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:	Riverside Residential
Name of provider:	St Michael's House
Address of centre:	Dublin 17
Type of inspection:	Short Notice Announced
Date of inspection:	20 April 2021
Centre ID:	OSV-0003600
Fieldwork ID:	MON-0032363

About the designated centre

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

Riverside Residential is a designated centre operated by St. Michael's House. This community based residential centre is located in Dublin. The centre provides residential support to adults with an intellectual disability. Residents with additional physical or sensory support needs can also be accommodated in the centre. The house is a bungalow set on a small campus with one other residential service, two day services and a leisure centre. The house contains seven single bedrooms one of which is used for staff. There is a kitchen and dining area, a living area and a separate sitting room available for residents. Local amenities within the area includes shops, restaurants, and hotels. There is transport available for residents use. The centre is managed by a person in charge and staffed by a team of social care workers and health care assistants.

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
Tuesday 20 April 2021	08:30hrs to 17:45hrs	Amy McGrath	Lead

What residents told us and what inspectors observed

Throughout the course of the inspection the inspector had an opportunity to briefly meet with all six residents living in the centre. One resident chose to speak to the inspector. In line with infection prevention and control guidelines, the inspector ensured that physical distancing measures and use of personal protective equipment (PPE) was implemented during interactions with all residents and staff and during the course of the inspection.

Residents views were ascertained by speaking with one of the residents, observing residents in their home, speaking with staff members, and a review of documents and records.

It was noted that residents participated in house meetings where matters about the day to day operation of the centre were discussed and decisions were made. However, with the exception of the most recent resident's meeting (which contained information about resident's views and opinions on matters) minutes were seen to be generic in nature, with the same notes recorded in the same fields in multiple records. Improvement was required to ensure that residents were consulted and participated to the best of their ability at resident's meetings, and that their views and opinions were accurately recorded.

One resident briefly spoke to the inspector and they appeared enthusiastic in sharing their plans for the day. They also discussed some recent events including their birthday celebrations. The resident seemed familiar with the COVID-19 restrictions and shared some examples of how they had impacted them, specifically in relation to reduced access to activities outside of the centre.

Residents were observed in living and dining areas and appeared to be comfortable in their home. The inspector observed some interactions between some staff and residents and it was seen to be respectful and polite. Residents were seen speaking with staff and discussing their plans for the day.

With regard to the premises, the inspector observed that the physical environment of the house was clean and for the most part, in good decorative and structural repair. Residents each had their own bedroom, and there was a second living area that residents could use to accommodate visitors or spend time alone. Residents bedrooms were decorated in line with their own tastes and preferences. The centre had a range of assistive equipment and devices to facilitate accessibility for residents in their home.

While records indicated there were potential safeguarding risks in the centre, the provider did not make sufficient evidence available to the inspector in order to evaluate if residents were receiving a safe and high quality service. This deficit is discussed later in the report.

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 to each resident living in the centre.

Capacity and capability

There were significant deficits found with regard to the governance and management arrangements in the centre. It was not demonstrated that there were clear lines of accountability for the delivery of the service at individual or organisational level and the inspector found that some organisational practices impeded stakeholders in fulfilling their responsibilities under the regulations. The inspector had considerable concerns in relation to the information governance arrangements in the centre. Some records requested during the course of the inspection were not made available. Following this inspection, the provider was requested to attend a meeting with the Office of the Chief Inspector in line with the escalation and enforcement process. The provider received a written warning, warning them that any further breaches of the Health Act, with regard to failing to provide information to an inspector, may result in prosecution.

While it was demonstrated that the provider had appropriate systems in place to meet some of the specific requirements of regulation 23 (governance and management), in terms of carrying out an annual report, and six-monthly unannounced visits to the centre, it was not demonstrated that the provider or key stakeholders had sufficient knowledge of their responsibilities under the regulations.

There was a newly appointed person in charge employed in a full time capacity. The person in charge supervised a team of staff nurses, social care staff and health care workers. While the person in charge demonstrated a comprehensive understanding of their responsibilities under the regulations, the inspector found that some of the governance and management arrangements inhibited the person in charge in carrying out their role and fully exercising their responsibilities.

There were sufficient staff available at the time of inspection to meet residents' assessed needs. While there had been a number of changes to the staffing arrangements in the months prior to the inspection, the provider had endeavoured to ensure continuity of care to residents. There was a roster in place that reflected the staffing arrangements in the centre.

The inspector reviewed a sample of staff records and found deficits in relation to the some of the requirements of schedule 2 of the regulations. While the provider had obtained some of the information required under this schedule (for example, Garda Vetting reports and references from previous employers) some of these records were not available; for instance, there were no records of disciplinary matters or other correspondence to the employee.

