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:	Glenanaar
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	08 December 2021
Centre ID:	OSV-0002380
Fieldwork ID:	MON-0026737

About the designated centre

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

Glenanaar is a designated centre operated by St. Michael's House located within a campus setting in North County Dublin. It is a residential home for six adults with an intellectual disability and additional needs which require nursing care. The centre is a bungalow which consists of a kitchen, dining room, sitting room, staff office, staff sleepover room, sensory room, shared bathroom and shower room and six individual bedrooms for the residents. The centre is located close to local shops and transport links. The centre is staffed by a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff.

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
Wednesday 8 December 2021	09:00hrs to 15:45hrs	Amy McGrath	Lead

What residents told us and what inspectors observed

There were five residents living in the centre at the time of inspection, with no vacancies. The inspector met with all residents who lived in the centre and communicated with some residents with the support of staff. The inspector observed residents in their home throughout the course of the inspection and spoke with staff who worked in the centre. The inspector also received two completed resident questionnaires which were filled out with the support of resident advocates to share residents' views on the service.

This inspection was announced in advance. The inspector arrived to the centre and was greeted by the person in charge who carried out a temperature check in line with the visiting arrangements for the centre. On arrival, some residents were having their breakfast and were seen receiving support with eating and drinking from staff members. There was a household staff present who was observed tidying the kitchen at this time. Breakfast time was seen to be relaxed and comfortably paced; staff were observed speaking to residents while they supported them with their meal, for example, checking they were happy with their food or asking if they were ready for a cup of tea.

The centre is located in a campus setting in a North Dublin suburb. The premises is a large bungalow and consists of six bedrooms, three bathrooms (two of which contain bathing facilities), a large living area, kitchen, dining room and sensory room. The premises also contains a number of storage rooms, a medication room, a utility room, staff office and staff bedroom, and a sensory room.

One resident was still in bed when the inspector arrived and got up and got ready for the day later in the morning in accordance with their own preference. Residents were seen watching television in the living area which was decorated for Christmas. The premises was nicely decorated throughout, with a large Christmas tree, festive lights, window decorations and ornaments.

All residents had their own bedrooms, which were neatly decorated and well furnished. Each bedroom contained personal items such as family pictures, photo albums, art work and posters. A number of bedrooms had ceiling hoist equipment in place to meet residents' physical support needs. Ceiling hoists were also present in bathrooms. Where residents required support with personal or intimate care, handwash facilities were available in their bedrooms.

A review of residents' care plans found that residents preferred a quiet and relaxed environment, with minimal noise and disruption. The inspector noted a quiet and calm atmosphere during the course of the inspection, with relaxed and friendly communication between residents and each other, and residents and staff. The inspector noted that where required, residents received support to manage their behaviour in accordance with their personal care plans.

The questionnaires received revealed that residents were happy with the services and facilities provided in the centre. One resident shared that they would like to participate more in the food shopping. Staff told the inspector that food shopping was usually carried out by household staff, with residents deciding at weekly residents' meetings what they would like to have for meals and snacks for the following week. One resident stated they needed more space to store their personal belongings. The questionnaires also described how each resident enjoyed the activities they engaged in both in their home and in the community. Residents mentioned enjoying activities such as trips to restaurants, museums, cinemas and theatres. One resident shared that they would like to go out to the local community more often and would enjoy going for a coffee or visiting the local shop more often.

Residents' questionnaires also noted that residents knew how to make a complaint where necessary. It was noted that one complaint took longer to resolved than the complainant would have liked. A review of complaints by the inspector showed that complaints were managed in accordance with the provider's own policy, with updates provided at regular intervals. There was evidence that considerable effort was made to resolve the complaint in a timely manner.

Overall, it was found that residents were in receipt of good quality and person centred care that met their assessed needs and promoted development and independence. It was evident that residents' views and preferences were considered in the day to day running of the centre. It was noted that staff regularly advocated for residents' at staff and resident meetings and that this affected change where necessary.

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

Capacity and capability

The inspector found that Glenanaar met, and in some cases exceeded the requirements of the regulations in key areas of service provision and was embracing the national standards in areas such as general welfare and development and infection prevention and control. The governance and management arrangements promoted a culture that encouraged feedback and empowered residents. There was a range of oversight measures in place to ensure that residents received a safe, quality service that met their individual assessed needs. Sub-compliance was found with regard to the accuracy of the statement of purpose, and the annual review. Record keeping in relation to staffing also required improvement in order to fully comply with the regulations.

