Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Arranmore
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 8
Type of inspection:	Unannounced
Date of inspection:	22 November 2022
Centre ID:	OSV-0003591
Fieldwork ID:	MON-0038440

About the designated centre

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

The designated centre is operated by St. John of God services and is situated on a campus based setting in South Dublin. It is a large one storey property that provides residential services for a maximum of 11 residents. There is one dining area, kitchen, 11 bedrooms, a staff office, a medication room, a family room and a TV lounge. There are two accessible bathrooms, two shower rooms and two toilets. There is a small grassy and paved area to the back of the building where residents, staff and family members can sit. There is also access to a swimming pool, day services, an oratory, gymnasium and multisensory room located on the campus. Residents are supported 24/7 by nursing staff, healthcare assistants and social care workers. Residents have access to multidisciplinary supports in the organisation such as; social workers, physiotherapists, occupational therapists, speech and language and psychology, as required.

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 (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 22 November 2022	18:50hrs to 20:40hrs	Jennifer Deasy	Lead
Wednesday 23 November 2022	10:00hrs to 13:30hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection completed over two days. The inspection was scheduled due to receipt of information of concern pertaining to the welfare of residents. In particular, concern was identified in relation to the staffing arrangements in the evenings and the quality and safety of care of residents during this time. For this reason, the inspection took place over two days. The first day was an evening inspection where the inspector observed the activities taking place in the centre and spoke to staff on duty regarding their roles and responsibilities. The second day focused on reviewing the paperwork and documentation in the centre.

The inspector arrived unannounced to Arranmore on the evening of the 22nd of November 2022. The inspector was greeted by a regular staff nurse. The staff nurse described the management arrangements for the evening shift and made contact with the person in charge and senior manager who attended the centre shortly after the inspector's arrival.

The inspector saw that the designated centre was very clean and tidy. All staff were wearing appropriate personal protective equipment. One staff was in the process of emptying bins and another was laundering residents' clothes. The inspector completed a walk-around with the staff nurse and saw all parts of the centre with the exception of one bedroom, where a resident was sleeping. Staff told the inspector that the resident had chosen to go bed early and that it was their will and preference to do so. The inspector saw that bathrooms, living areas, the kitchen and residents' bedrooms were all clean and very well-maintained.

The inspector met three residents who were in the living room. They were watching TV or interacting with their preferred toys and sensory activities. A staff was sitting with the residents and was available to them if required. Another staff was seen assisting a resident to the bathroom. The inspector saw interactions between staff and residents which were gentle, familiar and respectful. Some of the residents in the living room interacted with the inspector by smiling and vocalising.

Most of the other residents were in their bedrooms. The inspector was again informed that this was the residents' choice. Staff informed the inspector that many of the residents had complex physical needs and were tired after a day of activities. The inspector met those residents who were awake in their bedrooms. Some residents greeted the inspector by smiling or vocalising. One resident became very excited when staff told the inspector that they would be celebrating their 50th birthday this weekend and that a party was planned.

Those residents who were awake were listening to music, watching TV or watching sensory lights and bubble columns in their rooms. The atmosphere in the centre was found to be relaxed and calm. The inspector saw that all residents appeared comfortable in their home.

The centre was decorated in a homely way. Photographs of residents accessing the community and on their holidays were seen in the entrance hall. One resident had passed away earlier this year and the inspector saw that a table with photographs and mass booklets had been set up to remember them.

The inspector visited the centre the following day, on 23 November 2022 to review the quality of care provided to residents during the day time. The inspector sat in the dining room and reviewed documentation pertaining to the quality and safety of care. The inspector also had the opportunity to speak to staff who were on duty and some family members who attended the centre on the day of inspection.

The inspector saw that interactions between staff and residents on second day were familiar and relaxed. Staff spoke about supporting residents to access day service or their own individual preferred activities. One resident was seen to go bowling and to the bank, supported by two familiar staff. The inspector saw residents being offered cups of tea, snacks and having their care needs met in a gentle manner.

A chef was seen to be on duty who was preparing dinner for the day. This menu was displayed in a visual format in the dining room. A housekeeper was also seen to be working in the centre. The housekeeper cleaned residents bedrooms after they had left for day service.

The inspector met with family members who attended the centre on the day. Family members expressed concerns regarding recent changes to staff rosters and allocation of staff to their loved ones. The inspector also saw that there were other complaints recorded which pertained to staffing matters. Family members expressed that staff rosters had been changed at the end of October and that this had resulted in unfamiliar staff working with the residents. Family members expressed concern that the residents' needs were not being met as staff were unfamiliar with them and that there were insufficient care plans in place. This will be discussed further in the next two sections of the report.

Overall, the inspector found that the centre was a relaxed and calm environment and that residents were safe and comfortable in their home. While, the provider was required to review and enhance their staffing and oversight arrangements, the inspector was assured, on the basis of the inspection findings, that a good quality service was being provided to residents in this 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 enhancements were required to the oversight arrangements, and in particular, to the local management structures and the maintenance of staff rosters.

