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:	Obelisk DC
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	26 May 2023
Centre ID:	OSV-0008257
Fieldwork ID:	MON-0037562

About the designated centre

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

Obelisk DC is a designated centre operated by St John of God Community Services CLG. The centre is located in South Dublin and is registered for four beds and is intended to provide full-time residential support for adults with intellectual disabilities. Obelisk DC is a detached house, with ground-floor wheelchair access for people with mobility issues. Obelisk. Residents have their own private bedrooms and have access to shared kitchen, sitting rooms and large back garden which have facilities for relaxation. The centre is managed by a person in charge who is supported in their role by a social care leader and a team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Friday 26 May 2023	11:30hrs to 15:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This report sets out the findings of a short notice announced inspection.

The centre had the capacity for a maximum of four residents however, at the time of the inspection there were no residents living in the centre full-time. The provider had registered this centre in July 2022 for the purpose of supporting four adults with intellectual disabilities to transition into. Two residents would transition from a congregated setting as part of the provider's ongoing de-congregation strategy from another designated centre in their organisation.

However, due to difficulties in recruitment the provider had been unable to fully staff and resource the centre to enable residents to transition in and therefore, despite being registered mid 2022, the centre was not yet fully operational and no resident had moved in fully.

The provider had commenced operating the centre on a weekend basis and was supporting residents to spend overnights in the centre as part of their transition planning. The purpose of this inspection was to assess the current arrangements in place for residents that were staying on weekend breaks to ensure the service provided was of good quality and meeting the needs of residents during their stay.

The inspector made arrangements with the provider to attend the centre at a time when residents would be present to observe them in the home and assess the quality of service provision being provided. Two of the residents would be attending the centre for a short time to have some lunch before leaving again for the afternoon. The inspector had the opportunity to meet with these residents and observe interactions in their new home during the course of the inspection. The inspector used observations, in addition to a review of documentation, and conversations with staff to form judgements on the quality of service for residents while staying in this centre.

The centre comprised of a two storey house located in a housing estate in South County Dublin. The centre was located close to many services and amenities, which were within walking distance and good access to public transport links.

The person in charge accompanied the inspector on an observational walk around of the centre. They were knowledgeable and familiar with the assessed needs of residents. The premises was well maintained. It was found to be clean, bright, homely, nicely furnished, and appropriate to meet the assessed needs of the residents living there. The communal living areas included two sitting rooms, a large kitchen dining area, and a pleasant back garden area. The inspector was told that one of the residents liked to engage in gardening activities and that each residents' likes and dislikes were considered when planning activities.

The kitchen dining area and sitting room was designed to give each resident their

own space if they wished but also allowed for a shared living space options. The living area was split in two by a wall with a fire as a centre piece. The inspector was informed that the residents would continue to shop for furniture for the communal spaces as well as their own bedrooms so as to have input into the décor of their home as part of the ongoing transition process.

There are plans underway for one sitting room to be fitted with a sensory system and the person in charge is working with the provider's occupational therapist to explore this further.

There was a utility room with laundry facilities and a staff office. The bathrooms were clean, with visual guides on hand washing. Each bathroom had appropriate waste disposal in the form of pedal bins and paper towels were supplied. Colour coded cleaning equipment such as mops and buckets were stored in the utility room and press in the hall.

Each resident had their own bedroom, with adequate storage for their belongings. Residents' bedrooms were spacious, comfortable, and were in the process of being decorated to their tastes. Residents were involved in sourcing furniture and other décor and did this as part of their daily activities in conjunction with their transition plan.

The designated centre's complaints and designated safeguarding officers details and photographs were clearly displayed in the hall with easy read guidance on how to make a complaint also displayed. The notice board in the office had information on advocacy and Human rights and the provider had their own equality and human rights committee.

Residents were observed receiving a good quality person-centred service that was meeting their needs.The inspector saw that staff and resident communications were familiar and kind. Staff interacted warmly with residents, in a manner which supported their assessed communication and behaviour support needs. For example, one resident communicated using LAMH signs and staff supported them by explaining what each sign meant to the inspector.

Residents were observed to have choice and control in their daily lives and were supported by a familiar staff team who knew them well and understood their communication styles. Staff were responsive to residents' requests and assisted residents in a respectful manner. For example, throughout lunch one resident looked for reassurance around their plans for later that evening, staff were observed to provide them reassurance using verbal responses and lamh signs to explain what the plan was for later in the evening.

The residents' came to the designated centre for lunch after attending a zumba dance exercise class earlier. Staff supporting them explained to the inspector that activities were planned in consultation with each resident and these activities included swimming, dancing and gardening.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management

affects the quality and safety of the service being delivered.

Capacity and capability

The provider had commenced operating the centre on a weekend basis in January 2023 and was supporting residents to spend overnight(s) in the centre as part of their transition planning. The purpose of this inspection was to assess the current arrangements in place for residents that were staying on weekend breaks to ensure the service provided was of good quality and meeting the needs of residents during their stay.

Overall, it was found during this inspection that the provider's management arrangements ensured that a good quality and safe service was provided for residents.