The provider had recently undertaken a staffing review and had increased staffing levels to meet residents' emerging healthcare needs. It was found that there were sufficient staff available, with the required skills and experience, to meet the

assessed needs of residents. There was a planned and maintained roster however the roster did not include staff designations for all staff members, and as such it could not be determined on review of the roster if there was a staff nurse working each day. On further review with the person in charge it was found that the staffing arrangements were in accordance with the statement of purpose. The roster did not include household staff.

The inspector reviewed a sample of staff files and found that most of the information required to be maintained was available, such as Garda vetting records, personal identification and references. The record keeping system did not ensure that some records related to staff employment were easily retrievable and it was found that roles and responsibilities with regard to documents required under Schedule 2 of the regulations were not clear.

The person in charge ensured that staff had access to necessary training and development opportunities. The provider had identified some areas of training to be mandatory, such as fire safety management, positive behaviour support, and safeguarding. Staff had each received training in these key areas and had also received training in areas specific to residents' needs (such as feeding, eating and drinking, and medicines management) and infection prevention and control.

Staff were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities. A review of supervision records found that supervision meetings were used to oversee areas of responsibility and identify and plan areas for staff development.

There were effective management arrangements in place that ensured the safety and quality of the service was consistent and closely monitored. The provider had carried out an annual review of the quality and safety of the centre, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. It was found that the annual review did not comprehensively review the quality and safety of the service or assess that care and support was in accordance with the standards. While it was evident that the range of other audits undertaken were driving quality improvement, the annual review did not contain a qualitative review of the quality of service provision. For example, the annual review reported that there was a statement of purpose in place that had been recently reviewed; it did not identify that the statement of purpose contained inaccurate or insufficient information.

There was a complaints policy and clear complaints procedures in place. There was a person nominated to deal with complaints. A review of records found that complaints were managed in accordance with the provider's policy. Complaints were recorded and escalated appropriately, with a record of communication with the complainant maintained. Complaints were used to inform the delivery of care.

There was a statement of purpose in place that was reviewed an updated on a regular basis. While the statement of purpose contained the information required by Schedule 1 of the regulations, some of this information was found to be inaccurate. For example, the conditions of registration were not accurate and the criteria for

admission referred to the provision of respite. The statement of purpose was reviewed and amended on the day of inspection.

Regulation 15: Staffing

The inspector reviewed a number of staff files and found that the provider had ensured most of the required documents and information were present for employees. However, some records were not available in staff files and it was found that stakeholders were unclear of their responsibility with regard to the maintenance of Schedule 2 documents.

There was a planned and actual roster in place, however it did not accurately outline the roles and designations of all staff members.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector found that the person in charge promoted a culture of professional development and that staff had undertaken a range of training courses and development opportunities.

There were arrangements in place for staff and the person in charge to receive supervision.

Judgment: Compliant

Regulation 23: Governance and management

While the centre was found to be generally well governed, the annual review did not meet the requirements of the regulations in that it did not review whether care and support was delivered in accordance with the standards.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

While the statement of purpose contained the information required by Schedule 1 of

the regulations, some of this information was found to be inaccurate.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. A review of records found that complaints were recorded, investigated and resolved (where possible) in accordance with the provider's policy.

Judgment: Compliant

Quality and safety

The governance and management systems had ensured that care and support was delivered to residents in a safe manner and that the service was consistently and effectively monitored. Residents' support needs were assessed on an ongoing basis and there were measures in place to ensure that residents' needs were identified and adequately met. Overall it was found that the centre had the resources and facilities to meet residents' needs.

Despite national restrictions, and the closure of external day services, the staff team in the designated centre were ensuring residents could engage in meaningful activities and had choice and control over their daily lives. For example, residents used local amenities and facilities while following national guidance for physical distancing and hand hygiene and spent time on art and craft projects or hobbies of interest from within their home.

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs. While there were a number of restrictive practices in place, such as door locks, these were used as a measure of last resort and for the shortest duration of time. Any restrictive intervention had been assessed to ensure its use was in line with best practice. Where necessary, residents received specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk.

