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:	Rosetree Cottage
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Short Notice Announced
Date of inspection:	26 May 2021
Centre ID:	OSV-0002357
Fieldwork ID:	MON-0029163

About the designated centre

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

Rosetree Cottage is a designated centre operated by St. Michael's House. The centre comprises a six bedroom, detached bungalow located in as suburban area of North Dublin. The centre also provides a small garden to the rear of the centre for residents to use as they wish. There is also adequate communal space within the centre for residents use. Each resident has there own bedroom which has been personalised to their own tastes, interests and personal preferences. Rosetree Cottage is staffed by a Clinical nurse Manager 2 who is the Person In Charge, a Clinical Nurse Manager 1 is also assigned to the centre as a deputy manager to the person in charge and as part of the overall governance arrangement for the centre. The staff team consists of nurses, social care workers, care staff and a domestic worker. The person in charge is supported and supervised by a Service Manager, identified as a person participating in management for the centre and part of the overall provider's governance oversight of the centre.

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
Wednesday 26 May 2021	10:00hrs to 16:30hrs	Andrew Mooney	Lead
Wednesday 26 May 2021	10:00hrs to 16:30hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

In line with public health guidance the inspectors did not spend extended periods with residents. However, inspectors did have the opportunity to meet residents briefly and observe staff supporting them.

Inspectors observed that for the most part residents appeared comfortable and content in their home. However, despite very high levels of staff being present in the centre, it was evident that there was a high degree of restrictive practices utilised. While these restrictions were assessed as being required, they did detracted from the homely feel of the centre. This will be discussed further under quality and safety.

Residents appeared very comfortable with staff. During the inspection, inspectors observed staff supporting residents in a kind and respectful manner. This included staff spending time with residents and facilitating low arousal play activities and these interactions contributed to a friendly and homely environment.

During the inspection, inspectors observed good infection control practices in place, which included appropriate COVID-19 precautions. In line with national guidance, visitors access was limited to essential access only. However, the provider did have contingency arrangements in place, to ensure where appropriate, visitors could meet residents in a safe manner. These arrangements were under review in line with new visitors restriction guidance. There was appropriate hand sanitising facilities and staff wore appropriate personal protective equipment (PPE).

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements positively impacted on the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that the cumulative impact of non compliance across the inspection demonstrated that the current governance and management arrangements were insufficient and this negatively impacted the capacity and capability of the centre. The governance and management arrangements required improvement to ensure the effective governance, operational management and administration of the designated centre.

There were clearly defined management structures in place which identified the lines of authority and accountability within the centre and the centre was managed

by a suitably qualified and experienced person in charge.However, the person in charge had responsibility for other centres. The provider had systems in place to monitor and review the quality of services provided within the centre, such as The unannounced inspections and an annual review of quality and care . However, these systems failed to self identify pertinent concerns and drive improvements in the centre. For instance, long standing concerns relating to the current fire evacuation arrangements had not be resolved in a timely manner. Furthermore, the general management of administrative systems required review to streamline the effective review of documentation within the centre.

The provider had ensured that staff had the required competencies to deliver a safe service to the residents of the centre. Staff were supported to carry out their duties to protect and promote the care and welfare of residents. During the inspection, the inspectors met with a number of staff and found them to be knowledgeable regarding residents' needs. Staff were observed interacting in a very positive and dignified manner with residents. There was also appropriate access to nursing care, in line with the statement of purpose. However, it was unclear if the staffing arrangements at night were suitable to meet the assessed needs of residents within the centre. This will be discussed further under quality and safety. Furthermore, rota maintenance required improvement to ensure staffing arrangements within the designated centre were clearly and accurately recorded.

A training needs analysis was completed in the centre and staff were provided with suitable training such as fire safety, manual handling and positive behaviour support. Staff demonstrated knowledge and competence in these areas and this resulted in positive outcomes for residents. However, there were significant gaps in refresher training that required review. For instance, not all staff had completed refresher fire safety training. Furthermore, the person in charge noted that formal supervision of staff had not been completed in 2021. This required review, to ensure there was effective arrangements in place to supervise staff.