The inspector found that, while there was a defined management structure in place, there were several vacancies in senior staff positions within the centre which were impacting on the oversight arrangements. There were vacant posts for a clinical nurse manager 1 (CNM1) and a social care leader at the time of inspection. This resulted in the person in charge taking on additional responsibilities and having a large remit. Therefore, while risks were responded to at a local level, there were gaps in paperwork and a delay in progressing local action plans in a timely manner. For example, while the person in charge was aware that some residents' assessments of needs had not been updated within the past 12 months and had asked staff to ensure that this was completed, there was no tracking system or ongoing monitoring of the actions required to ensure that this was completed.

There were also vacancies within the staff whole-time-equivalent. On commencing the first day of the inspection, the inspector was informed the staff team were short one staff nurse for the work shift that day. While the provider had attempted to fill this shift with agency staff, they had been unable to do so. However, based on observations of care and discussions with staff, this staffing resource deficit that this did not present as a risk to the safety or well-being of residents.

Other gaps in the roster, over the course of the inspection, had been filled with agency staff. Several of these agency staff had completed previous shifts in the centre. The inspector met several agency staff over the course of the two inspection days. The inspector found that these staff had received an induction and were aware of their roles and responsibilities. However, agency staff required support from familiar staff to meet residents' care needs. This did not support the efficient delivery of care and placed extra responsibilities on regular staff.

The roster for the centre required review. While a roster was in place, it was insufficiently detailed and it was not possible to validate if staffing levels were in line with the statement of purpose. The provider was required to conduct a full review of the roster and staffing arrangements in the designated centre.

The provider had in place a defined senior management structure. A person in charge was employed who knew the needs of the residents well. They reported to a Director of Nursing, who had recently been appointed to the centre in order to provide enhanced oversight. There was a system of regular support and supervision meetings in place for the person in charge and for front-line staff. The inspector saw that staff were performance managed and were supported to raise concerns regarding the quality of care.

The arrangements in place to respond to complaints were also reviewed by the inspector. The inspector saw that, while there was a complaints policy and procedure in place, these were not implemented fully. In particular, complainants were not responded to within the time-frame and in the format as set out by the complaints policy. The inspector spoke to family members and was assured that complaints were being listened to and that attempts were being made to resolve these locally. However, enhancements were required to ensure that the complaints

policy was implemented and that concerns were escalated if they were unresolved to the satisfaction of the complainant.

Overall, the inspector found that enhancements were required to the oversight arrangements in the designated centre. In particular, there was a gap in the local management systems. The inspector was informed verbally that the provider had recruited a CNM1 and a social care lead who would act as supports for the person in charge. These roles were in the process of being filled at the time of inspection. Furthermore, the provider was required to review the roster arrangements to ensure that the staffing complement was in line with the statement of purpose and was appropriate to meet the needs of the residents.

Regulation 15: Staffing

While the inspector saw that there appeared to be sufficient staff to meet the needs of the residents during the inspection, the staffing arrangements required review and enhancement by the provider. The inspector found:

- The roster did not provide sufficient information on the staff who had been on duty on a particular day or their qualifications
- Where there were gaps in the roster, it was unclear who had filled these shifts
- The inspector was informed that, at times, the provider was unable to fill gaps in the roster. The contingency arrangements required review to ensure that staffing levels were in line with the statement of purpose and were sufficient to meet the residents' needs.
- Due to the absence of required information on the roster, the inspector was unable to verify that the staffing levels were in line with the statement of purpose. It was also unclear how much reliance the provider had on relief or agency staff
- Agency staff were in receipt of an induction and were aware of their roles and responsibilities pertaining to the broader running of the designated centre. For example, staff were aware of cleaning and laundry duties. However, agency staff reported that they required support and oversight from regular staff to meet residents' care needs. This did not support the efficient delivery of care and placed extra responsibilities on regular staff.

Judgment: Not compliant

Regulation 23: Governance and management

Changes had recently been made to the oversight arrangements of the designated centre. A new person in charge was appointed in 2022. They reported to the

Director of Nursing who had recently been added as a stakeholder to the designated centre to support oversight of quality and safety of care.

There were several vacant senior staff posts which were impacting on the oversight of care. For example, a clinical nurse manager 1 and social care leader post were all vacant at the time of inspection. The provider stated that two of these posts had been filled and that the staff were due to commence in post in December 2022. These vacant posts resulted in the person in charge having a very large remit as they had taken on additional responsibilities which would normally be filled by those employed in those roles. The impact of this was that, although risks were being responded to at a local level, there were gaps in the paperwork and documentation evident in the centre.

All staff had been in receipt of supervision by the person in charge and regular staff meetings were held. The inspector saw that staff were supported and performance managed and that they had the opportunity to raise concerns about the quality and safety of care.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had effected a complaints policy which was available in the designated centre. Information pertaining to the complaints procedure was displayed in the entrance hallway. A log of complaints was available. This inspector reviewed this log and found that there had been several complaints made in recent weeks by family members. Many of these pertained to staffing and roster issues.

