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:	Breaffy House
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	07 September 2023
Centre ID:	OSV-0002389
Fieldwork ID:	MON-0034459

About the designated centre

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

Breaffy house is a designated centre operated by St Michael's House located in an urban area in North County Dublin. It provides a residential service for up to seven adults with disabilities. A bed sharing arrangement is in place in the centre, therefore a maximum of six residents are accommodated in the centre at any one time. The centre is a large detached two-storey house which consisted of kitchen/dining room, two sitting rooms, six bedrooms, a staff sleepover room, an office and two shared bathrooms. The centre is located close to amenities such as public transport, shops, restaurants, churches and banks. 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:	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 (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
Thursday 7 September 2023	10:10hrs to 17:00hrs	Kieran McCullagh	Lead
Thursday 7 September 2023	10:10hrs to 17:00hrs	Ann-Marie O'Neill	Support

What residents told us and what inspectors observed

This was an unannounced inspection completed over one day and was facilitated by the person in charge and social care worker. Over the course of the day, inspectors also met with staff members and with two of the residents who lived in the centre.

The designated centre comprised of one two-storey building, located in an urban area of North County Dublin. The centre is located close to amenities such as public transport, shops, restaurants, churches and banks. Five residents were present in the centre on the day of inspection. Upon inspectors' arrival to the centre, four of these residents were out of the centre attending day services. One resident was present in the centre and was observed relaxing in the kitchen area colouring. Inspectors were informed the resident had chosen to retire from day services in previous years and as such was being supported by a staff member from the centre during the day time. The staff member present with this resident informed inspectors that this better suited the resident as it enabled them to choose their own routine.

Inspectors had the opportunity to meet with this resident who told them that they "loved living here". The resident spoke about a recent holiday they had been on and a trip to see one of their favourite singers in concert. Staff members on duty supported the resident to communicate with the inspectors and were seen to interact pleasantly and respectfully with them throughout the course of the inspection. In the afternoon, inspectors met one other resident when they returned from their day service. From speaking with both residents, it was evident that they felt very much at home in the centre, and were able to live their lives and pursue their interests as they chose.

Due to some peer-to-peer compatibility needs in the house, there had been an arrangement implemented to support and minimise interactions between some residents, and as such residents' daily routines and activities were organised and scheduled to facilitate this. Staff supported residents in the evening and at weekends to go to activities in the community. For example, residents enjoyed meals out, going out for walks and shopping, day trips and holiday destinations. Staff on duty knew the residents well, and described the supports in place to ensure they had a meaningful day, and that they were cared for as appropriate. In addition to the person in charge, there were three staff members on duty during the day of the inspection. The person in charge and a staff member spoken with demonstrated that they were familiar with the residents' support needs and preferences.

The person in charge described the quality and safety of the service provided in the centre as being very good and personalised to the residents' individual needs and wishes. They spoke about the current staff compliment and acknowledged the challenges in relation to the reliance on the use of relief and agency staff to meet the assessed staffing complement. Observations carried out by inspectors, feedback from residents and documentation reviewed provided suitable evidence to support

this.

Inspectors carried out a walk around of the centre in the presence of the person in charge and staff. Each resident had their own ground floor bedroom, and had access to a shared bathroom, two sitting rooms, utility room, staff office and kitchen. Residents' bedrooms were laid out in a way that was personal to them and included items that was of interest to them. For example, residents' bedrooms included family photographs, pictures and memorabilia, ornaments and soft furnishing and fittings that were in line with the residents' preferences and interests.

To the rear and front of the centre, was a well-maintained garden area, that provided outdoor seating for residents to use, as they wished. Since the last inspection, the provider had made some home improvements to this centre, to include, new accessible bathroom and refurbished utility room. The staff told inspectors that the bathroom provided residents with better and more accessible facilities with regards to their personal care.

Generally, the premises was well maintained however, some minor upkeep was required. These matters had been reported by the person in charge to the provider. For example, hallway flooring was damaged and required replacing, some air vents were visibly dusty and required cleaning, some walls and doors required repainting and some door jams and skirting boards were observed to be scuffed and worn in areas.