While most notifications were notified to the Chief Inspector in line with the requirements of the Regulations, not all quarterly notifications had been notified as required. A review of incidents and restrictions within the centre, demonstrated that not all minor injuries and restrictions had been notified.

Regulation 15: Staffing

Roster maintenance required improvement to ensure staffing arrangements within the designated centre were clearly and accurately recorded.

It was not clear that the current staffing arrangements were deployed effectively to ensure residents assessed needs could be met. For example it was unclear if the current night time arrangements were sufficient to safely evacuate all residents at night.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had completed refresher training. For example 9 staff required fire safety refresher training. The frequency of supervision arrangements within the centre was not in keeping with the providers own policy. For example no formal staff supervision had been completed in 2021.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements within the centre required improvement, to ensure the effective governance, operational management and administration of the designated centre. For example the cumulative impact of non compliance across the inspection demonstrated that the current arrangements were insufficient and this negatively impacted the capacity and capability of the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all quarterly notifications were notified to the Chief Inspector as required in the Regulation. For example not all restrictive practices or minor injuries were notified as required.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that the day to day practice within the centre ensured residents were safe and arrangements were in place to ensure that residents were safeguarded during the pandemic. However, improvements were required in fire precaution measures and positive behaviour support.

The provider had adopted a range of infection prevention and control procedures to

protect residents from the risk of acquiring a healthcare associated infection. The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. There were appropriate hand washing and hand sanitising facilities available throughout the centre. There were suitable arrangements for clinical waste disposal. Staffing arrangements were reviewed and staff rosters had been designed to limit any potential outbreak of COVID-19.

There were appropriate arrangements in place to ensure that residents had a personal plan that detailed their needs and outlined the supports required to maximise their personal development and quality of life. The service worked together with residents and their representatives to identify and support their strengths, needs and life goals. Residents were assisted to find opportunities to enrich their lives and maximise their strengths and abilities in line with current public health advice. However, not all aspects of these plans were reviewed annually as required, for example positive behaviour support plans and some health care plans required review.

In general the provider had ensured that there was appropriate fire safety measures in place, including detection and alarm system, fire fighting equipment and containment measures. However, deficits in some of these measures undermined the fire safety within the centre. For instance, despite conducting fire drills, it was unclear if the centre could be safely evacuated in the event of a fire at night. A record of a fire drill noted staff concerns regarding the procedure. While an action plan to address concerns was developed, it was not completed in a timely manner and no appropriate repeat fire drill was completed. Furthermore, one fire door was observed to have a hole, which could compromise the effectiveness of the the fire door. This was raised as a immediate action with the person in charge and assurance were given during the inspection, that corrective actions would be taken to address the containment concern.

Arrangements were in place to support and respond to residents' assessed support needs, including behaviour support plans. Staff were familiar with residents' needs and any agreed strategies used to support them. All staff received positive behaviour support training and this enabled staff to provide care that reflected up-to-date, evidence-based practice. However, not all positive behaviour support plans were reviewed as required. Additionally, during the walk through of the centre,inspectors observed numerous restrictive practices in place. While assessed as being required by the provider, it did diminish the homeliness of the centre. Furthermore, it was unclear if restrictions in use were the least restrictive option and for the shortest duration. ie the intermittent use of door locks in the kitchen where not monitored effectively, as there was no recording of when this restriction was or was not in use. Therefore the inspectors could not be assured that this restriction was only used as a last resort.

The provider had ensured that there were systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions at the centre were investigated appropriately. Staff had a good understanding of safeguarding processes and this ensured residents were safeguarded at all times.

Some improvements were required in relation to how safeguarding concerns were notified to the national safeguarding and protection team, as on a small number of occasions these had not always been completed within the required time frame.

Regulation 27: Protection against infection

Staff were observed to engage in good hand hygiene practices, wore appropriate PPE and were observed to socially distance where possible.

