



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

## Issued by the Chief Inspector

Name of designated centre:	Collins Avenue
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Short Notice Announced
Date of inspection:	14 August 2020
Centre ID:	OSV-0005059
Fieldwork ID:	MON-0030178

## About the designated centre

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

Collins Avenue is a designated centre operated by Saint Michael's House located in a suburban area of north County Dublin. The centre provides a community residential services to two adults (male and female) with a disability. The house is divided into two individualised areas separated by a door at the bottom of the stairs. The residents have individualised areas of the centre with access to a shared entrance, kitchen and dining area, store room and utility room. The upstairs of the centre contained a bedroom, sitting room, bathroom and two staff rooms for the sleepover staff. The downstairs contained a bedroom, bathroom, living room and the shared entrance, kitchen and dining area, store room, and utility room. The centre was staffed by a social care leader, social care workers and care workers. Residents had access to nursing support through a nurse on call service.

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

Number of residents on the date of inspection:	2
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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
Friday 14 August 2020	10:00hrs to 17:00hrs	Conan O'Hara	Lead

## What residents told us and what inspectors observed

The inspector had the opportunity to meet with the two residents living in the designated centre during the inspection. The inspector also observed care practices and elements of the residents daily lives in the afternoon of the inspection.

The residents spoken with said they liked living in the centre and told the inspector about their interests including exercise, family, TV programmes and movies they enjoyed. The inspector observed residents engaging in activities of daily living including accessing the community, cooking, relaxing in their home and watching TV. The inspector observed that residents appeared comfortable in their home and positive interactions between residents and the staff team.

## Capacity and capability

The inspection found that there was an defined management structure and an established staff team in place to ensure the service provided was of good quality. Overall, the inspector observed that residents appeared content in the centre and staff interacted with residents in a respectful and caring manner. However, improvements were required in relation to staff training.

There was a defined governance and management structure in place. The centre was managed by a person in charge who was suitably qualified, experienced and demonstrated a good knowledge of the residents and their needs. They were supported in their role by an experienced social care leader. While the person in charge was also a person participating in management and had significant management remit and responsibilities for a number of other designated centres, on the day of inspection these governance arrangements provided appropriate oversight of the centre. The inspector was informed that this arrangement was short-term due to the assessed needs of residents and it was not envisaged as a long-term arrangement.

There was quality assurance audits taking place including the six monthly and annual review for 2019 as required by the regulations. These audits identified areas for improvement. However, improvement was required on the management systems in place to ensure the service and premises was appropriate to the identified needs of the residents. For example, as identified in the previous inspection in 2019, the premises was not designed or laid out to meet the assessed needs of residents. While there was evidence that the provider had explored an alternative placement for one resident and developed plans to alter the lay out of the designated centre,

this issue remained ongoing.

The person in charge maintained a planned and actual roster. A review of the staffing roster demonstrated that on the day of inspection the staffing levels were adequate to meet the assessed needs of residents. There were three staff on duty each afternoon to support two residents. In addition, there was evidence of increased support in response to COVID-19 including redeployed staff from the provider's day service and additional hours of support available to residents. However, the previous inspection found that improvement was required in the effective continuity of care in line with the assessed needs of the residents. At the time of the inspection the centre was operating with 2.5 whole time equivalent vacancies. From the sample of rosters reviewed, there remained some reliance on regular relief staffing. The inspector was informed that the provider was in the process of recruiting to fill these vacancies.

There were systems for the training and development of the staff team. The inspector reviewed a sample of staff training records and found that, for the most part, the staff team were up-to-date in mandatory training such as Safeguarding Vulnerable Adults and Positive Behaviour Support. However, some refresher training was required in relation to Fire Safety and Manual Handling. This meant that not all of the staff team had up-to-date training to support all of the assessed needs of the residents.

The provider prepared a Statement of Purpose for the designated centre which was up-to-date and contained all of the information as required by Schedule 1 of the regulations.

The inspector reviewed a sample of incidents and accidents occurring in the designated centre and found that all incidents were notified to the Office of the Chief inspector as required under Regulation 31.

### Regulation 15: Staffing

There was an adequate number of staff on duty throughout the day to meet the needs of residents. However, there were currently 2.5 vacancies in the staffing complement and a reliance on the use of relief staff in the designated centre. This was not ensuring continuity of care and support for the residents based on their individual needs.

Judgment: Substantially compliant

### Regulation 16: Training and staff development

Not all of the staff team were up-to-date in mandatory refresher training such

as Fire Safety and Manual Handling.

Judgment: Substantially compliant

### Regulation 23: Governance and management

There was a clearly defined management structure in place. There were a number of quality assurance audits in place which included the six monthly unannounced provider visits. However, improvement was required on the management systems in place to ensure the service and premises was appropriate to the identified needs of the residents.

