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:	St Joseph's House for Adult Deaf and Deafblind
Name of provider:	Catholic Institute for Deaf People
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	29 June 2021
Centre ID:	OSV-0002090
Fieldwork ID:	MON-0032520

About the designated centre

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

St Joseph's House for Deaf and Deafblind Adults is located in a suburban area of South Dublin. It provides full-time residential services for up to 14 residents. Individuals using the services of this centre are adults and are deaf or deafblind. The designated centre recently underwent a reconfiguration of its premises and a reduction in the floor plan of the building. It is now comprised of three wings containing bedrooms, living space, bathrooms, kitchens, storage rooms and administrative areas. Residents are supported by a staff team which is comprised of a person in charge, team leaders, supervisors, a clinical nurse manager, staff nurses, carers, kitchen staff, household staff, drivers, transition team, and maintenance personnel.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 29 June 2021	10:00hrs to 15:30hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

From speaking with residents and from what the inspector observed, the services provided in this centre were found to have improved in the time since the last inspection. The inspector found that there was greater consultation with residents and they were much happier with the services they were in receipt of. Overall, the inspector observed that there had been a shift in the model of service provision towards a person-centred approach.

This inspection was completed as part of a regulatory plan for this centre following a number of inspections which identified poor levels of compliance with the regulations. The registered provider had previously submitted a notification to the Office of the Chief Inspector for the planned closure of this centre and the inspection was completed to monitor the implementation of a local closure plan. The inspector found that the registered provider was on course to close the centre by 31 October 2021 as per their conditions of registration.

At the time of the inspection there were 10 residents living in the centre and the inspector met with and spent time speaking with five residents. The inspector was supported by an independent interpreter during the course of the inspection to facilitate conversations with residents who were deaf and deaf blind. The interpreter also facilitated conversations with some staff members. Overall, the residents told the inspector that they were very happy and felt safe in the centre. They expressed that they were "nervous" and "apprehensive" about the plans to move to community settings but were also looking forward to it. Some residents informed the inspector that their only concerns centred on the availability of staff members in their new community settings who had fluency in Irish Sign Language (ISL).

Residents were observed to be engaging in a number of activities at the time of the inspection including art and crafts, watching television, relaxing in the garden and some were supported to engage in pastimes off site. Residents were very complimentary of the staff team and the supports provided by them. All interactions observed between staff and the resident group were respectful and kind. There was a relaxed and enjoyable atmosphere in the centre at the time of the inspection and it was clear that the management and staff teams had developed strong relationships with the resident group.

In addition to speaking with residents, the inspector received eight completed residents' questionnaires. The questionnaires asked for participant feedback on a number of areas including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, personal rights, activities, staffing supports and complaints. There was positive feedback received overall with the majority of residents indicating that they were satisfied with the service they were in receipt of. One resident stated that they enjoy "participating in art and sitting in the garden" and also "...learning how to cook". Another resident said "I enjoy visiting my new home, shopping for things for

my house and going food shopping". Other residents gave positive feedback on watching the "Euros football matches", "going for walks" and attending church services. Some other residents provided feedback such as "I would like more outings" and "I would like to go out more". While others raised their concerns about being able to communicate with their support staff. One resident stated "sometimes I find it hard when they don't know sign language" and another individual said "I would like if all hearing staff could have sign language to communicate with me".

The premises of the centre were found to be clean throughout and provided a sufficient number of toilets and showers to meet the needs of residents. While the premises were not homely in nature or suitable for the long term placement of residents, the inspector found that as a short term plan the centre provided for a reasonably comfortable environment for residents. There were individual bedrooms and good arrangements for storage of personal belongings.

It was clear that residents were enjoying a generally improved quality of life in the centre when compared to times of previous inspections. A number of residents had recently transitioned to community settings and were reported by the registered provider to be doing well since their moves. The residents who remained in the centre at the time of the inspection were receiving ongoing support from the transition team and the majority had well developed and agreed plans in place. In the case of two residents, the planning process was ongoing and while there was an absence of formal agreement on housing, there was a number of 'back up' plans in place if required. The inspector found that all residents met with were involved in the planning process and were well informed of their options and choices. All residents who required it now had the supports of an independent advocate. The inspector noted that an ISL instructor had recently been hired to support staff members to learn the language and to support augmented communication with residents.

While overall, the inspector found that there had been improvements in the standards of care and support being provided in the centre, there remained a number of areas which required ongoing development and improvement to ensure regulatory compliance. These included the continuity of staffing, clarity on the allocation of staffing in the centre, the maintenance of staff duty rosters, the premises of the centre and fire containment measures. Given the short time frame before the planned closure of the centre, the inspector found that there were no significant risks presenting for residents.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspector found that there had been improvements in the manner in which the centre was managed in the time since the last inspection. Residents were receiving improving standards of care and support and it was clear that the registered provider had made significant efforts to improve the services and to come into regulatory compliance. Despite this, there remained mixed levels of compliance with the regulations overall.

