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:	36 Elmwood Park
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Short Notice Announced
Date of inspection:	05 February 2021
Centre ID:	OSV-0002392
Fieldwork ID:	MON-0031875

About the designated centre

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

Elmwood provides residential care and support to adults with an intellectual disability. Residents with additional physical or sensory support needs can be accommodated in this designated centre. Elmwood can support residents with additional support needs such as alternative communication needs, specialist diet and nutrition programmes and residents with well managed health conditions such as epilepsy or diabetes. The centre can also support people with dual diagnosis intellectual disability and mental health diagnosis.
Elmwood offers support to residents in activities of daily living including support in personal care, meal preparation, organising, planning and participating in social activities. Multi-disciplinary support is available to assess and support residents' changing needs.

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 - 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
Friday 5 February 2021	10:30hrs to 16:30hrs	Andrew Mooney	Lead

What residents told us and what inspectors observed

In line with public health guidance and residents' assessed needs, the inspector did not spend extended periods with residents. However, the inspector did meet with five residents and observe them for short periods during the day of inspection. The inspector also had the opportunity to speak with three residents' representatives over the phone. The inspector used these discussions with residents, discussions with their representatives, observations, discussions with staff and a review of documentation to inform their judgements.

The inspector found their had been some compatibility issues between residents which had adversely impacted residents quality of life. This included residents being kept awake at night. However, since March 2020, not all residents were residing in the centre. This temporary arrangement was in response to the COVID-19 pandemic and it is expected that all residents would resume living in the centre in the near future. As a result of this temporary transition, compatibility issues were not currently presenting within the centre. Overall, the inspector found that residents were happy and content in their home.

During a walk around of the centre, the inspector observed residents moving around their home freely. Some residents spent time in the kitchen doing table top activities, such as art and crafts, others relaxed watching TV and some went for walks in their immediate community. Residents appeared very comfortable with each other and in the company of staff. Staff appeared to know residents well and they supported residents in a gentle and supportive manner. Staff supported residents to communicate with the inspector in line with their assessed communication needs and this enabled meaningful interactions with the inspector.

A review of complaints within the centre noted that there was a trend of complaints relating to compatibility issues within the centre. However, these issue were currently not presenting within the centre as not all residents were living in the centre at his point.

The centre had been reconfigured to include a residents bedroom downstairs. This was in response to complaints and compatibility issues. While this reconfiguration supported the resident, the door to the bedroom required attention. This room was previously a sitting room and there were transparent glass panels in the door. While some of these panels had been covered, not all had. This had the potential to negatively impact the residents right to privacy. This was discussed with the resident and they confirmed it was something they'd like addressed. The rest of the centre was nicely decorated and was well maintained. This contributed positively to the homeliness of the centre. A resident showed the inspector their bedroom. They were very proud of it and pointed out that they recently got a new TV in their bedroom. Their bedroom had many personal items that were important to the resident, including photographs and ornaments. The resident also outlined further plans they

had for decorating and further personalising their bedroom.

The inspector observed that there were some environmental restrictions in place, such as locked presses in the kitchen. These restrictions were in place to support a resident with their assessed needs. The impact of these restrictions were minimised on other residents, as they had keys to access these locked areas. The inspector observed a resident with a key accessing these areas independently and without restriction.

At the time of inspection the provider had implemented all appropriate guidance in response to the COVID-19 pandemic. Unfortunately, this did limit residents access to community activities but was in keeping with current public health guidance. Furthermore, visitor access was limited to essential access only. The provider had contingency arrangements in place where, when appropriate and in line with public health guidance, visitors could meet residents in a safe manner.

Residents who spoke with the inspector said they were very happy in their home. They told the inspector that it was a nice place to live and staff were kind to them. Residents also told the inspector having familiar staff made living in the centre more comfortable because they all knew each other very well.

Resident representatives were very complimentary of the service their relatives received within the centre. They highlighted that there was excellent communication from staff in centre. Staff and management kept them informed of important developments in line with their relatives wishes. Residents were supported to keep in contact with their representatives through regular phone calls, video calls and outside visits when public health guidance indicated it was safe.

