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:	Grangemore Rise
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Announced
Date of inspection:	18 October 2022
Centre ID:	OSV-0002341
Fieldwork ID:	MON-0028976

About the designated centre

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

Grangemore Rise is a designated centre operated by St Michael's House. The centre is located in North County Dublin. It provides community residential services for up to seven residents, over the age of 18 years, with intellectual disabilities and with support needs. The designated centre consists of a house and a detached apartment located to the rear of the house. The house is a two storey building and provides accommodation for up to six residents and consists of a storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The apartment is home to one resident and consists of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The designated centre is located close to local shops and transport links. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Tuesday 18 October 2022	09:35hrs to 15:25hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

Most of the residents had gone on holidays at the time of inspection. The staff team were also accompanying the residents. For this reason, the inspector did not have the opportunity to meet with all residents or staff on the day of inspection. However, many residents had completed questionnaires to inform the inspector of the quality of care in their home. Additionally, one resident had chosen not to go on holidays and this resident agreed to meet with the inspector and talk about their experiences of living in the designated centre.

In line with public health guidance, the inspector wore a face mask and maintained physical distancing when speaking to the resident and to those staff who were there on the day of inspection.

Overall, the inspector found that the residents were receiving quality care and were living in a home which was striving to provide a person-centred and safe environment.

The resident who was in the centre on the day of the inspection told the inspector that they were happy in their home. They described how they were supported by staff to attend medical appointments and to prepare meals. The resident spoke positively of the staff support. They informed the inspector that they had an issue previously. They said they spoke to their keyworker about this and that they were listened to and that the issue was resolved.

Through questionnaires, some of the other residents told the inspector that they were happy with the choices and control available to them in the designated centre. Residents also expressed that they felt confident in speaking up if they were not happy about something in their home and that staff would listen and respond to their concerns.

The inspector saw that the house was generally well maintained and was decorated in a homely manner. Residents had access to several sitting rooms which were furnished with comfortable couches and facilities for relaxation and entertainment. Residents' bedrooms were seen to be decorated in an individual manner. Residents' bedrooms contained pertinent information relevant to the running of the centre and the residents' own goals. For example, a copy of each resident's personal evacuation plan and their "all about me" goals were available in resident bedrooms.

There was maintenance required to several areas of the centre including the kitchen. The inspector was informed that these works had been identified in the provider's audits and were on a schedule of works.

The inspector also saw evidence of restrictive practices throughout the house including, for example, a keypad locked kitchen door. This will be discussed further

in the quality and safety section of the report.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impacted on the quality and safety of care.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to inform decision making for the renewal of the centre's certificate of registration. The inspector found that this designated centre met and exceeded the requirements of the regulations in many areas of service provision.

There were effective management arrangements that ensured that the safety and quality of the service were consistently monitored. The provider had implemented systems to support them in monitoring and reviewing the quality of service in the designated centre. There were a series of audits in place which identified presenting risks. Actions plans were derived from these audits. The inspector saw that actions were progressed in a timely manner.

There was also a clearly defined reporting structure which identified lines of authority and accountability. The provider had nominated a person in charge who was suitably qualified and experienced. They were available on the day of inspection and informed the inspector of the arrangements that supported them in having oversight of the designated centre. The person in charge was found to have an in-depth knowledge of the designated centre and the needs and preferences of the residents. The person in charge was supported in their role by a service manager, who, in turn reported to a director of services. Regular meetings were held between the person in charge and the service manager and any presenting issues or risks were escalated to the provider level.

There was a roster maintained for the designated centre which showed that staffing levels were maintained in line with the statement of purpose and at a level and skill mix suitable to meet the needs of the residents. Where there were gaps in the roster, these were filled from a panel of regular relief staff which supported continuity of care for the residents.

A training matrix was also maintained which showed that a very high level of staff training was completed. A staff supervision schedule was in place. This demonstrated that all staff were in receipt of supervision as frequently as the provider's policy. Regular staff meetings were also held. The minutes of these demonstrated that staff were kept informed regarding updates to the provider's policies, actions arising from audits and resident needs.

Several documents were reviewed in order to inform the application for the renewal of the centre's certificate of registration. These included the centre's insurance

documents and the statement of purpose. The inspector saw that the provider had effected a certificate of insurance to insure against injury to residents. The statement of purpose was reviewed and was found to contain the information as required by Schedule 1 of the Regulations.