Judgment: Compliant

Regulation 28: Fire precautions

There was appropriate fire fighting and detection equipment in place that was serviced as required. There was a procedure for the safe evacuation of residents and staff. However, improvements in how fire drills were completed were required. For instance, where challenges during fire drills were identified, repeat drills were not completed to demonstrate that residents could be safely evacuated. Additionally, fire containment measures within the centre required improvement as one fire door was observed to have a a hole in it.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were appropriate arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life. However, not all aspects of residents personal plans had been reviewed annually or more frequently as required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Appropriate supports were in place for residents with behaviours that challenge or residents at risk from their own behaviour. Although, no all positive behaviour

support plans had been reviewed as required.

However, it was unclear if restrictions in use were the least restrictive option and for the shortest duration. ie the intermittent use of door locks in the kitchen where not monitored effectively, as there was no recording of when this restriction was or was not in use.

Judgment: Not compliant

Regulation 8: Protection

The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse. Notifications were made to all appropriate agencies.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Rosetree Cottage OSV-0002357

Inspection ID: MON-0029163

Date of inspection: 26/05/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • PIC and CNM1 reviewed and updated staff roster on 27/05/21. Sytem was put in place at this time that roster would be updated weekly by either PIC or CNM1 . Any updates will record any changes to shifts and identify who is on shift and what their role is. • 2 staff on duty every night. Night time fire drill carried out on 27/05/21. All residents were evacuated. Evacuation report was reviewed with SMH fire officer.Repeat night time evacuations will now be held in a timely manner.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff have access to online training support through Both YourOTC & HSELand. PIC has reviewed centre training records. All staff will have completed outstanding training by 31/08/21. • PIC & CNM1 have drawn up a supervision schedule for current staff team. All staff will have received supervision at least once by 31/08/21. Future supervision will be scheduled in line with SMH supervision policy.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC and CNM1 reviewed all Governance and Management systems within the centre. CNM2 support from within the service was provided to assist in setting up systems that allow for continuous oversight and review of centre. • Position of permanent PIC/CNM2 has been filled and successful candidate is due to start by 31/08/21.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Quality & Safety Manager carried out Restrictive Practice Audit in centre on 25/06/21. All restrictions noted and brought to attention of SMH Positive Approaches Monitoring Group. All identified restrictions will be notified to HIQA in quarterlies going forward. • Prior to submitting quarterly notifications PIC or PPIM will review all incidents to indentify if they meet criteria for notification.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • 2 staff on duty every night. Night time fire drill carried out on 27/05/21. All residents were evacuated. Issues with times taking were highlighted and addressed. Future night time evacuations will now be held in a timely manner. • Fire door was fixed 28/06/21	
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:
• SMH Person Centred Planning (PCP) coordinator met with staff team on 07/06/21 to discuss principles of PCP and reviewing of Assessment of Needs (AoNs) and individual support plans(SP).PCP coordinator is currently reviewing all AoNs and SPs.Review to be complete as of 31/07/21. Going forward all plans will be evaluated quarterly and have full review annually.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Schedule is in place with Psychologist attached to centre to review all Positive Behaviour support guidelines. These are due to be complete as of 31/09/21

• Quality & Safety Manager carried out Restrictive Practice Audit in unit on 25/06/21. All restrictions noted and brought to attention of SMH Positive Approaches Monitoring Group (PAMG). All recommendations from PAMG will be implemented within centre and regularly reviewed.

• Restrictive log in place for door lock in Kitchen to record frequency and duration of use. Individual restrictions are logged through daily reports and reviewed through Monthly reports.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/09/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	31/08/2021

	as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2021
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	31/07/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2021
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/07/2021
Regulation 31(3)(a)	The person in charge shall	Substantially Compliant	Yellow	31/07/2021

	ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Substantially Compliant	Yellow	31/07/2021
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Substantially Compliant	Yellow	31/08/2021

	be multidisciplinary.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/09/2021