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 this inspection found that the capacity and capability of the centre ensured residents had a good quality of life. However, further strengthening of governance arrangements and the documentation of complaints outcomes was required.

There was a statement of purpose in place that clearly described the model of care and support delivered to residents in the centre. It contained all the information set out in the Regulations. However, this document required review as not all the information contained within it was accurate. For example a recent reconfiguration of the sleeping arrangements within the centre were not accurately reflected within the statement of purpose

There was a suitably qualified and experienced person in charge who demonstrated that they could lead a quality service and develop a motivated and committed team. There were clearly defined management structures which identified the lines of authority and accountability within the centre. Staff spoken with could clearly identify how they would report any concerns about the quality of care and support in the centre and highlighted that they would feel comfortable raising concerns if they arose. Staff reported directly to the person in charge, who in turn reported to a service manager. The centre had good oversight arrangements in place, including the completion of 6 monthly unannounced inspections of quality and safety and annual reviews. Where areas for improvement were identified within, plans were put in place to address them. For instance the 2019 annual review of quality of care identified the need to introduce nursing staff on the rota, which led to the successful recruitment of a staff nurse. This illustrated that the provider had the capacity to self identify and address issues in a timely manner. However,some management arrangements required further strengthening to ensure that the centre had the capacity to respond in a timely and consistent manner to information request from the Office of the Chief Inspector. Arrangements were not in place to ensure daily updates were consistently provided to the Office of the Chief Inspector as requested.

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.

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, infection control, fire safety and manual handling. The person in charge maintained a register of what training was completed and what was due. This training enabled staff to provide evidence based care and enabled them to support residents with their assessed needs. Staff supervision was structured and completed in line with the providers supervision policy.

During the inspection, the inspector reviewed the centres complaints log. This centre based log identified three complaints that could not be resolved locally. This log noted that the complaints had been escalated to the complaints manager and were being addressed. Post inspection, an overview of the progress of these complaints was submitted to the Office of the Chief Inspector. This overview noted as not all residents were now living in the centre, the issues pertaining to the complaints were no longer a concern and therefore the complaints had been closed. However, it was not clear from this record or records observed during the inspection, if complainants were satisfied with the outcome of these complaints.

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

The education and training available to staff enabled them to provide care that reflected up-to-date practice. Staff were supervised appropriate to their role.

Judgment: 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, some management arrangements required further strengthening to ensure that the centre had the capacity to respond in a timely and consistent manner to information request for the Office of the Chief Inspector. Arrangements were not in place to ensure daily updates were consistently provided to the Office of the Chief Inspector as requested.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure all details contained within the statement of purpose were accurate. For example a recent reconfiguration of the sleeping arrangements within the centre were not accurately reflected within the statement of purpose.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Documentation relating to the outcome of complaints did not clearly record the complainants level of satisfaction.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The centre was managed by a suitably skilled, qualified and experienced person in charge.

Judgment: Compliant

Quality and safety

There were systems and procedures in place to protect residents and promote their welfare, including robust arrangements to protect residents during the COVID-19 pandemic. However, it was unclear if the arrangements in the centre were suitable to meet all residents needs when the centre was at full occupancy. Furthermore, the arrangements in place to ensure all residents privacy and dignity could be maintained required immediate review.

The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. Unfortunately, despite the best efforts of staff and residents, there was an outbreak of COVID-19 within the centre. The providers contingency plan was implemented and this was effective in managing the outbreak. Records demonstrated that the provider had ensured adherence to enhanced infection control precautions and there were ample supplies of personal protective equipment (PPE). The provider ensured all relevant public health guidance was adhered to. Appropriate outbreak management meetings were conducted and additional supports were put in place to protect residents, including deep cleaning the centre, implementing enhanced staffing rotas, facilitating temporary transitions to appropriate care facilities and ensuring residents and staff had access to testing for COVID-19 as required. Residents and their representatives told the inspector that they were well supported during the outbreak. During the inspection, the inspector observed staff engaging in social distancing and wearing appropriate PPE. There were good hand washing and hand sanitising facilities available throughout the centre. There was also suitable arrangements for clinical waste disposal.