A full and complete application to renew the centre's certificate of registration had been submitted in a timely manner and in line with the Regulations.

Registration Regulation 5: Application for registration or renewal of registration

A complete application to renew the centre's certificate of registration was received.

The application included the information as required by Schedule 2 and Schedule 3 of the Regulations.

The appropriate fee to accompany the application for renewal was also paid.

The provider submitted a residents' guide, contract of insurance and evidence of compliance with planning and development acts.

Judgment: Compliant

Regulation 14: Persons in charge

A person in charge had been appointed for the designated centre. The person in charge was full-time and was suitably qualified and experienced. They held an appropriate qualification in health and social care management and had worked in a supervisory role for over three years. They had systems in place to ensure effective oversight of the designated centre including access to regular management days each week. They demonstrated knowledge of the regulations and their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the number and skill mix of staff were suitable to meet the needs of the residents and the size and layout of the designated centre.

The whole time equivalent staffing complement had been recently increased to

support the needs of a new, temporary admission.

A planned and actual roster were maintained for the designated centre.

Gaps in the roster were filled from a panel of in-house relief or familiar agency staff. This supported continuity of care for the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training including refresher training. A training matrix was available which demonstrated that there was generally a high level of compliance with training maintained in the designated centre.

Staff were in receipt of regular supervision, the frequency of which was in line with the provider's policy. A supervision schedule was in place for the remainder of the year to ensure staff had ongoing access to supervision.

Regular staff meetings were held which kept staff informed regarding updates to provider's policies and audits

Judgment: Compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents.

A copy of this contract was submitted to the Chief Inspector to support the application to renew the centre's certificate of registration.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre was resourced to ensure the effective delivery of care. The staffing complement had been recently increased to meet the needs of a new admission. The staffing complement was in line with the statement of purpose.

There was a clearly defined management structures in place which identified lines of

authority and accountability. The person in charge reported to a service manager. Regular meetings were held between the person in charge and service manager to address any identified concerns in the centre.

There were management systems in place to ensure that there was oversight of the designated centre and that the service provided was appropriate to meet the residents' needs. There were a system of audits which identified areas for service improvement. These audits included a six monthly unannounced visit as well as additional audits such as medications audit, safeguarding audit and infection prevention and control audit. Action plans were derived from these and it was evident that actions were progressed n a timely manner.

Findings of audits were communicated to staff at staff meetings. Staff were kept informed of any actions for which they were responsible and it was evidenced that staff were supported to exercise their professional responsibilities.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had in place a statement of purpose which contained the information as set out in Schedule 1 of the Regulations.

This statement of purpose had been recently reviewed and was available to residents and their representatives in the designated centre.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector found that the day-to-day practice within this centre ensured that residents were safe and were in receipt of a good quality service.

The inspector completed a walk-through of the premises with the person in charge and saw that the premises was clean and comfortable. The centre had recently been painted and previously identified issues with mould in one section of the house had been addressed. Residents each had access to their own bedrooms which were seen to be decorated individually. Residents had access to several sitting rooms and bathrooms. These were all seen to be well-maintained and were equipped with appliances to meet residents' needs and to support accessibility.

There was maintenance required to some areas of the premises. For example, the kitchen required repair as it was damaged. The provider had identified premises issues in their own audits and informed the inspector that these were all on a schedule of works to be addressed.

The centre was seen to be equipped with appropriate fire detection, containment and extinguishing measures. Automatic door closers were fitted to doors. Fire extinguishers were available throughout the centre. Staff had been in receipt of appropriate fire safety training and regular fire drills were held with the residents. These drills demonstrated that all residents could be evacuated in a safe time frame.

There were also measures in place to reduce the risk of residents contracting a healthcare associated infection. The provider had effected an outbreak management plan which detailed measures to be followed in the event of an outbreak of infection. Staff were in receipt of infection prevention and control (IPC) training and residents were kept informed of IPC measures through regular residents meetings.

A risk register was maintained for the designated centre which set out the risks and the control measures to mitigate against these. Individual risk assessments were available on residents' files for those residents who presented with individual risks. The control measures to mitigate against these risks were found to be proportional and in line with residents' needs.

In some instances, restrictive practices formed part of the control measures in place to mitigate against a risk. However, given the level of risk of harm to residents, these restrictive practices were found to be proportional. For example, some residents presented at risk of choking or ill-health due to a documented behaviour of ingesting non-food items or uncooked raw foods. A control measure was listed as a keypad lock on the kitchen door and supervision of these residents when in the kitchen.

