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:	Liffey 7
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Dublin 24
Type of inspection:	Unannounced
Date of inspection:	01 June 2022
Centre ID:	OSV-0002972
Fieldwork ID:	MON-0031768

About the designated centre

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

Liffey 7 Designated Centre is made up of two houses in a South Dublin housing estate. The two houses are supervised by one person in charge who is the social care leader. There is capacity for nine adults with an intellectual disability between the two houses. The first property is a semi-detached house which is adjacent to the second property. The first premises is comprised of six bedrooms (one with en suite), one communal sitting/dining area/kitchen and three bathrooms. The second property is a four bedroom semi-detached house. This house also has a kitchen, dining room/sitting room, and a bathroom. Both houses are connected through an inner door. Residents are supported by social care workers and health care assistants and have access to the local community using public transport and a centre based vehicle.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 1 June 2022	09:45hrs to 16:35hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection, scheduled to monitor ongoing regulatory compliance in the designated centre. The inspector had the opportunity to meet most of the residents on the day of inspection. Many of the residents chose to speak to the inspector in more detail about their experiences of living in the designated centre. The inspector used observations, conversations with residents and staff, as well as a review of documentation to form judgments on the quality and safety of care in the centre. The inspector wore personal protective equipment (PPE) and maintained physical distancing as much as possible during interactions with residents and staff.

Overall, the inspector found that residents were in receipt of a quality, person - centred service where their rights and choices were respected. Residents told the inspector that they liked living in the designated centre. One resident asked the inspector if she could put in the report that they really loved living there. The residents complimented the staff team, stating that they were very good and offered support to the residents when they needed it. One resident told the inspector of the significant support that staff gave to them during a recent hospital admission. The inspector also saw that residents' representatives had complimented the staff team in their feedback which was used to inform the annual review of the service.

Most of the residents were attending day service on the morning of inspection. There was one resident in the house at the time of the inspector's arrival. This resident told the inspector that they liked to have a lie in in the mornings and that they had chosen to attend a local community day activation centre rather than a provider run day service. This resident showed the inspector around the house. The inspector saw that the house was clean and tidy and that previous premises issues had been addressed by the provider. The inspector saw that there were some areas of the premises that required maintenance. For example, the kitchen in one of the houses had become quite worn and could not be effectively cleaned. This will be discussed further in the quality and safety section of the report.

The resident showed the inspector their bedroom which they shared with a fellow resident. The inspector saw that the bedroom was personalised for both residents and was generally well maintained. The inspector had the opportunity to meet with both residents in the shared bedroom and discussed this arrangement with them. Both residents informed the inspector that they were friends and that they had shared for a long time. They both stated that they were happy with this arrangement and that they did not wish to have their own rooms. The person in charge informed the inspector that a fourth bedroom in this house was currently used as a staff sleepover room and that this could be vacated for residents if one of the residents expressed a wish to have their own private bedroom.

Residents told the inspector about the many activities which they engaged in, both in -house and in the community. Residents stated that they played cards together,

watched TV, went out for meals in the local pub and for drinks. One resident used their tablet device to show the inspector photographs of them gardening and going for walks with friends.

The houses that comprised the designated centre were designed and laid out in a manner to meet the current needs of the residents. The furnishings in the sitting rooms were well maintained and communal living areas were decorated with resident photographs. Residents had access to two gardens. The accessibility of these had been improved by the recent installation of a ramp.The inspector saw that there was a bench in one of the gardens dedicated to the memory of a resident who had passed away. Resident bedrooms were furnished with appropriate storage. Some had televisions and all were decorated with personalised photographs, posters and ornaments.

Staff were observed interacting with residents in a kind and supportive manner. Staff spoken with were aware of residents' needs and preferences. Many of the staff had worked in the centre for some time and knew the residents well. Staff and residents were observed chatting and joking during the course of the inspection.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspector found that the provider had effective systems in place to ensure oversight of the quality and safety of care in the designated centre.

The provider had in place a series of audits including six -monthly unannounced visits and an annual review of the quality and safety of care. The annual review was completed in consultation with the residents and their representatives and reflected their feedback on the designated centre. The annual review was also written in easy -to -read language and was supported with pictures to enhance it's accessibility. The most recent six -monthly audit was completed in person in March of this year. Previous audits were conducted remotely in order to reduce footfall in the centre due to COVID-19. The six -monthly audit comprehensively reflected areas of risk in the centre and identified actions to address these. A time-bound plan was created from this audit. The inspector saw that several actions had been completed by the time of inspection.