Judgment: Substantially compliant

### Regulation 3: Statement of purpose

The centre's Statement of Purpose was up-to-date and contained all of the information as required by Schedule 1 of the Regulations.

Judgment: Compliant

### Regulation 31: Notification of incidents

All incidents and accidents were notified to the Office of the Chief Inspector in line with Regulation 31.

Judgment: Compliant

## Quality and safety

Overall, the inspector found that there were systems in place to ensure that residents received a safe service. However, improvements were required in relation to the centres premises and resident rights. Other areas for improvement identified included safeguarding, personal plans and fire safety.

The inspector completed a walk through of the designated centre accompanied by one member of the staff team. The layout of the centre required a restrictive

intervention in order to keep people safe. Each resident occupied individualised areas of the centre with access to a shared entrance, kitchen and dining area, store room and utility room. The residents had restricted access to these shared areas as, due to their assessed needs, they could not be in these areas at the same time. The two individualised areas were separated by a door at the bottom of the stairs. There was evidence of discussions with residents regarding this arrangement. However, this arrangement limited the residents' choice and control of their daily life and the inspector reviewed some incidents and complaints in relation to this.

In addition, the inspector found that some areas of the centre required maintenance and upkeep. For example, a broken window was observed on the landing. The inspector was informed that this was in the process of being addressed. Overall, in line with the previous inspection, the inspector found that the premises was not designed and laid out to meet the number and needs of the residents, some areas of the premises required maintenance and the arrangements in place for the sharing of the premises impacted on residents' rights.

The inspector reviewed the personal plans and found that each resident had an up-to-date assessment of need in place. This assessment informed the residents' personal plans which were found to be up-to-date and appropriately guided the staff team in supporting residents with identified health and social care needs. However, there was some improvement required in the personal plans to ensure that each identified need had a personal plan in place to guide the staff team. For example, the inspector found that personal plans did not appropriately guide staff on how to support residents with identified health care needs. While, there was evidence of supporting the residents with their healthcare needs and accessing allied health professional as appropriate, it required a formalised plan to ensure the staff team were appropriately guided in supporting the residents.

There were positive behaviour supports in place to support residents where required. The inspector reviewed a sample of the positive behaviour support plans and found that they were up to date and guided the staff team in supporting residents to manage their behaviour. There were a number of restrictive practices in use in the designated centre. There was evidence that these were identified and reviewed regularly by the Provider's Positive Approaches Management Group.

There were systems in place to safeguard residents. There was evidence that safeguarding concerns were identified, responded to and appropriately reported on. The previous inspection found that the policy and process regarding working with residents who can make repeated allegations, where the screening has established no reasonable grounds for concern, were not transparent or robust in the designated centre. Interim procedures had been developed to support the management of repeated allegations. A review of incidents demonstrated transparent recording, notifying and response to all allegations. The inspector was informed the provider was in the process of finalising the review of policies and procedures in relation to working with residents who can make repeated allegations where the screening has established no reasonable grounds for concern. Residents were observed to appear comfortable and content in the



service throughout the inspection and spoke positively about living in the designated centre.

There were systems in place for the assessment, management and ongoing review of risk. The person in charge maintained a risk register which outlined general risks in the centre and individual risks including behaviour, fire safety and COVID-19. The risk assessments outlined the control measures in place to manage and reduce the risk in the designated centre. In addition, individual risk assessments were in place outlining controls in place for risks including behaviour and specific healthcare needs.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing. There was a folder with information about COVID-19 and infection control guidance and protocols for staff to implement while working in the centre. The inspector observed that personal protective equipment including hand sanitizers and masks were available and in use in the centre.

There were arrangements in place for fire safety management. The centre had suitable fire safety equipment including emergency lighting, fire alarm and extinguishers which were serviced as required. Centre records demonstrated the fire drills were carried out regularly and each resident had a personal emergency evacuation plan in place which outlined the supports for each resident to evacuate the designated centre. However, some improvement was required in the containment and detection of fire. This had been identified by the provider's fire safety feedback report in August 2020 prepared by the provider's fire safety officer. The provider was taking measures as part of a service wide improvement plan to ensure that appropriate fire containment and detection would be in place.

### Regulation 17: Premises

The premises was not designed and laid out to meet the number and needs of the residents. Each resident occupied individualised areas of the centre with access to a shared entrance, kitchen and dining area, store room and utility room. The residents had restricted access to these shared areas as, due to their assessed needs, they could not be in these areas at the same time.

Judgment: Not compliant

### Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review

of risk.

Judgment: Compliant

### Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection.

Judgment: Compliant

### Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. However, improvement was required in the containment and detection of fire.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date assessment of need in place which informed the residents' personal plans. However, some identified needs did not have a personal plan in place to guide the staff team in supporting the residents.