This restrictive practice was documented on the centre's risk register and individual residents' risk assessments. It was further supported by positive behaviour support plans on residents' files. The restrictive practice was reviewed by the provider's rights committee. To mitigate against impact on residents' rights, the provider had in place an additional fridge in the sitting room which contained some residents' preferred food items which did not present a risk of choking or ill-health.

The inspector saw that there was one restrictive practice which had not been identified as such. One resident had limited access to their own toiletries due to a risk of ingestion of these. Their toiletries were kept in a locked press in the bathroom. This had not been documented as a restrictive practice or reviewed by the provider's rights committee. The person in charge committed to logging this as a restrictive practice on the day of inspection.

Some of the residents presented with behaviours that challenge. The inspector saw that comprehensive positive behaviour support plans were on file which detailed proactive and reactive strategies to support residents to manage their behaviour. Most staff had completed positive behaviour support training however two staff

required this.

The inspector reviewed the meal records for the designated centre and found that residents were offered choices of foods which were wholesome and nutritious. Those residents who had assessed needs in the area of feeding, eating, drinking and swallowing (FEDS) had comprehensive support plans on file.

A review of residents' files found that a comprehensive assessment of need had been completed for each resident within the past 12 months. This assessment of need was informed by relevant multi-disciplinary professionals and was used to inform a suite of care plans. Residents were also consulted about their goals and needs and their representatives were invited to attend this goal planning meeting. Some residents had identified a holiday as one of their goals and were on holiday at the time of inspection.

Residents' files also contained intimate care plans which were written in a person-centred and respectful manner. Intimate care plans detailed how staff should support residents in their care while maintaining residents' dignity and autonomy. The inspector saw that there were procedures in place to detect, respond to and report any allegations of abuse and that the relevant authorities were notified as required when any incidents of abuse occurred.

Regulation 10: Communication

Several residents' had an identified communication need detailed in their assessment of need. Those residents' file were found to contain an up-to-date communication support plan.

Staff had signed off on having read the communication support plan.

Several residents had taken their particular communication supports on holidays with them.

The person in charge comprehensively described the systems in place to support residents' communication needs.

Judgment: Compliant

Regulation 17: Premises

The premises of Grangemore Rise was generally clean, tidy and comfortable. The provider had completed recent maintenance of several areas of the designated centre. For example, the centre had been recently painted and mould issues identified on the last inspection had been addressed. However, there remained a

number of areas which required maintenance. The provider had self-identified these issues in their audit and had was in the process of addressing these. The areas which required maintenance included:

- The kitchen required repair as it was damaged and could not be effectively cleaned. The inspector was informed that the kitchen was on the refurbishment schedule however there was no time-frame for when this would be completed
- an upstairs bathroom radiator was seen to be very rusty. This had been identified in the provider's IPC audit as requiring addressing.
- The bathroom floor required repair as it was torn in two small areas. This had also been identified in the provider's IPC audit.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector saw that residents were consulted with regarding their menu planning at the weekly residents' meetings.

Records of menus were reviewed. It was found that residents were offered a wide variety of health and nutritious food.

Some residents had feeding, eating, drinking and swallowing (FEDS) needs. A review of these residents' files demonstrated that there were up-to-date FEDS and oral hygiene care plans available.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a residents' guide which met the requirements of Regulation 20. The residents' guide was written in easy-to-read language and was supported with pictures and photos. It was readily available in the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had implemented a risk management policy.

A risk register was maintained for the designated centre which was reflective of the presenting risks. Risk assessments were comprehensive and contained detailed control measures to mitigate against the risk.

Individual risk assessments were also available on residents' files. These detailed measures to control for the risk. Control measures were found to be proportional to the risk identified.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had implemented procedures in line with National standards for infection prevention and control in community services. There was ready availability of hand sanitising stations and personal protective equipment (PPE) throughout the designated centre. An IPC audit had been completed by the provider which informed a comprehensive action plan. An updated IPC policy was available for staff. The provider had also recently initiated new training in IPC for staff.

There was an outbreak management plan which had been recently updated. This included information on the procedure to be followed for some residents who found it difficult to self-isolate in the event of an outbreak.

Residents were informed regarding IPC at the residents meetings. Most recently, residents had been informed regarding the availability of a flu vaccination.

