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:	Ardbeg
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	28 September 2022
Centre ID:	OSV-0002352
Fieldwork ID:	MON-0035593

About the designated centre

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

Ardbeg is a designated centre operated by St. Michael's House. The designated centre consists of a terraced house in a suburban area of North Dublin. It provides 24 hour residential care and support to six adult residents with intellectual disabilities. On the ground floor of the building there is an entrance hallway, a modest sized kitchen space, a large dining room, two living rooms, a side entrance with a small toilet, a utility room, a large shared bathroom, and two bedrooms. On the first floor there are four bedrooms, one staff office area which also acted as a sleep over room and contained en suite facilities, a main bathroom, and a small storage space. Exterior to the building there is a small driveway to the front with space for parking one vehicle while at the rear of the building there is a large enclosed garden with patio and outdoor dining space. The staff arrangement for the centre consists of a person in charge and a staff team of 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
Wednesday 28 September 2022	10:00hrs to 16:25hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was carried out to assess the arrangements in place in relation to infection prevention and control (IPC) and to monitor compliance with the associated regulation. This inspection was unannounced. The inspector met and spoke with staff who were on duty throughout the course of the inspection. The inspector also had the opportunity to speak with most of the residents who lived in the designated centre.

On arrival to the designated centre, the inspector was greeted by a staff and two residents. The inspector saw that a staff meeting was taking place on the day of inspection. All staff were seen to be wearing appropriate personal protective equipment (PPE) in line with public health guidance. A relief staff had been scheduled to support the two residents who were not availing of day services on that day.

Two residents agreed to meet with the inspector and tell her of their experiences of living in the designated centre and of the IPC measures in place. The residents spoke positively regarding their home, telling the inspector that Ardbeg was a "friendly and relaxing home". The residents stated that the staff were helpful and provided support with household tasks, activities of daily living and with accessing the community. One of the residents had a healthcare appointment scheduled later that day and informed the inspector that a staff would support them with this. The other resident had planned to go swimming in the local swimming pool and for lunch in the community, with the support of staff.

Later in the day, the inspector had the opportunity to meet the other residents as they returned from day services. Many of the residents showed the inspector their bedrooms. The inspector saw that residents' bedrooms were individually decorated and were generally clean and well-maintained. One resident showed the inspector the jigsaws that they enjoyed completing and proudly showed the inspector how many of these had been framed and displayed on their bedroom walls.

Another resident told the inspector about their family and how they enjoyed receiving visits and accessing the community with them. There were no visiting restrictions in the designated centre at the time of inspection. This was in line with public health guidance.

The residents were well-informed regarding COVID-19 and of the measures that they should take to keep themselves safe. Some of the residents in the house had previously had COVID-19 and described following public health guidance and isolating in their bedrooms.

Many of the residents were also knowledgeable in relation to their own healthcare needs and plans. Residents described how they were supported to manage their

diagnosed health conditions.

The centre was seen to be comfortable and decorated in line with residents' preferences however it was in need of general maintenance and repair. There were several IPC risks identified on a walk-around of the designated centre. The person in charge was aware of these and the provider had compiled a schedule of works to address them. This will be further discussed in the quality and safety section of the report.

The inspector saw that interactions between staff and residents were caring and supportive. Staff were seen to support residents with activities of daily living in a manner which was respectful of residents' rights to dignity and autonomy.

In talking to staff, the inspector found that, while staff knew the residents and their care needs very well, there were inconsistencies in the implementation of the provider's IPC policy and of specific measures to prevent transmission of infection. This will be discussed further in the capacity and capability section of the report.

In summary, the inspector found that residents were happy living in Ardbeg and that they were supported by a staff team who knew them well. However, the designated centre required refurbishment in order to address IPC risks. Additional staff training in IPC policies and procedures was also required to reduce the risk of residents contracting a healthcare associated infection.

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

Capacity and capability

Overall, the inspector found that the governance and management arrangements were effective in identifying and responding to the majority of infection prevention and control risks in the designated centre. The provider had a clear organisational structure which identified individual roles and responsibilities in relation to IPC.

The provider had a series of audits in place which identified that there were improvements required to the premises in order to ensure that care was being provided in a safe environment. The provider's audits had also identified that some of the centre-specific guidance for the management of COVID-19 required review. Work was ongoing to address premises issues and COVID-19 documentation at the time of inspection.

The inspector also found that further oversight was required to staff practices to ensure that care was being provided in a manner which was in line with the provider's IPC policy and local operating procedures.

There had been recent changes to the oversight arrangements in the designated centre with a new person in charge and director of adult services having recently commenced in their roles. The person in charge had oversight of an additional designated centre. The inspector saw that the person in charge had mechanisms in place to support them in their role and to ensure effective oversight of both designated centres.