The provider was demonstrating they had the capacity and capability to provide a good quality service. The centre had a clearly defined management structure, which identified lines of authority and accountability. There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage the service.

There were effective management arrangements in place that ensured the safety and quality of the service was consistently and closely monitored. The provider had systems in place to monitor and review the quality of services provided within the centre such as a daily duties folder including a cleaning schedule, infection prevention control (IPC) checklist and a fire safety checklist.

Because this centre is newly registered and still transitioning residents, six-monthly unannounced visits and an annual review of quality and safety had not taken place. An infection prevention and control audit was carried out quarterly and the last one was completed in the last two months.

The centre had most of the necessary resources to provide care and support to the residents in an effective manner. These resources included the provision of suitable, secure, and comfortable premises with appropriate equipment and furnishings, access to the community and clinical care.

However, the designated centre did not yet have sufficient staffing levels to support all four residents to live in the centre on a full-time basis. At the time of the inspection there were a number of staff vacancies in the centre, an organisational recruitment process was underway and staff from the resident's previous centres have been identified to fill the posts, however the inspector was informed that staff identified for the service needed to be replaced in their current posts before they could be deployed to this centre.

As a result, the staffing arrangements in the centre, including staffing levels, skill-

mix and qualifications, were not effective in meeting the residents' assessed needs at this time meaning the centre was not able to provide a full service to its residents. This impacted on all four residents transition and full admission to the centre. Concerns from family members regarding the delay in admission had been addressed through communication and consultations with the families and residents and supports offered through the transition period.

As the service was running at the weekend on an ad-hoc basis, the person in charge endeavoured to have a planned roster on a bi-weekly basis, saying that sometimes, due to staffing deficits, the roster went on a week-by-week basis. The weekend was planned on a Friday morning and an email sent to all staff on duty regarding this plan.

The on-call arrangements were the same as the other designated centres under the provider and the person in charge reviewed the weekend on a Monday morning including the daily record and any notifiable events.

An up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

There was a current and up-to-date directory of residents available in the designated centre.

The centre had a copy of the policies and procedures set out in schedule 5 and these were readily available for staff use.

Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre that met the requirements of Regulation 14 in relation to management experience and qualifications.

There were adequate arrangements for the oversight and operational management of the designated centre at times when the person in charge was or off-duty or absent.

Judgment: Compliant

Regulation 15: Staffing

On day of inspection, there were a number of staff vacancies meaning that the designated centre could not operate on a full-time basis to meet the assessed needs

of its residents. As a result, the centre opened only at weekends.

While there was a actual roster, it was completed on a weekly/bi-weekly basis as an interim measure to support weekend visits and overnight stays as per the transition plans for some residents. The registered provider could not ensure that residents were receiving continuity of care and support suitable to their needs.

The provider was recruiting to fill the vacancies. In the meantime, the vacancies were mainly covered from within the provider's permanent staff team in other designated centres, or familiar relief staff to ensure continuity of care and support for residents. Staff had been identified to transition to the new centre with residents they were familiar with but this had been delayed while recruitment was underway to fill their current posts.

Judgment: Not compliant

Regulation 19: Directory of residents

A current and up-to-date directory of residents was available in the designated centre and included all the required information specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance structure which identified the lines of authority and accountability within the centre and ensured the delivery of good quality care and support that was routinely monitored and evaluated.

There were effective management arrangements in place that ensured the safety and quality of the service was consistently and closely monitored. The provider had systems in place to monitor and review the quality of services provided within the centre such as a daily duties folder including a cleaning schedule, infection prevention control (IPC) checklist and a fire safety checklist.

While the centre had most of the necessary resources to provide care and support to the residents in an effective manner, it did not have sufficient staffing levels to support all four residents to live in the centre on a full-time basis. The provider had failed to recruit a suitable staff team since its registration meaning the designated centre was not resourced to ensure effective delivery of care and support full time which was impacting on each residents transition to the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place which met the requirements of the regulations and schedule 1 and clearly set out the services provided in the centre and the governance and staffing arrangements.

A copy was readily available to the inspector on the day of inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had written, adopted and implemented the policies and procedures set out in schedule 5.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents who lived in the designated centre. The inspector found that the governance and management systems had ensured that care and support was delivered to residents in a safe manner and that the service was consistently and effectively monitored.

Residents' support needs were assessed on an ongoing basis and there were measures in place to ensure that residents' needs were identified and adequately met.

Each resident had their own transition plan which was individualised and resident led to suit each resident's needs. Clinical input was provided for oversight in the form of a multi-disciplinary team including psychology and occupational therapy.

Compatibility and familiarisation were considered throughout the plans and each resident had the support of their current key worker throughout the transition process. There was a rights awareness checklist included in each transition plan.

The premises was found to be designed and laid out in a manner which met residents' needs. There was adequate private and communal spaces and residents

had their own bedrooms, which were being decorated in line with their tastes. There was a garden to the back of the house that was accessible to residents and well maintained. Residents were supported to add to the design and upkeep of the garden area.

