

There were safeguarding measures in place to protect residents from suffering from abuse.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Laurels OSV-0003602

Inspection ID: MON-0025383

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The person In Charge has contacted Maintenance dept on the 15/02/2020 to complete a deep clean on the patio area. • Outside Cleaning contractors will complete a deep clean of The Laurels, Including the bathroom and tile area.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Awaiting 3 PAMG ('Positive Approaches Monitoring Group ') approval at time of inspection, 21/01/2020. 2 PAMG were subsequently approved since date of inspection. Awaiting one further approval as PAMG requiring further information for this Mechanical restriction.	

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 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	31/03/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/03/2020