There was a clear reporting structure in place in relation to IPC. The provider had nominated a lead person who had overall responsibility for oversight of IPC. Staff were aware of who this person was and of how to contact them with any concerns.

An IPC audit had been recently completed in the designated centre by a competent person. This audit comprehensively reflected the IPC risks and set out an action plan to address these. The inspector saw that some actions had already been completed. A schedule of works had been devised to address other risks and a budget submission had been completed in this regard.

The inspector reviewed the centre's COVID-19 risk assessments and outbreak management plans. The inspector found that these plans required review to ensure that they were sufficiently detailed in order to guide staff in the event of an outbreak. For example, the inspector was informed that some residents would find it difficult to self-isolate if they were to contract COVID-19. While staff were familiar with the procedure to keep residents safe in this instance, the outbreak management plans on residents' files were insufficiently detailed and did not set out the steps that staff typically followed when this occurred. The provider was aware of this risk as it had been highlighted in a recent six monthly audit and the inspector was informed that these plans were in the process of being reviewed.

The provider had also recently reviewed their IPC policy. The inspector was informed that this policy had been discussed at staff meetings. However, the most recent version of this policy was not available in the designated centre and staff informed the inspector that they had not had the opportunity to review the revised policy at the time of the inspection.

There was a well-established staff team working in the centre who knew the residents and their needs well. Many of the staff had worked in the centre for several years. There was a small panel of relief and agency staff available to fill any gaps in the roster. Staff were up-to-date with their training in COVID-19. However, in speaking to staff, the inspector found that there were gaps in staff knowledge of hand hygiene procedures. For example, staff were unsure if there was a need to wash their hands before putting on gloves to support residents with a healthcare procedure.

There were appropriate facilities in place for the disposal of healthcare associated waste, including sharps. Some residents required healthcare interventions which involved the use of sharps. However, a risk was identified whereby staff were unaware of the procedure to be followed in the event of a needle stick injury.

Quality and safety

The inspector found that residents were well informed regarding COVID-19 and the measures they should take to protect themselves from infection. Residents spoke to the inspector about the importance of washing their hands and described how they had worn face masks when public health guidance advised this. Several residents were also aware of the measures that needed to be followed in the event of them contracting COVID-19.

The inspector also saw, on a review of resident files, that residents were supported to understand their specific health care needs through accessible information leaflets and social stories. Regular keyworker meetings were held monthly. These provided residents with the opportunity to discuss any concerns with their keyworker and to make plans for the month ahead.

The residents in Ardbeg took responsibility for many of the household cleaning tasks. There was a visual cleaning schedule which showed which jobs residents were responsible for. Residents told the inspector about the jobs that they completed and were proud of how they helped to keep their home clean and tidy. Staff told the inspector that they provided support to residents in completing these tasks, as well as oversight to ensure that IPC measures were adhered to. For example, staff supported residents to identify the correct colour coded mop and bucket for each area.

The inspector reviewed residents' files and found that there was an up-to-date assessment of need available for each resident. This assessment of need was used to inform care plans for residents' health needs. There was an absence of one diabetes care plan however the person in charge stated that they were aware of this and that a plan was in the process of being drafted. Some care plans required additional information to guide staff where there were particular IPC risks. For example, a blood testing care plan did not provide sufficient information on hand hygiene and management of sharps.

The designated centre required refurbishment throughout. In particular, the main bathroom was observed to have substantial mould on the ceiling. An IPC audit had been completed which comprehensively reflected the risks and a schedule of works had been drawn up. The person in charge stated that the maintenance department were awaiting funding approval in order to progress with the schedule of works.

Cleaning schedules were in place for the designated centre however the inspector saw that there were gaps in these schedules and it was unclear therefore if cleaning was completed each day as required.

There was minimal invasive equipment being used in the designated centre. Equipment that was in the centre was seen to be clean and well-maintained.

There were appropriate procedures in place for the management of laundry.

The inspector saw that outbreaks of infection were quickly identified, recorded and responded to. Staff could competently describe the measures they took when a resident was suspected of having COVID-19 and the inspector found that these practices were in line with the COVID-19 contingency assessment. However, the isolation plans in place for each resident as well as the house outbreak management plan required review to ensure that they adequately detailed measures to be taken in the event of a confirmed case of COVID-19.

Regulation 27: Protection against infection

Premises works were required to ensure that care was being provided in a clean environment which minimised the risk of residents contracting a healthcare associated infection.