The centre was managed by a person in charge who was employed in a full-time capacity. They reported to the organisation's chief executive officer who in turn reported to the organisation's board. While the management structures were found to be clear, the inspector observed that there was an ongoing need for the development of effective management systems to allow the centre to operate to a high standard or to achieve its objectives. The provider had completed annual reviews and six monthly announced visits to the centre as required by the regulations, however, in some areas required greater oversight of the services being provided.

While the centre was found to be appropriately resourced, there was ambiguity as to what the agreed allocation of staffing resourced was. A review of staff duty rosters for a sample period found that the centre was operating at 27.38 full time equivalents instead of 29.6 as outlined in the centre's statement of purpose (dated 26 June 2021). The registered provider was not clear what the official allocation of staffing for the centre or the actual total number of full time equivalents being restored in the centre was. Despite this, the inspector observed that there were sufficient numbers of staff on duty in the centre with the right skills to meet the needs of residents. There was, however, a reliance on relief and agency staff to support the core staff team. This, the inspector found, resulted in discontinuity of care for residents.

Regulation 15: Staffing

The inspector found that the centre was appropriately resourced, however, there was considerable ambiguity on the part of the registered provider regarding the number of allocated staff members in the centre. The registered provider was found to be rostering fewer staff members than outlined in the centre's statement of purpose. In addition, the inspector found that there was a significant reliance on the use of agency and relief staff members to supplement the core staff team. As a result, there was discontinuity of care and support for residents. A review of staff duty rosters found that actual and planned rosters were not maintained as required and documents in place did not include titles or descriptors, grades of staff and completed shifts of some staff members.

Judgment: Not compliant

Regulation 23: Governance and management

There were noted improvements in the manner in which the centre was managed. The management structures were clear and there was enhanced levels of input from the interim CEO who had been appointed in the time since the last inspection. There were annual reports and six monthly unannounced visits to the centre completed and there was generally improvement in the standards of care and support being provided to residents. There remained, however, a need for the development and implementation of effective management systems to allow for good oversight of the care and support being delivered in the centre.

Judgment: Substantially compliant

Quality and safety

The inspector found that the residents availing of the services of this centre were in receipt of care and support which was of an improving standard and which had begun to shift towards a person-centred approach. Residents were living increasingly rewarding lives and told the inspector about how they were decorating their new homes and how they looked forward to moving from the centre. Staff members spoke about how residents were being supported to develop natural support networks in their new communities and availing of services for the deaf community.

There was clear evidence to demonstrate that the registered provider was ensuring that residents were were meaningfully engaged with during the development of their transition plans for moving from the centre to other services. Residents told the inspector that they were happy with the plans that were in place and felt included and listened to. All residents had been informed about the services of independent advocates and those who requested such supports had referrals submitted.

The inspector found that residents were appropriately protected and safeguarded from experiencing abuse in the centre. The staff team and person in charge were knowledgeable of the different types of abuse and the actions required to be taken in response to witnessing or suspecting incidents of a safeguarding nature. It was clear that the management and staff team were ensuring that residents were respected and supported in a dignified manner while availing of the services of the centre. A number of incidents of a safeguarding nature had occurred in the centre in the time since the last inspection and the inspector found that these had been appropriately followed up on in line with local and national policy.

Regulation 17: Premises

The premises of the centre were not appropriate for the long term provision of residential services. However, in a short term context, the premises were clean throughout and provided for individual bedrooms for residents along with a satisfactory number of toilets and shower rooms. There were two sitting rooms, kitchen spaces and storage facilities. A courtyard garden space had been recently renovated to provide an outdoor area for residents to relax.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

