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:	Fairview
Name of provider:	St Michael's House
Address of centre:	Dublin 3
Type of inspection:	Short Notice Announced
Date of inspection:	01 April 2021
Centre ID:	OSV-0002350
Fieldwork ID:	MON-0025114

About the designated centre

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

Fairview designated centre is a community based home in Dublin 3 operated by St. Michael's House. The centre provides residential care and support to adults with intellectual disabilities. The centre has capacity for three people to be accommodated in the house and at the time of inspection it was home to three gentlemen over 18 years of age. The centre is a two story house which consists of three individual bedrooms, music room, staff bedroom, kitchen/dining room, two sitting rooms, three bathrooms and staff office. The house is located close to local amenities such as local post office, bowling, shops and is well serviced by public transport. The house is staffed by social care workers who are available to residents on a 24 hour basis.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 1 April 2021	10:30hrs to 16:30hrs	Andrew Mooney	Lead

What residents told us and what inspectors observed

In line with public health guidance the inspector did not spend extended periods with residents. However, the inspector did have the opportunity to meet and speak with all three residents during the inspection.

The inspector observed a homely environment, that met the assessed needs of residents. Residents told the inspector that they had been involved in the redecoration of the centre. They were very proud of the work they had done, which included painting and gardening. Residents told the inspector that these initiatives had helped keep them busy during the pandemic. Residents showed the inspector their bedrooms and the communal areas within the centre. These were decorated in keeping with residents preferences. One resident showed the inspector some beautiful pieces of art they had completed. These were hung in communal areas and further enhanced the centre.

The centre was nicely decorated and had recently been renovated. These renovations included the installation of new windows. Residents said that these windows reduced the noise from the road and were a welcome addition to the centre. Furthermore, the centres back garden had been nicely upgraded and this created a secure comfortable area for residents to sit out in.

Residents appeared very comfortable with staff. The inspector observed staff supporting residents in a kind and respectful manner. This included staff spending time with residents and facilitating low arousal activities and these interactions contributed to a homely environment.

During the inspection, the inspector observed good infection control practices , which included appropriate COVID-19 precautions. In line with national guidance, visitors access was limited to essential access only. However, the provider did have contingency arrangements in place, to ensure where appropriate, visitors could meet residents in a safe manner. There was appropriate hand sanitising facilities and staff wore appropriate personal protective equipment (PPE).

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 positively impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection found that while residents were happy in their home the current

governance and management arrangements required improvement. Overall the governance and management arrangements within the centre were not effective and required enhancement.

There was a management structure in place that identified the lines of accountability and responsibility. However, the governance arrangements in place were not robust and this led to insufficient oversight within the designated centre. For instance the providers internal governance arrangements required the person in charge to complete monthly data reports for review by the service manager. However, these data reports had not been completed since August 2020. This was identified during a management meeting in January 2021 as a deficit, however, at the time of the inspection these reports had still not recommenced. Furthermore, while six monthly reports on the quality and safety of care were produced, the latest report failed to identify this know deficit and therefore a time bounded action plan to address this deficit had not been completed. This lack of effective oversight within the centre detracted form the centres overall capacity and capability.

Staffing arrangements at the centre were appropriate to meet the needs of residents and reflected what was outlined in the statement of purpose. From a review of the roster it was evident that there was also an appropriate skill mix of staff employed at the centre. The person in charge had ensured that there was both a planned and actual roster which was maintained. Staff spoken with were knowledgeable and informed of key areas such as residents' needs, safeguarding and infection prevention and control. The inspector observed staff supporting residents in a caring and dignified manor during the inspection

Staff were provided with suitable training such as fire safety, manual handling and positive behaviour support. However, there were some pertinent gaps in this training. For instance five of the nine staff within the centre, either needed to complete or refresh their COVID-19 training. A review of staff supervision within the centre found that the frequency of supervision had not been in keeping with the providers own policy. However, the inspector noted from review of supervision records that there had been improvements recently in the frequency of staff supervision.

During the inspection, the inspector reviewed the centres complaints log. This centre based log identified two complaints, one was resolved locally and the second was escalated to the service manager and resolved in a timely manner. On each occasion, complainants were satisfied with the outcome of their complaints. Furthermore, residents who spoke with the inspector were very clear on how to make a complain. This demonstrated that residents and their representatives were supported to exercise their right to raise issues and have these issues addressed in a timely manner.

Regulation 15: Staffing

There was enough staff with the right skills, qualifications and experience to meet

the assessed needs of residents at all times. There was an actual and planned roster in place and they were maintained accurately by the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

Not all pertinent staff training had been completed. For example, not all staff had completed COVID-19 training.

Staff supervision frequency was not in keeping with the providers policy.

Judgment: Not compliant

Regulation 23: Governance and management

The management structure was clearly defined and identified the lines of authority and accountability, specified roles and detailed responsibilities for all areas of service provision.

