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

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| Name of designated centre: | New Cabra Road |
| Name of provider: | St Michael's House |
| Address of centre: | Dublin 7 |
| Type of inspection: | Announced |
| Date of inspection: | 02 February 2022 |
| Centre ID: | OSV-0002345 |
| Fieldwork ID: | MON-0027306 |

## About the designated centre

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

New Cabra Road is a designated centre operated by Saint Michael's House located in Dublin city. It provides community residential services to six adults over the age of 18. The centre is a terraced three story house which consists of a living room, kitchen/dining area, sun room, a staff sleep over room/office, two bathrooms and six individual bedrooms. There was an enclosed garden and utility room/garage to the rear of the centre. The centre is staffed by a person in charge and social care workers. Staff have access to nursing support through a nurse on call service.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 3 |

## 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 2 February 2022 | 10:40hrs to 16:20hrs | Amy McGrath | Lead |

## What residents told us and what inspectors observed

This report outlines the findings of an announced inspection of this designated centre. The inspection was carried out to assess compliance with the regulations following the provider's application to renew registration of the designated centre. In line with public health guidance, the inspector wore a face mask and maintained physical distance as much as possible during interactions with residents and staff.

There were three residents living in the centre at the time of inspection, with two vacancies. The centre was not accepting admissions at the time of inspection due to active compatibility issues between the current group of residents. The inspector met all three residents; two residents chose to speak with the inspector and shared their views on the service. All three residents completed a resident questionnaire which were reviewed by the inspector.

On arrival to the centre one resident greeted the inspector. The resident showed the inspector their bedroom and played a song on their keyboard. The resident told the inspector how they also enjoyed playing the accordion and was looking forward to returning to music lessons. They also told the inspector that they were saving to buy a piano and were receiving support to plan this purchase.

Both other residents spent some time in the centre throughout the day, with some time spent out in the local community running errands and engaging in activities. Early in the inspection one resident asked for some peace and quiet in the kitchen and this was respected and facilitated by staff and the inspector. One resident showed the inspector some of the fire safety arrangements in the centre and was knowledgeable regarding the fire exits and evacuation arrangements.

The centre was comprised of a terraced three-storey house which consisted of a living room, kitchen/dining area, sun room, a staff sleep-over room/office and two bathrooms. There were six individual bedrooms, one of which was located on the ground floor. There was an enclosed garden and utility room/garage to the rear of the premises. The inspector carried out a walk-through of the premises and found that in general it was well maintained and in a good state of repair. Residents' bedrooms were decorated to their own individual tastes and contained personal possessions and decorative items.

Prior to the COVID-19 pandemic, the residents attended their own individual day services most days of the week however due the closure of day services residents had spent increased amounts of time in each others company. Staff were providing individual support to residents to engage in activities outside of the centre in accordance with government restrictions, however some relationships between residents had become fraught and there was increasing conflict between them.

Some residents had made complaints regarding their lived experience and the inspector noted that these complaints had not been followed up in line with the

provider's policy. One resident told the inspector they liked when the centre was quiet, but didn't like when people were making lots of noise. A resident shared in a questionnaire that they were unhappy when people slammed doors. Through a review of notifications, documents, and discussion with staff it was found that residents' quality of life was significantly impacted by each others behaviour. There had been a substantial number of adverse incidents recorded including incidents of verbal abuse, physical threats, and instances whereby a resident's behaviour prevented another resident receiving medical care or support.

Staff had implemented a number of safeguarding measures in an attempt to minimise the negative impact of the ongoing incompatibility issues. It was found that activities and staffing requirements had to be navigated to reduce the risk of compatibility related behavioural incidents occurring in the house.

Notwithstanding, the inspector found that the person in charge and staff were endeavouring to ensure that the wellbeing and welfare of residents living in the centre was maintained by a good standard of evidence based care. Residents were supported by a team of social care workers, which as previously mentioned had been increased in number in response to safeguarding concerns.

Residents appeared comfortable in each staff members' company and were seen to communicate their needs and preferences to the staff supporting them. There were a number of familiar staff members employed in the centre who provided good continuity of care for residents. In order to provide the additional staff support required to implement safeguarding plans there were some shifts covered by agency staff. Residents noted in questionnaires that they did not like the amount of different staff in their home.

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 impacted on the quality and safety of the service being delivered to each resident living in the centre.