Cleaning schedules were maintained and the house was seen to be very clean.

There were some premises issues which presented an IPC risk however these have been outlined under Regulation 17.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had in place arrangements to detect, contain and extinguish fires. There was evidence that the fire alarm system, fire extinguishers and emergency lighting were regularly serviced and maintained. Monthly fire checks were also completed in the designated centre.

Emergency equipment required to evacuate residents in the event of a fire was readily available. An evacuation aid was available to evacuate a resident who

required this. Fire drills were completed regularly in both day and night time scenarios. A record of these evacuations was maintained. The inspector saw that all residents could be evacuated in a timely manner.

Fire safety was discussed at residents' meetings.

There were policies and local operating procedures available to guide staff in the event of a fire. Staff had signed off on having read the fire safety policy. All staff had received fire training in recent months.it look

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Several residents' files were reviewed on the day of inspection. They were found to contain a comprehensive assessment of need. The assessment of need had been updated within the past 12 months. Residents and their representatives were involved in the review of their person plan. Their goals for the year were identified through a planning meeting with the resident and their representative. Goals were displayed in an accessible manner in resident bedrooms for those who chose this.

The assessment of need was used to inform detailed care plans which outlined the supports required to meet the residents' needs. There was a system in place to ensure that care plans were kept up-to-date. Keyworkers reviewed the residents' files monthly and made note of any updates or changes required.

The designated centre was found to be designed and laid out to meet the needs of residents as assessed. Residents had access to accessible equipment and facilities as determined by their assessment of need.

Judgment: Compliant

Regulation 7: Positive behavioural support

The majority of staff had received training in positive behaviour support. However, there were two staff who had not received this training at the time of inspection. The inspector was informed that these staff were engaging in further education and a decision had been made therefore not to put them on the behaviour support training course. However, given the assessed needs of the residents and the fact that many had positive behaviour support plans in place, it was not evidenced that this was sufficient reason to exempt these staff from the course.

Many of the residents had positive behaviour support plans on file. These had been recently reviewed and updated. Staff had signed off on having read the support

plans.

There were several restrictive practices in place in the designated centre due to the assessed complex needs of the residents. In particular, some residents presented with complex behaviours relating to food and inedible items which presented a risk of choking or a risk of infection. Restrictive practices included a keypad access door to the kitchen and staff supervision while residents were in the kitchen. These restrictive practices had been reviewed and signed off on by the provider's rights committee. The rationale for these restrictive practices were outlined in residents' behaviour support plans and were further supported by comprehensive risk assessments.

The inspector saw one restrictive practice which had not been identified as such. One resident had restricted access to their toiletries due to a risk of ingestion of these. This residents' toiletries were kept in a locked press. While it was acknowledged that this resident was supported with their personal care at all times by staff, the potential for this to be considered a restrictive practice had not been identified by the provider and recorded as such. Without the recording of the restrictive practice, it could not therefore be evidenced that this restrictive practice was in place for the shortest duration necessary and that all alternative measures had been considered before implementing this practice.

Judgment: Substantially compliant

Regulation 8: Protection

There were protocols and procedures in place to ensure that all safeguarding incidents were identified, recorded and reported appropriately. Safeguarding plans were in place for those residents who required them. There was evidence that incidents of abuse were reported to the national safeguarding team as well as to the Chief Inspector as required by the regulations.

Residents were supported to discuss safeguarding incidents with staff and were encouraged to report any incidents of abuse.

Intimate care plans were available on residents' files. These were up-to-date and were written in a respectful manner which detailed steps to be taken to support residents' dignity and autonomy.

All staff were up-to-date in mandatory training in Children First and Safeguarding Vulnerable Adults.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Grangemore Rise OSV-0002341

Inspection ID: MON-0028976

Date of inspection: 18/10/2022

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Replacement of kitchen is currently on organisations list of works that are to be carried out in 2023. Requests submitted to maintenance department to address rust on radiator in bathroom and repair Altro floor in bathroom. This work is expected to be completed Jan 2023.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All staff requiring Positive Behavioural Support Training have been up forward for this training, with all staff expected to have it completed by July 2023 Submission made to Positive Approaches Monitoring Group, with regard to the use of restrictive procedures. Submission due for review 15/11/2023	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2023
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/07/2023
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are	Substantially Compliant	Yellow	25/11/2022

	considered before a restrictive procedure is used.			