Inspectors observed the provider had carried out some works to fill in holes on the grounds outside the centre however, not all of these holes had been repaired and inspectors observed a large hole which could pose as a trip hazard in one area near the outside shed. While the provider had purchased and fitted a large new storage shed, inside inspectors observed the shed required de-cluttering in order to maximise its storage potential and ensure staff could easily access items stored in it.

From what inspectors were told and observed during the inspection, it was clear that residents had active and rich lives, and received a good quality service. The service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

For the most part, the care and support provided to the residents was person-centred and the provider and person in charge were endeavouring to promote an inclusive environment where each of the residents' needs and wishes were taken

into account.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a social care worker, who was knowledgeable about the support needs of the residents living in the centre.

Inspectors found that improvements from the last inspection had been completed and had resulted in positive outcomes for residents. There were some improvements required on this inspection, regarding premises and risk management procedures however, these are discussed in the quality and safety section of the report.

The provider had notified incidents in the service to the Chief Inspector of Social Services and had internally identified a pattern in incidents being reported in this centre from local management. The provider demonstrated evidence of action being taken to manage this, which included up-to-date safeguarding plans and planned activities for residents in the evenings and during weekends.

The education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. The training needs of staff were regularly monitored and addressed to ensure the delivery of quality, safe and effective services for the residents. Inspectors found that for the most part, staff had been provided with the organisation's mandatory training and that the majority of this training was up to date. However, some staff were overdue refresher training and supervision as per the provider's policy was not up to date.

There were relevant policies and procedures in place in the centre which were an important part of the governance and management systems to ensure safe and effective care was provided to residents including, guiding staff in delivering safe and appropriate care. However, on review of the Schedule 5 policies and procedures in place, inspectors found five polices had not not been reviewed at intervals not exceeding three years as per the Care And Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013.

The governance and management systems in place were found to operate to a good standard in this centre. The provider had completed an annual report of the quality and safety of care and support in the designated centre and there was evidence to demonstrate that the residents and their families were consulted about the review. A six-monthly unannounced review of the centre had taken place in May 2023 of the quality and safety of care and support provided to residents and there was an action plan in place to address any concerns regarding the standard of care and support provided.

Regulation 15: Staffing

The registered provider had ensured the skill-mix and staffing levels allocated to the

centre was in accordance with the residents' current assessed needs. The staff team comprised of the person in charge and social care workers. There were three staff on duty during the day, and two staff at night-time, one waking and one in a sleepover capacity.

There was a planned and actual roster maintained that reflected the staffing arrangements in the centre, including staff on duty during both day and night shifts.

Due to vacancies and leave within the existing staff team the provider was attempting to ensure continuity of care and support through the use of regular relief and agency staff, however this was a challenge. Owing to the assessed needs of the residents it was important that they were supported by a core familiar and consistent staff team who had a good understanding of individual and collective needs. Overall, the continuity of care and support to residents could not always be assured.

Although the person in charge told inspectors that the provider was in the process of actively recruiting staff to back fill current vacancies, there was a reliance on the use of relief and agency staff to meet the assessed staffing complement.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff were supported and facilitated to access appropriate training including refresher training that was in line with the residents' needs. A staff training schedule was in place, however it did not include oversight of relief or agency staff training needs and a number of staff were overdue refresher training in the following:

- Fire Safety
- Feeding, Eating, Drinking and Swallowing

As per the provider's policy staff were to receive supervision on a quarterly basis. However, following review of the supervision schedule only two staff had received two supervision meetings and three staff members had received one supervision meeting to date.

Judgment: Substantially compliant

Regulation 23: Governance and management

On the day of the inspection, there was a clear management structure in place with clear lines of accountability. It was evidenced that there was regular oversight and monitoring of the care and support provided in the designated centre and there was

regular management presence within the centre. The staff team was led by an appropriately qualified and experienced person in charge.

The person in charge reported to a service manager. They also held monthly meetings which reviewed the quality of care in the centre. A series of audits were in place including monthly local audits and six-monthly unannounced visits. In addition monthly data audits were undertaken, including audits of residents' personal planning, goal trackers and centre achievements.