There were appropriate arrangements in place to ensure that residents had a personal plan 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 assisted to find opportunities to enrich their lives and maximise their strengths and abilities in line with current public health advice. As noted earlier in the report, some compatibility issues relating to resident had been previously identified. While this compatibility issue was not currently presenting, it would require immediate review, if all residents were living in the centre again.

As discussed previously residents ability to maintain their privacy and dignity was negatively impacted as their bedroom door had a glass panel that could be seen through. This was raised with the person in charge and arrangements were made during the inspection to address this concern.

Appropriate supports were in place to support and respond to residents' assessed support needs. This included the on-going review of behaviour support plans. Staff were very familiar with residents needs and any agreed strategies used to support residents. Restrictive procedures were implemented when assessed as required. This included the use of environmental restrictions such as locked presses. Restrictions were implemented in line with the providers policy on restrictive practices, which included the authorisation of their use from the Positive Approaches Monitoring Group (PAMG). This ensured appropriate oversight and review of these practices. Furthermore, measures were put in place to reduce the impact of these practices on others living in the centre.

The provider had ensured that there were systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centre's policy. Staff had a good understanding of safeguarding processes and this ensured residents were safeguarded at all times.

The provider had put systems in place to promote the safety and welfare of residents. The centre had a risk management policy in place for the assessment, management and ongoing review of risk. This included a location-specific risk register and individual risk assessments which ensured risk control measures were relative to the risk identified. This enabled residents to live full lives without undue restriction. Incidents that occurred were reviewed for learning and where appropriate, additional control measures were put in place to reduce risk.

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified.

Judgment: 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 5: Individual assessment and personal plan

There were appropriate arrangements in place to ensure that residents had a personal plan that detailed their needs and outlined the supports required to maximise their personal development and quality of life.

Judgment: Compliant

Regulation 8: Protection

The person in charge initiated and carried out an investigation in relation to any incident, allegation or suspicion of abuse and took appropriate action where a resident was harmed or suffered abuse.

Judgment: Compliant

Regulation 9: Residents' rights

A residents ability to maintain their privacy and dignity was negatively impacted as their bedroom door had a glass panel that could be seen through.

Judgment: Not compliant

Regulation 7: Positive behavioural support

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

were implemented, they were applied in accordance with the providers policy.
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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for 36 Elmwood Park OSV-0002392

Inspection ID: MON-0031875

Date of inspection: 05/02/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In response to non-compliance under Reg 23 (1) (c) Management arrangements will be strengthened to ensure that the centre has the capacity to respond to the Office of the Chief Inspector daily when required. Completed: 8/2/21	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: In response to non-compliance under Reg 3 (2) The PIC revised the Statement of Purpose to include a recent reconfiguration of sleeping arrangements and has submitted this to HIQA. Completed: 8/2/21.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: In response to non-compliance under Reg 34 (2) (f) A chronological list regarding follow	

up actions taken, following service user complaints, has been updated and is currently on file in the designated centre along with complaints forms detailing the complaints made and outcome for the service users. Going forward complaints and satisfaction levels of service users will be recorded and kept on file in the complaints and compliments folder within the designated centre. Completed: 8/3/21

At an organizational level, an accessible complaints form is currently being developed with an SMH service user consultation group and the risk and incidents manager. The aim of this is to support service users in SMH to voice their concerns in a more accessible way than the current form allows and will record service user's satisfaction levels during the process. 09/21

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: In response to non-compliance under Reg 9 (3) The PIC arranged for covering over the glass panel of the bedroom door for the Resident impacted. This was completed on 8/2/21.

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 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	08/02/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	08/02/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a	Substantially Compliant	Yellow	30/09/2021

	complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	08/02/2021