## Capacity and capability

Overall it was found that while the governance and management arrangements in place were effectively monitoring the quality and safety of the service, due to changing needs of residents, the provider was not ensuring that residents were safe and enjoyed a good quality of life. Despite significant effort on the part of the provider and person in charge, the living arrangements for residents were not conducive to a safe and comfortable living environment.

There was a statement of purpose in place that was reviewed and 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 information in relation to the whole time equivalent number of

staff was not reflective of the number found to be scheduled in the centre. The necessary changes were made on the day of inspection.

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting most of the residents' assessed needs. There was a planned and actual roster maintained by the person in charge. Staffing arrangements took into consideration any changing or emerging needs of residents and endeavoured to facilitated continuity of care. However, some vacancies pertaining to the additional staffing required to implement safeguarding measures were filled by agency staff and due to the support needs of residents, the use of agency staff often contributed to behavioural incidents.

A number of systems of oversight were in place to ensure the quality of care and support was monitored at all times. A suite of audits had been completed by the person in charge, which included medication, fire safety and health and safety audits. In addition to this, the provider ensured unannounced visits to the centre were carried out. The two most recent unannounced provider visits set out clearly defined action plans to address areas identified as requiring improvement. Actions were allocated to a relevant manger and were time bound. There was evidence that actions were followed through on with most actions complete.

The provider had identified that there were compatibility issues within the centre. An overarching safeguarding plan had been implemented which included measures to support the reduction of incidents occurring in the house and to mitigate the risks associated with these incidents. For example, the provider had made a decision not to accept admissions in respect of the two vacancies in the centre until the safeguarding risks had been mitigated. The safeguarding issues had been escalated and reported to the appropriate agency and the safeguarding plan was monitored, reviewed and updated as required. However, while there had been some reduction in the frequency of incidents, overall, the plan was not fully effective and residents were exposed to potentially abusive and controlling behaviour on a regular basis. The provider was consulting with residents, their families, staff, and external agencies in order to develop a more long term plan to address the compatibility issues. The person in charge had referred residents to an external advocacy agency to ensure their will and preference was considered in planning discussions.

There was a complaints policy and associated procedures in place. There was an identified complaints officer and residents were supported to make a complaint where they chose to. However it was found that complaints were not managed in accordance with the provider's own policy. Residents had not received a response to their complaint, there was no evidence that complaints were reviewed and residents were found to make multiple complaints about the same issue with no resolution.

## Regulation 15: Staffing

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting residents' assessed needs. The use of

agency staff was found to impact continuity of care and was not conducive to the implementation of residents' behaviour support plans.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Overall, there were effective management systems in place in the centre that were contributing to person centred care and support. Monitoring systems had identified a trend of incidents between residents and there was a proactive approach to addressing the issue.

The provider and person in charge were ensuring oversight through regular audits and reviews. There was an audit schedule in place in the centre and the provider had completed unannounced visits to the centre every six months. An annual review of care and support in the centre had been carried out for the year 2021.

Judgment: 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. For example, the whole time equivalent number of staff was not reflective of the staffing present in the centre.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

The inspector found that complaints were not managed in accordance with the provider's own policy. Residents had made similar complaints multiple times and had not received a response from the provider.

Judgment: Not compliant

## Quality and safety

The governance and management arrangements in the centre did not fully support the provision of safe and quality care. While there were some good practices observed at a local level, the quality of care was significantly impacted by ongoing safeguarding issues that were attributable to resident incompatibility. The inspector found that although the provider had implemented strategies to reduce the compatibility issues in the house, the overall impact of the incidents was effecting the residents' lives in a negative manner.

There was a comprehensive assessment of need in place for each resident, which identified their health care, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness. Residents' communication needs had been assessed and there were support plans in place where necessary. Residents were supported to communicate using preferred methods.

It was found that there was adequate and nutritious food available, and the arrangements in place facilitated choice and participation. Residents were supported to prepare and cook their own food where they chose to, and had full access to their kitchen area and facilities. Residents contributed to choices about meals and grocery shopping, and purchased items themselves in local shops and grocers.

There were arrangements in place to protect residents from the risk of abuse, including an organisational policy and clear procedures. There was an identified designated officer, and it was found that concerns or allegations of potential abuse were investigated and reported to relevant agencies. Although safeguarding concerns were investigated and reported according to the provider's policy, there remained ongoing safeguarding risks. Residents regularly experienced verbal abuse, witnessed verbal altercations and threats of violence, and were restricted in accessing some parts of their home or receiving care due to the behaviour of others.