These audits identified any areas for service improvement and action plans were derived from these. The inspectors saw that actions were progressed across audits.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider ensured that all policies and procedures outlined in Schedule 5 were prepared in writing and implemented in the centre.

However, the following five polices had exceed their three years review time line as per the Care And Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013:

Admissions, including transfers, discharge and the temporary absence of residents
Communication with residents
Monitoring and documentation of nutritional intake
Provision of information to residents
The creation of, access to, retention of, maintenance of and destruction of records

Judgment: Substantially compliant

Quality and safety

This inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality. Residents were receiving appropriate care and support that was individualised and focused on their needs. The provider and person in charge were endeavouring to ensure that residents living in the centre were safe at all times, but some improvements were required.

Inspectors found that residents' wellbeing and welfare was maintained by a good standard of evidence-based care and support. They observed residents to have active lives and participate in a wide range of activities within the community and

the centre.

Residents chose to live their lives in accordance with their will and personal preferences. They were also supported to maintain relationships meaningful to them, for example, with their families. Residents spoken with were happy in the centre, and inspectors found that the service provided to them was safe and of a good quality.

There were good arrangements, underpinned by robust policies and procedures, for the safeguarding of residents from abuse. Inspectors reviewed the safeguarding arrangements in place and found that staff had received training in safeguarding adults. In addition, there were clear lines of reporting for any potential safeguarding risks and a staff member spoken with was familiar with what to do in the event of a safeguarding concern. While there were some safeguarding concerns at times within the centre staff and the person in charge were taking appropriate steps to safeguard residents.

Generally, the premises was well maintained, however some minor upkeep was required, and had been reported by the person in charge to the provider. There was sufficient communal space, and a nice garden for residents to enjoy. The premises was meeting the residents' needs, and residents spoken with said they were happy with their home.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. There was an up-to-date policy on risk management available and each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. There was evidence to demonstrate the risk management policy's implementation in the centre from a review of the risk register, personal risk assessments for residents and incident recording logs. However, some minor improvements were required to the risk register to ensure information and analysis of risks, presenting in the centre, were accurate and could inform the provider of the of the most pertinent risk themes which may require more enhanced and considered centre specific control measures and/or resources.

On review of a sample of residents' medical records, inspectors found that medications were administered as prescribed. Residents' medication was reviewed at regular specified intervals as documented in their personal plans and the practice relating to the ordering; receipt; prescribing; storing; disposal; and administration of medicines was appropriate.

Regulation 10: Communication

The registered provider had ensured that residents were supported to communicate in accordance with their needs and wishes.

Staff were observed to be respectful of the individual communication style and preferences of the residents as detailed in their personal plans and all residents had

access to appropriate media including; the Internet and television.

The person in charge had also scheduled Total Communication training for all staff to participate in.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the premises was in line with the centre statement of purpose. Overall, inspectors observed the design and layout of the premises was suitable to meet residents' individual and collective needs.

Since the last inspection, there had been some home improvements works completed to the centre, which resulted in positive outcomes for residents. For example, a new bathroom provided residents with better and more accessible facilities with regards to their personal care.

Residents had access to facilities which were maintained in good working order. There was adequate private and communal space for them as well as suitable storage facilities. For the most part, the centre was well maintained, clean, comfortable and suitably decorated.

However, a number of issues identified by the provider's internal auditors remained outstanding which included: hallway flooring was damaged and required replacing, some air vents were visibly dusty and required cleaning, some walls and doors required repainting and some door jams and skirting boards were observed to be scuffed and worn in areas.

In addition, inspectors observed the provider had carried out some works to fill in holes on the grounds outside the centre however, not all of these holes had been repaired and inspectors observed a large hole which could pose as a trip hazard in one area near the outside shed. While the provider had purchased and fitted a large new storage shed, inside, inspectors observed the shed required de-cluttering in order to maximise its storage potential and ensure staff could easily access items stored in it.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had an up-to-date risk management policy in place. There was evidence to demonstrate its implementation in the centre from a review of the risk

register, personal risk assessments for residents and incident recording logs.