In addition to the provider led audits, the person in charge had implemented an annual schedule of in -house audits to be completed each quarter. These audits looked at areas such as the mealtime experiences of residents, residents finances

and medication management and provided enhanced oversight of the designated centre.

There were clear lines of authority and accountability in the centre. The staff reported to the person in charge who, in turn, reported to a residential co-ordinator. A staff supervision schedule was in place and all staff had received supervision in line with the provider's policy. The person in charge also accessed monthly supervision sessions as well as a monthly one to one meeting with the residential co-ordinator regarding the running of the designated centre. Staff spoken with were aware of the reporting structure. Staff informed the inspector that they felt supported in their roles and were aware of their responsibilities. The inspector saw that staff used a communication book and a diary to support the handover of information between staff during shifts. The inspector saw staff checking these books on the commencement of their shift.

There were no staffing vacancies at the time of inspection. A planned and actual roster was maintained which showed that the staffing levels were in line with the residents' assessed needs. A small panel of relief staff was used to fill any gaps in the roster, this supported continuity of care for residents.

There were high levels of mandatory and refresher training maintained in the designated centre. All staff were up -to -date in all areas of mandatory training which included fire safety, safeguarding, infection prevention and control and safe administration of medications. Staff had also completed additional training in line with assessed needs of the residents. For example, staff had completed dysphagia training as some residents had feeding, eating, drinking and swallowing care plans. .

The centre's adverse incident log was reviewed. Generally there was a low number of incidents for this centre. All incidents had been logged and reported to the chief inspector as required.

Regulation 15: Staffing

A planned and actual roster was maintained for the centre which detailed that there was an appropriate number and skill mix of staff to meet the needs of the residents. The centre was operating with a full staffing whole time equivalent. Where relief staff were required, these came from a small consistent panel which supported continuity of care for residents.

Judgment: Compliant

Regulation 16: Training and staff development

A high level of mandatory and refresher training was maintained. All staff were up -

to -date in all identified training needs. Staff were also in receipt of regular supervision. Staff reported to the inspector that they felt supported in their roles.

Judgment: Compliant

Regulation 23: Governance and management

There were clear lines of authority and accountability in the designated centre. The centre was run by an experienced person in charge who knew the residents and their needs well. The person in charge received their own supervision and support from a residential co-ordinator. The provider had in place a series of audits to support effective oversight of the service. These audits were complemented by a schedule of quarterly audits run by the person in charge. Audits informed comprehensive time-bound plans which aimed to drive service improvement. There was evidence that actions were progressed across these audits.

Judgment: Compliant

Regulation 31: Notification of incidents

A log of incidents was maintained. There was a low level of incidents in the centre. These were reported to the chief inspector as required.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspector found that the centre was providing a high level of quality care and support to residents which was respectful of residents' choices, rights and preferences. There was evidence that residents were actively consulted with in the day to day running of the centre and that their expressed choices were listened to and respected. The inspector saw that some improvements were required to the premises particularly in one of the houses.

On arrival to the designated centre, the inspector saw that the provider had procedures in place to mitigate against the risk of COVID-19. Staff were seen to be wearing appropriate personal protective equipment (PPE). There was availability of masks, a thermometer for temperature checks, and hand sanitiser at the door. Visual information regarding COVID-19 was displayed on a notice board. There was

a bin for disposal of used PPE which was marked as a designated PPE bin. There also was a clearly identified donning and doffing area to be used for PPE in the event of an outbreak of COVID-19. Fixed hand sanitisers were available at multiple locations throughout the houses and an emergency PPE box was available in each house. The emergency PPE box included alginate bags for the laundering of soiled linen.

The environment of the house was generally clean and tidy. The inspector saw that bathrooms and kitchens were clean. The centre had access to colour coded mops and buckets. Furnishings throughout the house including the sitting room furniture and blinds were clean and well maintained. Cleaning schedules were completed for various areas of the house and staff were aware of their roles and responsibilities in maintaining good standards of environmental cleanliness.

Staff were aware of the procedures to be followed to prevent the transmission of infection when supporting residents with their assessed healthcare needs. Staff were also aware of the risks which may present in supporting certain healthcare needs and how to mitigate against these. For example, some residents required support with taking insulin. Staff were aware of the risk of needle stick injury and had practices in place to prevent this. Additionally staff were aware of the procedure to be followed in the event of such an injury. This procedure was further visually set out in the staff office on a flow chart.