While there was a comprehensive safeguarding plan in place to mitigate the safeguarding risk, the inspector found that while the current living arrangements were in place, the risk of continued behavioural incidents remained, and as such, the provider could not be assured that residents were protected from all forms of abuse at all times. The provider had commenced a consultation with residents, multi-disciplinary clinicians and external agencies with a view to developing a more effective longer term plan.

While residents' day to day experiences in their home were not optimal, it was found that the person in charge and staff members endeavoured to support residents to exercise their rights. Residents were central to decisions about their lives, for examples, residents made their own choices with regard to the resumption of day services and how they would like to spend their days. Residents were provided with information in an accessible format to make informed decisions about their healthcare. The person in charge had referred each resident to an external advocacy agency in order to support them in sharing their views and preference for the longer term living arrangements.

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 found to be clean and hygienic and there were a range of hygiene checklists and audits in place to ensure that this was maintained. There were hand washing and sanitising facilities available for use. There were clear procedures in place to follow in the event of a COVID-19 outbreak in the centre, with a range of resources available. There was an outbreak of COVID-19 in the centre in 2021 that was limited to one resident. There was adequate personal protective (PPE) equipment available.

The inspector reviewed the fire safety arrangements in the centre and found that residents and staff were knowledgeable of the fire safety procedures. Residents took part in planned evacuations, and learning from fire drills was incorporated into personal evacuation plans. There were suitable fire containment measures in place, and the provider had installed self close devices on doors. Fire fighting equipment was available, and regularly serviced. Staff had received training in fire safety and on-site fire drill training.

## Regulation 10: Communication

There were communication support plans in place for each resident. Residents had access to a range of media resources such as televisions, radios, and smartphones. Residents had access to the Internet.

Judgment: Compliant

## Regulation 18: Food and nutrition

There were arrangements in place that ensured residents were provided with adequate nutritious and wholesome food that was consistent with their dietary requirements and preferences. Residents were supported to buy, prepare and cook their own meals in accordance with their abilities.

Judgment: Compliant

## Regulation 27: Protection against infection

There were arrangements in place to prevent or minimise the occurrence of a healthcare associated infection. 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 premises was found to be clean and tidy.

Judgment: Compliant

## Regulation 28: Fire precautions

There were fire safety management systems in place in the centre, which were kept under ongoing review. Fire drills were completed regularly and learning from fire drills was reflected in residents' evacuation plans.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need in place for each resident, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

Judgment: Compliant

## Regulation 8: Protection

The inspector found that although the provider was endeavouring to manage and implement strategies to reduce the compatibility issues in the house, the overall impact of the incidents was affecting residents' lives in a negative manner.

Without further intervention, the provider could not be assured that residents were protected from all forms of abuse at all times.

Judgment: Not compliant

## Regulation 9: Residents' rights

Residents were referred to an external advocacy service to support them in making decisions about their future.

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| 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 23: Governance and management | Compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 34: Complaints procedure | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for New Cabra Road OSV-0002345

## Inspection ID: MON-0027306

## Date of inspection: 02/02/2022

**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:<br>• The PIC and PPIM continue to monitor staffing levels within the designated centre based on meeting the needs of the residents. This monitoring is responsive to the changing needs of residents within the DC and adaptive and responsive to each residents support needs.<br><br>• Regular familiar relief staff are block booked for any planned staff absences, should the need arise for emergency backfilling at short notice, every effort is made to ensure regular relief or agency staff are placed within the designated centre. | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>• Statement and purpose was updated on the 2nd of February and submitted to relevant parties. | |
| Regulation 34: Complaints procedure | Not Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All complaints have been reviewed by the person in charge and communication to the complainant has been completed.

• The service manager has requested a review of all complaints by the organisations complaints and incident manager.

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
• There are noted compatibility issues within the centre however extensive multi disciplinary work is underway to support residents within their current placements with the view to one or more residents been supported to find alternative accommodation. The rights and views of each resident are taking into consideration in line with the Assisted Decision Making Act and external advocacy services.

• Safeguarding support plans are in place for all residents within the centre.

• The staff team are exceptionally responsive and proactive to safeguarding concerns.

• Interagency meetings with the HSE are on going pertaining to same.

## 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 | 31/12/2022 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 02/02/2022 |
| Regulation 34(2)(d) | The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process. | Not Compliant | Orange | 30/06/2022 |
| Regulation 34(2)(f) | The registered provider shall ensure that the | Not Compliant | Orange | 30/06/2022 |

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| | nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied. | | | |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 31/12/2022 |