However, the effectiveness of governance assurance mechanisms required improvement. For instance despite self identifying that data reports were not being produced in the centre, in line with the providers policy, no concrete measures were put in place to address this. Furthermore, this was not reported in any of the provider six monthly reports on the quality and safety of care within the centre. Additionally the annual review did not take account of the standards.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints process was user-friendly, accessible to all residents and displayed prominently. Complaints were resolved in a proactive and timely manner.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the day to day practice within the centre ensured residents were safe and arrangements were in place to ensure that residents were safeguarded during the pandemic. However, improvements were required in how incidents were reviewed to ensure learning was taken from incidents.

There was a risk management policy in place which outlined the measures and actions in place to control risk. There were systems in place for the assessment, management and ongoing review of risk; the person in charge maintained a risk register that accurately reflected the known risks in the centre and there were records of incidents and accidents that occurred. The person in charge had ensured that risks pertaining to residents were identified. However, improvements were required in review of adverse incidents. A pattern of adverse incidents was identified but the review of these incidents did not document clearly what learning was taken from them and what control measures were put in place to reduce the likelihood of a recurrence. This a lack of appropriate review increased the risk of a recurrence of incidents which could negatively impact residents.

There were appropriate arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life. The service worked together with residents and their representatives to identify and support their strengths, needs and life goals. Residents were supported to access and be part of their community in line with their preferences and assessed needs.

A positive approach to responding to residents' assessed needs was developed. Staff were familiar with the strategies adopted to support residents. However, some of the techniques outlined within a positive behaviour support plan, could not be implemented effectively as staff required refresher training. This training situation required review to ensure staff could effectively implement residents support plans. Where assessed as being required, restrictions were implemented with the informed consent of residents and/or their representatives. All restrictions were reviewed regularly to ensure they were the least restrictive option for the shortest duration possible. Furthermore, incidents that related to behaviours of concern were reviewed in conjunction with appropriate multi-disciplinary team members.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Safeguarding plans were developed and safeguards put in place as required. Residents also had intimate care plans developed as required which clearly outlined their wishes and preferences. These measures ensured residents were protected at all times.

The provider had adopted a range of infection prevention and control procedures to protect residents from the risk of acquiring a healthcare associated infection. The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. There were appropriate hand washing and hand sanitising facilities available throughout the centre. There were suitable arrangements for clinical waste disposal. Staffing arrangements were reviewed and staff rosters had been designed to limit

any potential outbreak of COVID-19.

The inspector observed good fire safety measures in place, including a fire detection and alarm system, fire fighting equipment and fire doors with self closing mechanisms throughout. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire. These measures ensures residents and staff were protected in the event of a fire.

Regulation 26: Risk management procedures

The system of reviewing adverse incidents required improvement to demonstrate learning from these events. For instance there was a pattern of incidents noted where the review of these incidents was insufficiently documented.

Judgment: Not compliant

Regulation 27: Protection against infection

The prevention and control of healthcare-associated infections was effectively and efficiently governed and managed. Staff were observed to maintain social distancing and demonstrated good hand hygiene during the course of the inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector observed good fire safety measures in place, including a fire detection and alarm system, fire fighting equipment and fire doors with self closing mechanisms throughout. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were appropriate arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required

to maximise their personal development and quality of life.

Judgment: Compliant

Regulation 7: Positive behavioural support

Appropriate supports were in place for residents with behaviours that challenge or residents at risk from their own behaviour.

Judgment: Compliant

Regulation 8: Protection

The person in charge initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse.

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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Fairview OSV-0002350

Inspection ID: MON-0025114

Date of inspection: 01/04/2021

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC will ensure that staff complete all staff training and refresher training and will coordinate with the training department to ensure this happens. • The PIC had ensured that all Out standing Training has been completed or dates have been set for this training by the 5/7/2021. • The PIC has discussed the PBS guidelines of one Resident with the Psychologist attached to the Resident and these have been updated to enable the staff to support the Resident. • The PIC will review and update the centre training tracker on a monthly basis and liaise with the Training Department where required.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The PIC will ensure that all auditing tools are completed in a timely fashion and that any and all issues will be escalated to the Service Manager as required. • The PIC will ensure that actions on any audit or inspection are actioned and are completed in a timely fashion. • The PIC has put in place a tracker for Staff supervision and will ensure that this is followed, to be in line with the organisational policy regarding staff supervision. • The Annual Review will be reviewed and presented in line with the standards for residential services for children and adults with disabilities.	

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The PIC will put in place a more robust procedure for assessing, reviewing and lowering risks in the Designated Centre. • An analysis of any risks will be reviewed and an action plan developed to reduce the risk. • The PIC will ensure that all risk assessments are updated with the actions that are necessary to lower the risk. This will be reflected in the unit Risk Register.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	05/07/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/05/2021
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.	Not Compliant	Orange	28/04/2021
Regulation	The registered	Substantially	Yellow	09/07/2021

23(1)(d)	provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Compliant		
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	30/04/2021