The registered provider was found to have sensitively engaged with and supported residents to plan for their long-term futures. In some cases, residents had been discharged from the centre to other residential placements or nursing homes as per their transition plans. In other cases, transition plans had been developed with the input of residents and were awaiting housing approval before moving. The inspector found that this was a resident-centred process and was progressing according to the planned date for closure of the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector found that while there had been improvements made by the registered provider regarding fire precautions, there remained an absence of appropriate fire containment measures in the centre. Emergency lighting had been installed in the centre in the time since the last inspection, however, there was an absence of fire doors in the majority of locations which required them. Where there were fire doors in place, the inspector observed that some had been wedged open. There were individual personal emergency evacuation plans in place for residents and fire drills were being completed on a regular basis and these demonstrated that residents and staff could be evacuated from the centre in a reasonable time frame.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that staff members spoken with had a good understanding of the various types of abuse and the actions required if they witnessed, suspected or had an abusive incident reported to them. Residents told the inspectors that they felt safe living in the centre. There was a safeguarding policy in place and the inspector found that this was informing practice.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence available to demonstrate that the centre was operated in a respectful manner and residents were supported to exercise their personal rights. The resident group were encouraged to actively contribute to the operation of the centre and to decisions being made. There was independent advocacy service inputs available to those who requested them and residents were afforded choice where possible. There were a number of examples of residents exercising control over their own lives and long-term planning processes which resulted in positive outcomes for the group.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Joseph's House for Adult Deaf and Deafblind OSV-0002090

Inspection ID: MON-0032520

Date of inspection: 29/06/2021

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:
The Registered Provider will ensure that the number, qualification and staff skills are appropriate to the assessed needs of residents with the following actions:

a) The Registered Provider has carried out a full review of the statement of purpose to ensure clarity on numbers required in the centre to meet residents assessed needs and this has been communicated to staff. This will be reviewed and updated as each service user transitions into the community to continue to ensure the safe running of the centre.

b) The Registered Provider will implement a new rostering system by 20th August 2021. The system will reflect the total number of hours required for each department based on the number and assessed needs of residents in line with the statement of purpose for the centre and report on actual hours against the statement of purpose. The rostering system will include titles, brief job descriptions, grades of staff and completed shifts of all staff members in each department.

c) The Registered Provider will oversee the transition to an effective management and rostering cloud based system by 31st December 2021 to ensure oversight of good care and support is delivered consistently and any areas for improvement can be identified and plan delivered to address them.

d) The Registered Provider is actively recruiting for staff who have FETAC level 5 as a minimum and up to level 7/8, this will continue until all positions within the centre are successfully filled.

e) The Registered Provider is in negotiations with the funder to agree terms and conditions to reflect the specific skill need for staffing with ISL in the centre and agreement will be in place by 31st October 2021.

f) The Registered Provider has put in place a revised management structure, effective 1st June 2021.

g) A Part time Irish Sign Language tutor is in place to assist new staff with ISL to facilitate communication with residents.

h) The Person In Charge has ensured that staff files have been audited in the previous 6 months and audits on personnel files will take place every 6 months to ensure ongoing compliance.

i) The Person In Charge will continue to carry out staffing supervision to ensure any gaps in supports are addressed promptly

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
a) The Registered Provider has commissioned an interim online system to be put in place to facilitate access for all staff to rosters, training schedules, HR processes, policies and procedures, templates for incident reports, complaints, handovers and any other documents required on an ongoing basis. This will be completed by 20th October 2021. (This will be superseded by the effective management and rostering cloud system when it is in place at the end of 4th quarter.)
b) The Registered Provider has put in place a revised management structure, effective 1st June 2021.
c) The Registered Provider has ensured that there are adequate policies, procedures, protocols, and guidelines in place to guide practice as identified in Regulation 4, Schedule 5.
d) The Person in charge meets with the service provider on a monthly basis to review systems that are in place in order to ensure that the service is safe and appropriate for residents. These meetings are minuted.
e) The Registered Provider completes an annual review and actions from the annual review are closed out to agreed deadline

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
a) The Registered Provider will continue to ensure that all wings in the residence including Riverside, Woodlands and Kinsella are appropriately maintained, and will oversee that the maintenance schedule of works is carried out to ensure the centre is maintained to a good standard and where any additional maintenance/upgrades are identified this will be actioned to enhance the lives of the residents in the centre. This will be carried out in consultation with residents.
b) Residents are encouraged and supported to use the independent training areas for laundry, cooking and computer skills. This will continue until all residents have transitioned out of the centre

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: a) The Registered Provider has a system in place to ensure the safe and prompt evacuation of residents where necessary, in the event of fire. b) The Registered Provider has ensured that all staff and residents are made aware of the protocols to be followed in the case of fire and to ensure fire doors remain closed at all times. Tool talks have been implemented to promote better understanding of the protocols in place. c) The Registered Provider will continue to carry out regular fire drills (minimum four times per annum). The next fire drill has been scheduled for week commencing 2nd August 2021 to measure the effectiveness of the evacuation process using night-time staffing levels to stress test the evacuation procedures and put in place any actions/ mitigants as a result of learnings from the process. d) The Registered Provider will ensure staff and residents are re-familiarised with the fire evacuation plan	

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	20/08/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/10/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	20/08/2021

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant		30/09/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/10/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/10/2021

Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant		31/10/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	20/10/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2021