



Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Lar Foley House
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	14 October 2021
Centre ID:	OSV-0002339
Fieldwork ID:	MON-0034485

About the designated centre

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

Lar Foley House is a community based residential centre for up to seven children and young adults with disabilities operated by St. Michael's House. The designated centre is located in North Dublin in a suburban area. The centre comprises a two-storey building, with five bedrooms on the ground level, and a two bedroom self-contained apartment on the upper level. It provides full-time care to children and young adults. A team of staff nurses and support staff provide care and support to young people with intellectual disabilities, and can support residents with physical disabilities and complex health care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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
Thursday 14 October 2021	9:00 am to 4:40 pm	Amy McGrath	Lead
Thursday 14 October 2021	9:00 am to 4:40 pm	Marguerite Kelly	Lead

What residents told us and what inspectors observed

This inspection was carried out to assess the arrangements in place in relation to infection prevention and control and to monitor compliance with the associated regulation. This inspection was unannounced. The inspectors met and spoke with staff who were on duty throughout the course of the inspection, and met with three of the six residents who lived in the centre. Inspectors also observed residents in their home as they went about their day, including care and support interactions between staff and residents.

Lar Foley House is a large two storey home located in a busy suburb. The centre comprises ground floor accommodation for five residents and a separate first floor apartment that can accommodate up to two residents. At the time of inspection there were six residents living in the centre. The ground floor of the premises consisted of five bedrooms, one kitchen and dining room, one large living area, a staff office, two en-suite shower rooms (which were each shared by two bedrooms), one large bathroom, a sensory room, a storage room and a second living space. There was a small utility room available on the ground floor that served both units of the centre. The first floor consisted of two bedrooms, a staff bedroom, an open plan kitchen, dining and living space, and two bathrooms.

On arrival, the inspectors were met by the person in charge and a member of staff who took inspectors' temperatures and completed a symptom check as part of the visitors procedure. Inspectors observed staff wearing appropriate personal protective equipment, in line with national guidance throughout the course of the inspection.

Some residents were in school when inspectors arrived, while others were engaged in activities in their home. Inspectors observed staff interactions with residents to be warm and personal. Staff were seen to be familiar with residents' communication methods and were responsive to their requests and needs. Later during the inspection, some residents were heard enjoying a music therapy session in the main living room.

The inspectors completed a walk-through of the premises with the person in charge. Each resident had their own bedroom, with some residents sharing an en-suite bathroom with another person (there were two bathrooms that were each accessible from two bedrooms). Some premises risks were identified during this walk-around that were highlighted to the person in charge including damaged surfaces, inappropriate storage of items including laundry and cleaning equipment, broken bathroom fixtures and damaged door frames. A significant risk related to an open pipe in a bathroom was addressed on the day of inspection.

Residents were supported by a team of nurses and social care workers. There was a housekeeping staff employed to manage the cleaning and upkeep of the premises on a day to day basis - this person was employed in a full time capacity and worked

five days per week. At times when the housekeeping staff was not available, housekeeping duties were the responsibility of staff on shift. Inspectors found that staff were not familiar with the procedures for cleaning areas of the premises, for example while the housekeeping staff had colour coded cloths for different areas and specific cleaning agents, staff members reported that they used a supply of cloths and domestic cleaning agents that were stored in the shed. There was a utility area that served both units of the premises. The utility area was very small with limited floor space, it was observed that mop buckets were stored on the counter tops above the laundry facilities.

While the house appeared to be visibly clean in most areas, there was insufficient guidance in place to direct thorough cleaning of the environment and equipment. There was a sink present in each of the bathrooms, including the staff bathroom with hand soap and single use towels available, although there was no designated clinical hand-washing facility. Inspectors noted that the location and numbers of sinks in the centre was less than optimal and were not satisfied that an appropriate hand-wash sink would be available at all required times. There were a number of hand-sanitiser points located throughout the premises; all but one of these containers was empty on the day of inspection.

The following sections of the report will present the findings of the inspection with regard to the capacity and capability of the provider and the quality and safety of the service.

Capacity and capability

The governance and management arrangements were found to be ineffective in assessing, monitoring and responding to infection control risks. The provider did not demonstrate that there were adequate structures or arrangements in place to measure and oversee performance in this area. The inspectors found that infection control practices in the centre were largely ad-hoc in nature and had not been implemented on the basis of an assessment of the specific infection control risks in the centre.