While the inspector saw that complaints were recorded and responded to locally, it was not evident that the complaints policy was being fully implemented. In particular, the provider had failed to reply in writing within the time frame as set out in their own policy to the complainant. It was also not evident, that where complaints were unable to be resolved locally to the satisfaction of the complainant, that these were escalated to a formal investigation by a complaints officer who did not work in the designated centre.

Judgment: Substantially 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. Overall, the inspector found that residents were in receipt a good quality and person-centred service. However,

improvements were required to the residents' assessments of need and care plans to ensure that they were up-to-date and comprehensively reflected the needs of residents.

The inspector saw that residents had the opportunity to engage in a wide variety of activities as per their needs and preferences. Most of the residents were relaxing in their rooms on the evening of the first day of inspection. Residents were seen watching TV, listening to music or engaging with sensory toys. Residents' bedrooms were furnished with Televisions, radios and their preferred activities for relaxation. On the second day of inspection, residents were seen going to day service or being supported to access the community. A review of documentation showed that residents had access to variety of both in-house and community-based activities. These included breakfast clubs, curling, bowling and massage therapy.

The provider had enhanced their mechanisms for consulting with residents. Regular resident meetings were held. Activities and choice for meals were discussed at these meetings.

There were also appropriate systems in place to ensure that residents were protected from abuse. Where safeguarding concerns had been identified, the inspector saw that these were responded to promptly, notified to the relevant bodies and investigated. Staff spoken with were aware of their safeguarding roles and responsibilities.

The inspector reviewed a sample of residents' files over the course of the inspection. The person in charge had identified that several residents' assessment of need and care plans required updating and stated that staff had been asked to ensure that this was completed. There was however no tracking system in place to monitor progress towards updating care plans. The inspector saw that most of the assessments of need which were reviewed were out of date. Care plans were also found to be out of date and required review.

Overall, the inspector saw that residents were in receipt of a person-centred service and that the care provided in the centre was of good quality. However, improvements were required to assessments of need and care plans to ensure that these were updated and therefore to be certain that care was being provided which was in line with residents' needs.

Regulation 13: General welfare and development

The inspector saw, through a review of documentation and on observations of daily activities, that residents had a wide variety or activities for recreation and occupation available to them. The centre was equipped with televisions, radios, sensory toys and lights for relaxation. Residents were seen leaving the centre to attend day service or to access the community for shopping or bowling. The inspector saw that some residents had been on holidays in the past few months.

The inspector saw that residents' meetings were held regularly and that residents were consulted with regarding the daily running of the centre including the activities to be held and the meals to be cooked.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed four residents' assessments of need and care plans. The inspector saw that, while all residents had an assessment of need on file, three of these had not been updated within the past 12 months in line with the Regulations. One assessment of need had not been updated since January 2021.

Additionally, some care plans in these files required review and updating.

A full review of the assessment of need and care plans was required by the provider to ensure that they comprehensively reflected residents' needs and identified the supports required to meet those needs.

Judgment: Not compliant

Regulation 8: Protection

The provider had ensured that there were systems in place to protect residents from abuse.

Safeguarding concerns were reported promptly and were investigated.

Safeguarding plans were in place where a concern had been identified.

Staff spoken with, including agency staff, were aware of their safeguarding roles and responsibilities and of how to escalate a concern.

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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Arranmore OSV-0003591

Inspection ID: MON-0038440

Date of inspection: 23/11/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Rosters developed to show actual and planned roster with all staff on duty clearly stated • Agency staff will get in-depth induction to ensure they have all the relevant information to support the residents they are allocated to • Sick leave to be monitored, back to work interviews will be held for all staff returning from sick leave, any staff where there is a concern re sick leave are referred to HR • Staff to contact CNM1 / CNM3 when reporting sick for duty during regular hours • Annual leave will only be granted in line with weekly limits Regular relief / agency will be requested to fill any gaps in the roster	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: CNM1 commenced in role on December 5th 2022. Social care leader will commence on January 16th January and will assume PIC role for Liffey 8 Supervision schedule for supervision, probation meetings and PDR's is in place for 2023	

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints that are presented will be acknowledged by letter by the PIC
Once the complaint is resolved we will provide a written outcome to the complainant
Information on the complaints process is available to all residents in an accessible format and will be provided to families as requested

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All MPPS will be audited by 31.12.2022 with actions carried out by 13.01.23.
As part of this review an assessment of need will be done on each resident and updates to care plans will be made as appropriate

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.	Substantially Compliant	Yellow	31/01/2023
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.	Substantially Compliant	Yellow	31/01/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	31/12/2022

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/01/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	16/01/2023
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	16/01/2023
Regulation 34(2)(b)	The registered provider shall ensure that all	Substantially Compliant	Yellow	31/12/2022

	complaints are investigated promptly.			
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Substantially Compliant	Yellow	31/12/2022
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	31/12/2022
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 complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/12/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Not Compliant	Orange	31/01/2023

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/01/2023
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/01/2023