The premises of one of the houses, number three, was generally well maintained. However, the premises of number two required enhancement. The kitchen was observed to be damaged. The cabinet doors above the hob were damaged and the laminate on the inside of the cabinets was peeling. Additionally, the countertop in this kitchen was damaged and was beginning to peel in areas. This looked unsightly and could not be effectively cleaned.

Painting was also required in the kitchen of number two and in the hall. The flooring and wardrobes in one resident's bedroom were due to be replaced. The inspector saw that there was only one bathroom in the premise of number three however the residents informed the inspector that this was not an issue. The person in charge stated that residents could access the bathroom in the adjoining house if required however residents stated that this rarely was necessary.

The provider had generally effected adequate procedures to detect, contain and extinguish fires in the designated centre. The fire panel, emergency lighting and fire extinguishers were regularly serviced. Final exits were thumb locks and were easy to open. Residents were actively involved in the fire evacuation procedures. On the day of inspection, one resident was nominated as the fire warden. This resident talked the inspector through the procedure to be followed in the event of fire and showed her the fire exits. Regular fire drills were held which demonstrated that residents could be evacuated in a timely manner. One resident had refused to evacuate on two occasions over the past 12 months. Education was completed with this resident and the inspector saw that subsequent to this all residents had evacuated in a timely manner during drills. The provider had recently commissioned a fire audit from an external contractor. This audit had identified several areas for improvement. The

provider was in the process of addressing these at the time of inspection. One area for improvement noted was that an external cavity wall required investigation to be assured that it was of an adequate standard.

A review of several residents' files was completed. The inspector saw that each resident had a comprehensive assessment of need completed which had been reviewed within the past 12 months. The assessment of need was used to inform care plans. Some residents had declined to take part in a review of their personal plan and their wishes were documented and recorded. Care plans were however updated as required and were written in a person -centred manner.

Residents accessed a variety of healthcare supports including diabetic clinics, endocrinology, psychiatry and dietetics. Attendance at these appointments was documented and accessible information regarding healthcare was available on residents' files. Some residents had declined particular healthcare interventions and this was clearly documented and capacity assessments were completed if these were required. For example, one resident had a feeding, eating, drinking and swallowing care plan in place which detailed that they should avoid certain foods. Staff noted that this resident often chose to eat these foods when out for meals in the community. A capacity assessment was completed by a competent professional to determine the resident's comprehension of the risks involved. The assessment determined that the resident understood the risks and had capacity to make choices regarding their food choices. Residents had also been supported to engage in health promotion activities. For example, some residents had engaged in smoking cessation programmes.

There had been a very low number of safeguarding incidents in the designated centre. The inspector saw that where these incidents had occurred that they were reported in a timely manner to the national safeguarding office and to the chief inspector. Safeguarding plans were in place for those residents who required them. All staff had completed training in safeguarding vulnerable adults. Intimate care plans were also available on residents' file. These care plans were written in person-centred language and clearly detailed residents' preferences in relation to their support in their intimate care. Staff spoken with were aware of residents preferences in this regard.

The designated centre was operated in a manner that respected the rights of the residents who lived there. Residents were actively consulted with regarding the day to day running of the centre and had freedom to exercise choice and control in their lives. House meetings were held which discussed rights and access to advocacy services. Residents told the inspector that they felt their rights were respected. Each resident had their own safe in their bedroom to store their money. Several residents also chose to keep their bedrooms locked. Residents' files detailed their consent for staff to review their information and reminded staff to treat the information with sensitivity and confidentiality. A rights awareness checklist was completed annually with each resident. This reviewed any restrictive practices, access to environment, money, social opportunities and diet choices. Staff had also supported residents to access day services of their choice and to maintain contact with social clubs and friends in areas where residents had previously lived. As previously detailed, two

residents in this centre shared a bedroom. The residents were clear that this was their choice and preference.

Some of the residents had assessed communication needs documented on their files. Staff had received communication training and, on the day of inspection, were scheduled to attend further training. Staff were aware of residents' communication support plans and of how to support residents to communicate. There was accessible information available to residents who required this. For example, the inspector saw accessible information on how to video call family members which was created specifically for one resident. Visual menu boards detailing residents' meal choices for the week were also available. Staff supported residents to use augmentative modes of communication such as tablet devices to communicate with the inspector.