There were a range of policies in place at an organisational level, including a policy on infection prevention and control that was updated in 2020. The inspectors found that while the policy contained information about best practice, including standard and transmission based precautions, it did not contain specific guidance for the implementation of standard precautions at a local level. Furthermore, it did not identify roles and responsibilities for staff and did not provide sufficiently clear guidance with regard to training requirements or risk assessment.

While there were clear lines of authority in the centre, this did not extend to infection prevention and control. It was not demonstrated that staff were clear with regard to their roles and responsibilities in relation to infection prevention and control. There was a nominated person in the centre who was responsible for

infection prevention and control; this person had not received training in this area. The provider had an infection prevention and control specialist available at an organisation level; it was found that this resource was under-utilised and staff spoken with could not identify who this person was.

The inspectors were not satisfied that staff had received appropriate training commensurate to their role and the assessed needs of residents. A review of training records found that staff had not received training in infection prevention and control which includes standard precautions. The training matrix indicated that 11 out of 20 staff had not received refresher training in hand hygiene in line with the provider's own policy. Hand hygiene training had been provided online with no assessment of visual competency. Significant improvement was required to ensure that workforce planning considered the infection control risks in the centre and that all staff had training appropriate to their role and responsibilities.

Most staff had received training in relation to COVID-19. Given the nature of the care and support needs of residents in this centre, inspectors were significantly concerned with regard to the training deficits in the centre; some staff spoken with did not demonstrate an understanding of transmission based precautions and were not clear of their responsibilities in the event of an outbreak. Staff spoken with did not know what action to take in the event of a needle stick injury. An urgent action in relation to staff training was issued following the inspection.

The systems in place to monitor quality and safety did not include an assessment or evaluation of infection control risks. The inspectors were not satisfied that the reporting structures in place were effective in identifying or escalating risks in this area. A review of records such as team meeting notes, management meeting records and supervision records found that infection prevention control was not discussed in any detail or included as an agenda item at any of these forums. While there were a range of auditing systems in place, an infection control audit had not been carried out in the centre. Inspectors found that there was very little oversight of infection control risks in the centre. This resulted, at times, in inadequate control measures that were not effectively monitored. For example, there were known infection control risks with regard to the premises with control measures in place that had not been developed based on an assessment of risk, and risks associated with percutaneous endoscopic gastrostomy (PEG) feeding had not been assessed.

Inspectors requested to view the provider's COVID-19 outbreak contingency plan. Despite numerous requests a comprehensive contingency plan was not made available to inspectors on the day of inspection. Inspectors were not assured that the provider had a robust management plan in place to implement in the event of a COVID-19 outbreak. This was of particular concern given the medical vulnerabilities of some residents. An urgent action was issued in relation to this following the inspection.

Overall it was found that the governance and management arrangements had failed to ensure that infection prevention and control risks were identified and managed in a prompt manner. There were significant concerns raised with regard to staff

training and the oversight of the quality and safety of the service provider to residents with respect to infection control.

Quality and safety

The governance and management arrangements in the centre did not support the ongoing and consistent provision of safe and quality care, in relation to infection control. Whilst there were some good practices observed in relation to the delivery of health care and person centred care, the quality of the service was significantly impacted by the under-utilisation of infection control quality assurance systems.

The inspectors found that residents had access to a comprehensive range of health care services to promote good health. There were health care plans in place for complex health care needs, and these were found to provide clear guidance as to how residents' needs were supported. There was some evidence seen that resident advocates were involved in decision making, such as decisions regarding influenza vaccination, but there was very little information about how infection prevention and control was managed in the centre.

Residents' lives had been significantly impacted by the COVID-19 pandemic, with restrictions placed on how they spend their time. Inspectors saw that efforts were made to ensure residents enjoyed meaningful activities and had opportunities for leisure and recreation while these restrictions were in place. There was a large garden with an accessible playground, raised flower beds and picnic tables for residents to enjoy when the weather permitted. Some residents had returned to school and activities provided by external persons had recommenced, such as music therapy. It was noted that there were outstanding restrictions in place with regard to visits to the centre, with outdoor visits only available to residents families; this had not been reviewed in line with the most recent national guidelines and there was no risk assessment in place in relation this restriction.

While there was evidence that staff were implementing practices in accordance with national guidance, such as the use of PPE and testing of residents who were symptomatic of COVID-19, inspectors were not assured that infection control procedures in the centre were being fully implemented in line with national standards and guidance. There were significant deficits observed on the day of inspection in relation to infection control and the provider could not demonstrate that they had a full and detailed outbreak management plan for COVID-19. While there had been no confirmed cases of COVID-19 in the centre amongst residents, inspectors were not satisfied that the provider was fully prepared to manage an outbreak if one occurred.