The provider was aware of these risks as identified in their own IPC audit. The inspector was informed that the provider's maintenance department were awaiting budget approval in order to progress the schedule of works.

Documentation in the centre pertaining to COVID-19 required review to ensure that it was in line with current public health guidance and sufficiently detailed to guide staff. For example:

- The visitor's folder at the front door contained outdated guidance on visiting and an outdated risk assessment from 21/07/2020
- Some risk assessments on individual residents' files for containment of COVID-19 were out of date
- Individual COVID-19 management plans required review to ensure that they were comprehensive and detailed how to support residents who could not self-isolate.
- The IPC policy in the centre was out of date. Staff were unfamiliar with the provider's most recently updated IPC folder.
- Enhanced oversight of hand hygiene practices was required. Staff were unfamiliar with 5 key moments of hand hygiene.
- Staff required additional training and support to manage specific IPC risks such as the management of sharps and needle stick injuries.
- Some care plans, such as a blood testing care plan, required additional information to ensure that control measures were sufficiently detailed to reduce the risk of residents or staff contracting or transmitting a healthcare associated infection
- A diabetes care plan was absent from a resident's file.
- There were gaps in cleaning schedules and it as unclear if regular cleaning was therefore being completed.

Judgment: Substantially 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	
Quality and safety	
Regulation 27: Protection against infection	Substantially compliant

Compliance Plan for Ardbeg OSV-0002352

Inspection ID: MON-0035593

Date of inspection: 28/09/2022

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 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

• PIC contacted the SMH Housing Association manager who assured all premise works that are required to ensure that the care is being provided in a clean environment that will minimise the risk of residents contracting a health care associated infection willl be completed by 31/03/2023.

• The visitor's folder at the front door contained outdated guidance on visiting and an outdated risk assessment from 21/07/2020:

• Out-of-date risk assessment removed. Information in visitors folder updated 26/10/2022.

• Some risk assessments on individual residents' files for containment of COVID-19 were out of date:

• Out-of-date risk assessemnts removed 26/10/2022. Containment of Covid-19 risk assessments were updated 19/09/2022, copies of these now in service user's files.

• Individual COVID-19 management plans required review to ensure that they were comprehensive and detailed how to support residents who could not self-isolate:

• Individual Covid-19 management plans updated 26/10/2022 for service users who can not self isolate.

• The IPC policy in the centre was out of date. Staff were unfamiliar with the provider's most recently updated IPC folder.

• Latest updated version of SMH IPC policy and appendices now in IPC folder. Policy emailed on 26/10/2022 to all staff to read. IPC policy and appendices will also be discussed and read through at next staff meeting on 29/11/2022.

• Enhanced oversight of hand hygiene practices was required. Staff were unfamiliar with 5 key moments of hand hygiene.
• PIC emailed SMH Infection Control Nurse to arrange practical training and assessment in the area of hand hygiene for Ardbeg staff team in line with SMH IPC policy. Infection Control nurse confirmed to attend staff meeting on 29/11/2022 to deliver practical training and assessment of hand hygiene to staff team. PIC emailed IPC policy and relevant appendices i.e. hand hygiene guidance as set out in SMH IPC policy to all staff. IPC policy and appendices will also be discussed and read through at the next planned staff meeting on 29/11/2022 and noted in staff meeting minutes.

• Staff required additional training and support to manage specific IPC risks such as the management of sharps and needle stick injuries.
• PIC emailed SMH Infection Control Nurse on 26/10/2022 to arrange practical training and assessment in the area of hand hygiene and to include specific IPC risks such as the management of sharps and needle stick injuries for Ardbeg staff team in line with SMH IPC policy. Infection Control nurse confirmed to attend staff meeting on 29/11/2022 to deliver practical training and in hand hygiene, managemnt of sharps and needle stick injuries to staff team. IPC policy and appendices will also be discussed and read through at the next planned staff meeting on 29/11/2022 and noted in staff meeting minutes.

• Some care plans, such as a blood testing care plan, required additional information to ensure that control measures were sufficiently detailed to reduce the risk of residents or staff contracting or transmitting a healthcare associated infection

• Service user's care plans reviewed and updated 26/10/2022.

• A diabetes care plan was absent from a resident's file.

• Diabetes care plan now in place. PIC contacted SMH training department to arrange diabetes training for the staff team.

• There were gaps in cleaning schedules and it is unclear if regular cleaning was therefore being completed.

• Cleaning will be discussed at upcoming staff meeting on 29/11/2022.
• Email sent to all staff re: ensuring cleaning checklist is filled in consistently to reflect the actual cleaning that staff are carrying out.
• PIC reviews cleaning schedule/checklist weekly.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/03/2023