While this demonstrated there was good implementation of the risk management policy in the centre, there were some minor improvements required to the risk register to ensure information and analysis of risks, presenting in the centre, were accurate and could inform the provider of the of the most pertinent risk themes which may require more enhanced and considered centre specific control measures and/or resources. For example, falls were identified as a risk in the centre however, the risk register was capturing each specific resident's risk of falling rather than assessing and identifying falls as an overall presenting risk theme in the centre.

Inspectors noted other risks, that presented in the centre, were also being captured in the risk register in a similar way. This required improvement.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were safe practices in relation to the ordering, receipt and storage of medicines. There was a system in place for return of out of date medication and a form was stamped by the pharmacy. The medication administration record clearly outlined all the required details including; known diagnosed allergies, dosage, doctors details and signature and method of administration.

The provider had appropriate lockable storage in place for medicinal products and a review of medication administration records indicated that medications were administered as prescribed. Residents had also been assessed to manage their own medication but no residents were self administering on the day of inspection.

Judgment: Compliant

Regulation 8: Protection

Overall good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice. At the time of this inspection there were ten safeguarding concerns open however, they had been reported and responded to as required and safeguarding plans were in place to manage these concerns.

The provider had appropriate arrangements in place to safeguard residents from harm or abuse. All staff had received training in safeguarding, and there was a safeguarding policy to guide staff.

All residents' personal plans were detailed in relation to any support they may

require with their personal and intimate care. These documents were person-centred and identified residents specific preferences in this area including supports that made them feel safe and secure when staff were assisting.
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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Breaffy House OSV-0002389

Inspection ID: MON-0034459

Date of inspection: 07/09/2023

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: · The PPIM in conjunction with Service Provider, to organise a recruiting drive for the Designated Centre. · The Person in Charge is workng with the newly appointed Relief Staff Co-Ordinator on a monthly basis with planned roster to fill vacancies (04/10/2023).	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · Every quarter, the Service Provider's internal online training system will be reviewed and a up to date audit of trainings completed will be available. · The Person in Charge has set up a robust notification of trainings due and filing system within the Designated Centre of trainings completed by staff (21/09/2023). · Overdue refresher training was completed by staff (09/10/2023). · The Person in Charge informed the newly appointed Relief Staff Co-Ordinator of relief staff working within the Designated Centre and the Relief Staff Co-Ordinator will provide oversight for their training (04/09/2023). · The Person in Charge has placed with Training Records memos received from staffing agencies regarding completed mandatory trainings (11/10/2023). · The Person in Charge will highlight on planned roster 4 hours supervision per month to ensure dedicated time available for both staff and Person in Charge. Audit of supervisions will be maintained by the Person in Charge.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:	

The Service Provider is currently reviewing the policy outlined in the report.

• Admissions, including transfers, discharge, and the temporary absence of residents – Reviewed and awaiting approval.
• Communication with residents' - Policy is currently under review but progressing. It has been reviewed by the external Data Protector Officer (DPO).
• Monitoring and documentation of nutritional intake – Policy is under review as part of the Nutrition Policy.
• Provision of information to residents - The provision of information policy is currently under review but progressing. It has been reviewed by the external DPO.
• The creation of, access to, retention of, maintenance of and destruction of records- Policy is currently under review but progressing. It has been reviewed by the external DPO.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
· The Person In Charge and the team have linked with TSD and Housing Association to confirm completion dates for damage to hallway flooring, painting of communal areas and doors, repair to door jams and skirting boards (29/09/2023).
· The Person In Charge has included in Designated Centres cleaning schedule the cleaning/dusting of air vents (11/10/2023).
· The Person In Charge and the team have linked with TSD regarding completing repairs to all potholes noted on emergency routes and grounds (29/09/2023).
· The Person In Charge and the team have decluttered the shed to maximize the storage potential (25/09/2023). Maintaining the shed added to the weekly cleaning scheduled (11/10/2023).

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
· The Person In Charge completed an overarching Falls Risk Assessment for the Designated Centre and has ensured this and other overarching Risks Assessments are captured on High Risk Register or clearly identified at beginning of Service Users Risk Register (11/09/2023).

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(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	31/03/2024
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	12/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2023
Regulation 17(1)(b)	The registered provider shall ensure the	Substantially Compliant	Yellow	30/06/2024

	premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.			
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	30/09/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/12/2023