The designated centre was located in a residential area with easy access to public transport, shops and community facilities such as a swimming pool nearby accessed by all residents in this house.

The provider had implemented measures to identify and assess risks throughout the centre.

The inspector observed good fire safety systems including fire detection, containment and fighting equipment. The exit doors were easily opened to aid a prompt evacuation, and the fire doors closed properly when the fire alarm activated. The fire panel was addressable and there was guidance displayed beside it on the different fire zones in the centre.

There was evidence that the designated centre was operated in a manner which was respectful of all residents' rights. Residents were observed engaging in activities together such as mealtimes and going on outings in the community.

Residents' daily plans were individualised to support their choice in what activities they wished to engage with and to provide opportunity to experience live in their local community.

There were suitable care and support arrangements in place to meet residents' assessed needs. A number of residents files were reviewed and it was found that comprehensive assessments of need and support plans were in place for these residents. These were transferable and went with the resident to their other designated centre while their transition took place.

There was a daily folder for each resident in the designated centre each containing a familiarisation plan, diary of appointments, positive behaviour support plans and protocols for duration of stay.

Each resident had a social story to explain what was happening around the move to their new home, this was written in an easy-to-read format and was accessible to each resident.

There was regular contact between the staff team, the residents, and their families. A secondary contact was provided for each resident in the event their next of kin was not available.

All residents had their own personalised day service provision and had access to transport and the community when they wanted. They were supported to access activities pertaining to their own likes and dislikes such as swimming and dance classes.

Overall, the inspector found that the day-to-day practice within this centre ensured

that residents were receiving a safe and quality service.

Regulation 13: General welfare and development

Residents' daily plans were individualised to support their choice in what activities they wished to engage with and to provide opportunity to experience live in their local community.

Each resident was consulted on their transition plan and on what activities they wished to engage with and are supported to engage in local events and activities should they wish to do so.

Residents had access to a range of opportunities for recreation and leisure. Residents were supported to engage in learning and development opportunities. Throughout the transition period each resident's access to services was maintained.

Judgment: Compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

The centre was modern in design and provided large spacious communal area options. The centre was maintained to a high standard and was observed to be clean, bright, warm, homely, nicely furnished, and comfortable throughout.

There was adequate private and communal space for residents as well as suitable storage facilities.

The registered provider had made provision for the matters as set out in Schedule 6 of the regulations.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge and the provider has ensured that each resident has received support throughout their transition by continuing to provide consistent and known staff to each resident and providing up-to-date information to each resident.

Compatibility assessments were completed and familiarisation plans in place.

Residents' daily plans were individualised to support their choice in what activities they wished to engage with and to provide opportunity to experience live in their local community.

Residents files with care and support plans were transferable and went with the resident to their other designated centre while their transition took place. There was regular contact between the staff team, the residents, day service and the other designated centres and family members.

There was a daily folder for each resident in the designated centre each containing a familiarisation plan, diary of appointments, positive behaviour support plans and protocols for duration of stay.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a centre specific risk register in place and associated risk assessments which had been risk rated and assessed.

A risk management policy was in place which was up-to-date.

Residents risk assessments were personalised to the need of each resident and included a supporting me to stay safe and well screening tool.

All residents risk assessments were individualised based on their needs and included a positive behaviour support plan and personalised emergency evacuation plans.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety systems including fire detection, containment and fighting equipment. The exit doors were easily opened to aid a prompt evacuation, and the fire doors closed properly when the fire alarm activated.

There was a comprehensive fire safety register in place which outlined general fire precautions and staff duties and responsibilities.

The person in charge had completed regular fire safety checks and fire drill records

were up-to-date.

The inspector observed that all of the fire doors, including bedroom doors and the kitchen door, closed properly when the fire alarm activated. The fire panel was addressable and there was guidance displayed beside it on the different fire zones in the centre.

There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting arrangements.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant

Compliance Plan for Obelisk DC OSV-0008257

Inspection ID: MON-0037562

Date of inspection: 26/05/2023

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We are doing all we can to recruit healthcare workers so we can open this location for seven days per week. The recruitment has been challenging and in the absence of being able to recruit staff to fully open the house we have been ensuring that two of the residents are spending once night per week in the premises in line with their transition plan and MDT recommendations. It is planned that the third resident will join for overnights in September. The fourth resident will move into the house when it is fully open in line with his will and preference. Staff will endeavor to support the residents to transition as smoothly as possible via their transition plans, however ultimately it is the residents' choice and needs that will inform these moves. All transition plans are completed with the full participation of the resident and their circle of support. The transitions outlined above are facilitated by staff familiar to the residents.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We are committed to the recruitment of staff to open this center. Unfortunately, recruitment is very challenging at present. The following actions have been taken to recruit staff to fill vacancies and recruit additional staff to meet new service needs: • Interviews take place weekly • We have contacted colleges and arranged for members of the residential management	

team to speak to the students so we can share the positive experiences of working in this field

• We are exploring all options in an attempt to secure healthcare workers so that we can ensure we have a strong workforce both for our current residential houses and for new houses coming on board – including Obelisk Walk.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/10/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/10/2023