Furthermore, in the case of one resident, there was minimal information available with regard to their colonisation status and inspectors were not satisfied that this

had been appropriately risk assessed or that necessary information was shared on transfer to other agencies.

Inspectors found that residents were at risk of infection as a result of the provider failing to ensure that procedures consistent with the standards for infection prevention and control were implemented by staff. Although the premises appeared visibly clean, the procedures, frequency and methods for housekeeping and environmental and equipment cleaning were vague; there was a checklist in place to prompt cleaning of areas however these did not contain sufficient detail to inform staff of the method and frequency of cleaning. There was a housekeeping staff available five days per week with staff managing housekeeping duties outside of these times. Inspectors spoke with staff members and housekeeping staff and found inconsistencies in their understanding of the procedures and the roles and responsibilities of staff.

Some rooms in the centre were multi-purpose, for example the medication storage room was used to store PPE, medical devices, hoists and clinical waste. Inspectors observed that clinical waste receptacles (such as those used for sharps) were stored in close proximity to bags of liquid feed to be administered to residents by PEG feed. Inspectors were not assured that the cleaning arrangements for medical equipment or devices such as nebulisers had been determined based on best practice.

Inspectors found that laundry was not managed in a manner that protects it from contamination. During the walk-around of the premises, inspectors saw clean linen stored on the floor, found that cleaning equipment and supplies were stored in the laundry area, and mop buckets and mops stored on shelving above the washing and drying machines. Some staff told inspectors that soiled laundry was sluiced prior to washing, which is contrary to the provider's own infection control policy. A spill kit (used for the management of liquid spills that present an infection risk) was also stored in the laundry. The spill kit contained chlorine based tablets which were out of date in 2020.

Inspectors found that significant improvement was required in relation to monitoring and addressing infection control risks in the premises. The condition of some surfaces in the premises was seen to be damaged and therefore compromised the effective cleaning of surfaces. For example, damaged wood surfaces were found in shared areas, there was chip-board and unfinished wood surfaces found in residents' bedrooms and bathrooms, some of which was seen to be damp and swollen, and some bathroom fixtures were rusted with one shower head broken. There was an exposed pipe in one bathroom that had not been sealed following works in the bathroom. This was addressed on the day of inspection. The drain in one bathroom was seen to be blocked with water pooled in the shower.

Inspectors noted that there had been efforts made by the person in charge to address some of the premises issues - these had not been addressed in a timely manner through the provider's maintenance procedures. An urgent action was issued in relation to premises at the end of the inspection.

Regulation 27: Protection against infection

Systems and resources in place for the oversight and review of infection prevention and control practices were not effective. Inspectors observed practices that were not consistent with national standards for infection, prevention and control in the community services. Throughout the inspection, inspectors found a number of areas where adherence to national guidance and standards required improvement. These include the following:

- There was limited access to alcohol gel, as all but one of the dispensers checked were empty. There were some bottles of gel placed on window sills but these were not in plain view of where care was taking place.
- There were minimal housekeeping procedures to guide staff to clean the centre. The current system did not adequately guide staff in their roles and responsibilities.
- Inspectors were not satisfied that the management of soiled linen was in accordance with best practice.
- There were many examples of walls and surfaces with flaking paint and chipped wood which would making cleaning of these surfaces very difficult.
- There was also several instances where untreated or unpainted wood was used to cover damaged walls - this material is difficult to clean effectively.
- There were no environmental, hygiene or infection control audits to drive and improve the safety and quality of the service.
- There was no evidence that communal or resident specific equipment was cleaned or was on a cleaning schedule. This was evidenced by dust seen on equipment.
- There was no evidence that toys or play equipment was washed in between resident use.
- There was no designated clinical room to store and prepare sterile supplies for aseptic procedures and feeds. The room used to prepare such procedures also was a store room for supplies, resident wheelchairs and hoists.
- There was no designated clinical wash hand basin.
- Facilities for and access to staff hand wash sinks were less than optimal throughout the centre. While residents' sinks were used, this arrangement could not guarantee a sink was available if the bathroom was in use; two residents' bathrooms were shared.
- There was no evidence that the centre was sharing information about a residents colonisation status on transfer to another service, despite using a detailed transfer document.
- Staff did not have training appropriate to their role with regard to infection control and standard precautions.
- The provider's infection control policy did not effectively guide staff practice.
- Infection control risks in the centre had not been appropriately assessed, with some risks not identified. In the case of risks that had been assessed, it was found that some of the control measures noted were not in place. For example, the risk assessment regarding clinical waste management stated

that staff had received specific training in this area- a review of training records found that this was not the case.