The inspector reviewed the safeguarding arrangements in place and found that residents were protected from the risk of abuse. Staff had received training in safeguarding adults. There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency. There were intimate care plans available that guided the delivery

of person centred and dignified care.

Residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community and were supported to maintain relationships with friends and family. It was found that residents were central to their personal planning process, and that their will and preference was respected with regard to decision making. Residents were supported to set and achieve personal goals in order to enhance their quality of life.

There was a risk management policy and associated procedures in place. There was an accurate risk register in place that reflected the risks identified in the centre. The processes in place ensured that risk was identified promptly, comprehensively assessed and that appropriate control measures were in place.

There were arrangements in place to prevent or minimise the occurrence of a healthcare-associated infection. Risks associated with infection prevention and control had been identified and assessed. There were control measures in place in response to identified risks and there were clear governance arrangements in place to monitor the implementation and effectiveness of these measures. The provider had developed a range of policies and procedures in response to the risks associated with COVID-19, and these were well known to the person in charge and staff. Staff had received training in infection control and hand hygiene. There was adequate and suitable personal protective equipment (PPE) available and guidance was provided to staff in relation to its use. Resident were supported to avail of immunisation programmes according to their will and preference.

There were suitable fire safety arrangements in place, including a fire alarm system, emergency lighting and fire fighting equipment. Records reviewed showed that the equipment was serviced at regular intervals. There were emergency evacuation plans in place for all residents, and these were developed and updated to reflect the abilities and support needs of residents. Staff had received appropriate training in fire safety, including training in specific evacuation techniques.

Regulation 13: General welfare and development

Residents had access to a range of opportunities for recreation and leisure. Residents were supported to engage in learning and development opportunities. Support plans and assessments undertaken supported further development in areas such as personal relationships, community and social development, and emotional development. Resident were supported to maintain and develop personal relationships and friendships.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management arrangements ensured that risks were identified, monitored and regularly reviewed. These included measures to manage infection control risks. Risks specific to individuals, such as falls risks, had also been assessed to inform care practices.

Judgment: Compliant

Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19. The centre was maintained in a clean and hygienic condition throughout. Hand washing and sanitising facilities were available for use. Infection control information and protocols were available to guide staff, and staff had received relevant training.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which was regularly serviced.

Inspectors found that residents took part in planned evacuations, and that learning from fire drills was incorporated into personal evacuation plans

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices were logged and regularly reviewed and it was evident that efforts were being made to reduce some restrictions to ensure the least restrictive were used for the shortest duration. Where residents presented with behaviour that challenges, the provider had arrangements in place to ensure these residents were supported and received regular review.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. Staff were appropriately trained, and any potential safeguarding risk was investigated and where necessary, a safeguarding plan was developed.

There were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care, and these plans promoted dignified care practices.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glenanaar OSV-0002380

Inspection ID: MON-0026737

Date of inspection: 08/12/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 15 (a) The Person in Charge shall ensure there is a planned and actual staff rota, showing staff on duty during the day and night and that is properly maintained. The Person in Charge will ensure that all actual and planned rosters will include accurate information outlining the roles and designations of all staff members going forward 15 (b) The Person in Charge shall ensure that he has obtained in repect of all staff the information and documents specified in schedule 2. The Person in Charge has a folder of staff information and documents and has agreed with Service Manager the relevant information to be included. This will include Parental leave, maternity leave documentation, reduced hours applications, staff performance plans and requests for extended annual leave. Outside of this the relevant staff information will be kept in the HR department where The Person in Charge can request access to, as required	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 23 (b) There is clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of provision	

(d) There is an annual review of the quality and safety of care and support in the designated centre which is completed annually by the Service Manager and PIC in line with the relevant stakeholders. The Service Provider has updated their annual review template and going forward it will be used to meet the current regulation. This will be made available to residents and their representatives

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
3.1 The Register Provider shall prepare in writing a statement of purpose containing the information set out in schedule 1

The statement of purpose has been updated in line with schedule 1 and is updated as required. The statement of purpose is made available to residents and their representatives.

The Person in Charge has sent an updated Statement of purpose to HIQA on the 15/1/22

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(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	01/03/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	01/03/2022
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	01/04/2022

Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	15/01/2022