Judgment: Substantially compliant

### Regulation 6: Health care

Residents were supported to manage their health care conditions. Residents had access relevant allied health professionals in line with their assessed needs.

Judgment: Compliant

### Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and there were positive behaviour support plans in place as required.

Restrictive practices in use in the centre were identified and there was evidence of regular review.

Judgment: Compliant

### Regulation 8: Protection

Residents told inspectors they were happy in the designated centre and appeared comfortable in their home. However, a final policy and process regarding the working with residents who can make repeated allegations, where the screening has established no reasonable grounds for concern, remained outstanding.

Judgment: Substantially compliant

### Regulation 9: Residents' rights

The layout of the premises and the arrangements in place to safeguard residents limited their choice and control of their daily life in their home.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Collins Avenue OSV-0005059

Inspection ID: MON-0030178

Date of inspection: 14/08/2020

## 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: <ul style="list-style-type: none"> <li>• Recruitment is an ongoing process in SMH to address vacancies within the service. SMH is committed to filling these vacancies. The vacancies will be filled as soon as is practicably possible.</li> <li>• There is active discussion within the service area to try to look at staffing skill mix and abilities to better support the residents within the DC.</li> <li>• 1 DSW post is being upgraded to SCW post.</li> </ul>	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: <ul style="list-style-type: none"> <li>• All staff have been set up on SMH online Your OTC. Where they can access and complete Mandatory training.</li> <li>• All mandatory training shall be scheduled and completed in line with requirements. Training plan will be updated and reviewed by PIC/PPIM.</li> </ul>	
Regulation 23: Governance and management	Substantially Compliant

<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> <li>• PIC/Service manager has met with Director of Services and Architect around premises and plan to divide current house into 2 dwellings.</li> <li>• Time bound plan has been developed to address the issues around premises</li> <li>• See Time bound plan for details</li> </ul>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> <li>• PIC/Service manager has met with Director of Services and Architect around premises and plan to divide current house into 2 dwellings.</li> <li>• Time bound plan has been developed to address the issues around premises</li> <li>• See Time bound plan for details</li> <li>• Smaller counter area with fridge in place for resident upstairs. The usage of this area to be reviewed with a view to further develop the promotion of daily living skills and engagement in activities that would typically take place in kitchen; such as baking or cold food preparation to enable engagement in such activities outside of house agreement arrangements.</li> <li>• Review of availability and access to facilities such as laundry room to take place and system of better facilitating resident to engage in household maintenance and upkeep skills to be developed and implemented</li> </ul>	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> <li>• The organisation has in place a system for prioritising environmental fire deficits arising from internal fire inspections in a systematic risk based way.</li> <li>• St Michael's House Fire Safety Officer has completed a detailed fire audit of the designated centre on the 13th August 2020, and actions identified are in the process of being implemented.</li> </ul>	
Regulation 5: Individual assessment	Substantially Compliant

and personal plan	
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ul style="list-style-type: none"> <li>• AON have been reviewed to ensure all areas of needs identified have corresponding support plans in place.</li> <li>• Support plans have been developed for any outstanding areas and are in place to guide staff in supporting the residents.</li> </ul>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> <li>• All Allegations are followed in line with National Safeguarding Policy.</li> <li>• We have developed Safeguarding guidelines to support staff working with residents who can make repeated allegations where the screening has established no reasonable grounds for concern.</li> <li>• The guidelines are developed in consultation with psychology and are specific to the individual.</li> <li>• Governance and oversight is provided by the DO and the SMH Safeguarding Forum.</li> <li>• Guidelines that were in draft format will be finalized and reviewed as necessary by SMH Safeguarding Forum.</li> </ul>	
Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <ul style="list-style-type: none"> <li>• Risk management strategies and risk assessments are reviewed quarterly or as required.</li> <li>• Both the residents have detailed AON and support plans as well as PBS plans clearly outlining the need for structure and predictability as well as consistency on a day to day basis. This promotes the residents well being.</li> <li>• House agreement is in place to support structure for the residents, with sharing of common spaces. This is discussed and reviewed regularly with residents at house meetings</li> <li>• Smaller counter area with fridge in place for resident upstairs. The usage of this area to be reviewed with a view to further develop the promotion of daily living skills and engagement in activities that would typically take place in kitchen; such as baking or cold food preparation to enable engagement in such activities outside of house agreement arrangements.</li> <li>• Review of availability and access to facilities such as laundry room to take place and</li> </ul>	



system of better facilitating resident to engage in household maintenance and upkeep skills to be developed and implemented.

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
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	28/02/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	29/04/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and	Not Compliant	Orange	29/04/2023

	objectives of the service and the number and needs of residents.			
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	29/04/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	29/04/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal	Substantially Compliant	Yellow	30/09/2020

	development in accordance with his or her wishes.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2020
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	29/04/2023