- There was no COVID-19 outbreak management plan available.

Judgment: Not 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	
Quality and safety	
Regulation 27: Protection against infection	Not compliant

Compliance Plan for Lar Foley House OSV-0002339

Inspection ID: MON-0034485

Date of inspection: 14/10/2021

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 27: Protection against infection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>Provider's Response:</p> <p>The Registered Provider and Person in Charge have reviewed and updated an outbreak Contingency plan. This includes</p> <ul style="list-style-type: none"> • Local guidelines to manage Covid-19 • Covid outbreak contingency house plan • An essential guide to working in the designated centre. • All relevant SMH policies and HSE information regarding the management of infection control can be found in the Infection Control Folder in Lar Foley. <p>Completed Date 01/11/2021</p> <p>Governance and Management:</p> <ul style="list-style-type: none"> • SMH Infection Control Policy has been reviewed, and, amendments have been made to reflect organisational and staff, roles and responsibilities, including the 'nominated person' within each designed centre. This policy will be ratified by the 15th Dec 21. All staff will read and sign updated policy by 22/Dec /21 • The PIC and Service Manager will review all IPC Risk Assessments, audits, and control measures as part of their scheduled management meetings. The next scheduled meeting :10/12/21 • The PIC has added IPC as a standard set agenda item for team meetings which occur every six weeks. Completed 19/11/21 • All visits to the house are planned within current public health guidance. This Guidance is filed in The Infection Control folder. 	

Premises:

The Registered Provider and Person in Charge in conjunction with the Technical Services' Department have agreed a schedule of upgrade works to include

- Repair to bathroom drainage systems, replacement flooring in the bathroom and adjacent bedrooms. Completed date 29/10/2021
- Redecoration / repair to paintwork in kitchen, halls, living areas, bathroom and all non-painted wood surfaces. Due for completion 04/12/21
- Replacement to kitchen worktops .Due for completion 20/12/21
- Storage areas have been cleared of unnecessary items Completed 27/11/21
- Storage area will not be used for aseptic procedures or enteral preparations Complete 29/11/21
- New shelving is being ordered and will be completed by DATE 22/12/21

Training :

- The PIC has completed a Training Needs Analysis with the Training Officer. This training includes public Health/HSE/SMH information, procedures and guidance with regard to Covid 19, IPC information, Policies and protocols, hand hygiene, coughing and sneezing etiquette, correct use of PPE, cleaning in the work environment. It also covers Covid symptoms, how it spreads and SMH procedures to follow if suspected/confirmed cases.
- All staff have completed IPC and Covid training by Monday 25th October 2021 Complete.
- Training requirements will be discussed at team meetings and updated training records will be available in the Centre for review.

IPC Measures

- All staff will have completed mandatory covid training by Monday 25th October. Complete
- A hygiene audit was completed by the Infection Control Clinical Nurse on the 11/11/21. All actions from this audit will be completed by 20/12/21
- The number of hand sanitising dispensers has been increased and have been strategically placed throughout Lar Foley, which ensures better access to hand sanitising. These dispensers are checked daily and refilled as necessary by staff. This is monitored as part of the daily check list. Completed 25/11/21.
- The PIC has reviewed and updated all cleaning schedules used within the Centre. These now include all items to be cleaned (including all rooms, toys, specialist equipment, laundry etc), product used, frequency of cleaning. Cleaning / decontamination processes are now clearly identified and detailed. A dedicated staff is nominated each day to ensure daily cleaning and the PIC/PPIM monitor this on a weekly basis to ensure compliance and quality. Completed 19/11/21
- The PIC has clearly identified the colonisation status on updated hospital passports ,communication passports and all other relevant documentation for residents. Completed 27/11/21
- Spill kits are not in use as part of IPC measures. All have been disposed of. Completed 25/10/21

- The PIC has reviewed and updated all PPE measures within the Centre to include audit and implementation. PPIM will audit PPE supplies once a week. Completed 19/11/21
- All staff have familiarised themselves with SMH policies in relation to infection control ,including waste management , management of linen , environmental hygiene ,body

fluids and hand hygiene.SMH policies has been added as a standard set agenda item for team meetings . Completed 19/11/21

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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	19/10/2021