Food was available to the residents which was wholesome and nutritious. There was fresh fruit available on the dining tables of the designated centre and the fridges were stocked with fresh foods including cooked meats, yoghurts, milk and fruit and vegetables. Opened food was stored in hygienic and labelled bags and containers and was dated. Menu planners were reviewed and it was evident that there was a variety of nutritious meals provided in the centre. Residents were consulted with regarding their meal choices and this was displayed on a visual menu. Some residents had feeding, eating, drinking and swallowing (FEDS) plans in place. Staff were aware of residents' FEDS plans and had completed training in this area.

Regulation 10: Communication

Residents were assisted and supported to communicate at all times. Staff were aware of residents' communication support plans and were in receipt of appropriate training in order to implement these plans effectively. Residents had access to multi-media devices for communication and were supported to use assistive technology as per their assessed need and preferences.

Judgment: Compliant

Regulation 17: Premises

There were several premises issues identified, particularly in the number two house. These included:

- the kitchen cupboards and counter-top were worn and damaged
- the kitchen required painting
- one resident bedroom flooring and cupboards required maintenance

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was a variety of wholesome and nutritious meals and snacks available to the residents in the designated centre. Meals were cooked, prepared and stored in a safe and hygienic manner. Meals were provided which were consistent with residents' dietary needs and preferences. Several residents had FEDS care plans on file. Staff were familiar with these plans and had received training in this area.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had effected policies and procedures in line with the National Standards for infection prevention and control in community services. There were adequate measures in place to mitigate against the risk of residents contracting COVID-19 or a healthcare associated infection. The centre was clean and staff were aware of their roles and responsibilities in delivering care in a clean and safe environment. Staff were knowledgeable regarding standard precautions as well as additional precautions to be taken when supporting residents with assessed healthcare needs.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had in place measures to detect, contain and extinguish fires. Residents were informed and had been in receipt of education regarding fire safety. The provider had commissioned an external contractor to conduct a review of their fire safety systems. Several actions were identified which were in progress at the time of the report. One action included the investigation of an external cavity wall to be assured that it was of an adequate standard.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had a comprehensive assessment of need on file which had been reviewed annually or as required. The assessment of need was written in a person centred manner and was used to inform care plans. Care plans clearly detailed the supports required to meet residents' assessed needs. These care plans were developed in a person centred approach and were regularly reviewed to take into account changes in circumstances.

Judgment: Compliant

Regulation 6: Health care

Residents in the designated centre had a range of assessed healthcare needs. There were procedures in place to ensure that residents had access to appropriate health care as per their assessed needs and their choices. Residents accessed a variety of healthcare professionals including endocrinology, diabetic clinics, psychiatry and retinal clinics.On occasion, residents had declined an intervention and their wishes were respected and recorded. The provider had ensured that capacity assessments were completed to ensure that residents' rights were respected in this regard.

Judgment: Compliant

Regulation 8: Protection

There were procedures in place to ensure that residents were protected from all forms of abuse. Allegations of abuse were recorded and investigated in a timely manner. Safeguarding plans were implemented as required. Intimate care plans were available on residents' files. Staff were aware of the safeguarding measures in the designated centre and were informed regarding their safeguarding roles and responsibilities.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the rights of each residents. Residents were informed regarding their rights and staff actively worked to inform and uphold residents' rights. Residents told the inspector that they had choice and control in relation to their daily lives. There were procedures in place to ensure that residents' rights to privacy and dignity were respected.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Liffey 7 OSV-0002972

Inspection ID: MON-0031768

Date of inspection: 01/06/2022

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: An action plan in relation to these works will be drafted by the maintenance team and a timeline identified for same. The PIC has liaised with the maintenance manager and timeline will be identified before week ending 3rd July. The required kitchen works have been identified and added to the maintenance app along with discussed at the PICs Monthly Designated Centre meeting with her coordinator and Programme manager on 16th June 2022. The Operations Manager and Programme Manager completed an environmental walk around with the PIC on 8th June and all maintenance and redecorating issues were highlighted and the PIC has added them to the maintenance list, some had already been identified by the PIC. These include; painting of the house, flooring and wardrobes. A schedule for the works to be complete has been identified.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All actions from the Fire safety reports were reviewed with the PIC and maintenance manager on (date). The PIC also met and reviewed the report with the Coordinator and Programme Manager on 16th June 2022. The actions have been escalated to the health & Safety Officer and a plan for addressing these will be put in place. The maintenance team have reviewed the Cavity barrier and it will be completed by 30th August 2022.	

All actions identified have been added to the QEP by the PIC along with those responsible and deadline dates.

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	01/10/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	01/06/2023
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	01/06/2023