The inspector found that the system in place for ensuring the necessary documents had been obtained was ineffective; while there was a checklist in place that had been completed for each of the staff files, the items on the list pertained to the prescribed information under a schedule that did not apply in this case. The inspector was not assured that the provider had sufficient knowledge of their responsibilities under the regulations, and it was found that this attributed to non-compliance in this area. The inspector made further requests for this information and it was not received.

There were arrangements in place to monitor staff training requirements. The provider had ensured staff had received training in areas such as safeguarding and fire safety management. The inspector found that supervision was not being carried out in accordance with the provider's own policy. A review of supervision records available raised further concern in relation to information governance. The inspector found that frequent changes in management positions resulted in some records being missing or unavailable.

The information governance arrangements were not ensuring secure record-keeping and file management systems were in place. Throughout the course of the inspection the inspector sought various records and documents pertaining to the delivery of care to residents and found that some pertinent records were not accessible to the person in charge. A number of records were not made available to the inspector despite numerous requests to senior personnel, these included records regarding to staffing matters, and safeguarding. The inspector extended the duration of the inspection in order to facilitate the provider obtaining these records, and also travelled to another location where the records were said to be held. The requested information had not been received when the inspection concluded at 17.30.

It is acknowledged that the provider submitted additional information the day after the inspection occurred, however as the inspection had concluded, this was not accepted or reviewed as evidence for the purpose of this inspection. The information received will inform a review of the provider's statutory notifications.

Regulation 14: Persons in charge

There was a person in charge in the centre, who was a qualified professional with experience of working in and managing services for people with disabilities. They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process.

Judgment: Compliant

Regulation 15: Staffing

The inspector reviewed a number of staff files and found that the provider had not ensured all of the required records and documents relating to employees (as prescribed in schedule 2 of the regulations) had been obtained.

The person in charge did not have access to information that they were required to obtain and manage under the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

There was a policy in place with regard to the supervision of staff. It was not demonstrated that staff supervision had occurred in accordance with the provider's own policy.

The inspector had concerns with regard to the record management of supervision documents, and found deficits in the provision of supervision to staff members. The inspector was not satisfied that staff were appropriately supervised; the arrangements in place were found to be inadequate in ensuring staff performed their roles to the best of their ability.

Judgment: Not compliant

Regulation 21: Records

The inspector had significant concerns with regard to the information governance arrangements. It was found that some records were not appropriately maintained. The inspector found that record management practices obstructed key stakeholders in accessing important and pertinent records. Furthermore, records requested by the inspector in order to review compliance with the regulations, were not made available.

Some records set out in the schedules of the regulations were not made available to the inspector on the day of inspection; some of these records were not accessible to the person in charge, who has responsibility for obtaining these records under the regulations. For example, the person in charge did not have access to records relating to staff employment, including records of disciplinary action.

Judgment: Not compliant

Regulation 23: Governance and management

A number of regulatory non-compliances found on this inspection were directly attributable to poor governance and management arrangements. The inspector found that management systems did not facilitate accountability, and that some practices impeded staff members from fulfilling their legal and professional responsibilities.

The inspector found that while staff were facilitated to raise concerns about quality and safety issues, the provider had not ensured that there were effective arrangements in place to support, develop and performance manage all members of the workforce to exercise their responsibility for the quality or safety of the service being delivered.

Judgment: Not compliant

Quality and safety

The inspector was not assured that the governance and management systems were consistently ensuring that the service delivered to residents was safe or of good quality.

The provider had carried out a comprehensive assessment of need for each of the residents in areas such as health care, social care and well-being. There were a range of personal plans in place for residents, and these were seen to contain in depth guidance. Assessments had been reviewed on a regular basis and were updated to reflect any changing needs.

The inspector reviewed the safeguarding arrangements in the centre. Prior to the inspection, the provider had notified the Office of the Chief Inspector of a number of allegations of abuse that were made in relation to the residents in the centre. The provider had reported these allegations to the relevant statutory agencies. The inspector saw records that suggested these allegations had been investigated, and there were safeguarding plans in place. On further inspection, it was found that these records did not contain specific information of the allegations, or the scope and findings of the investigation. Furthermore, the safeguarding plans in place were seen to be vague and did not include sufficient detail of the measure to be taken to protect residents from the risk of abuse.

The inspector was concerned that active safeguarding plans were not guiding safe care, and that documents referred to in safeguarding plans were not available to the person in charge, who had responsibility under the regulations to take appropriate action to safeguard residents.

The inspector requested further information with regard to the management of safeguarding allegations. This information was not made available, despite numerous requests. The provider did not demonstrate that they had taken the appropriate measures with regard to investigating and responding to allegations of abuse.

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need in place for each resident, which identified their health care, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed the safeguarding arrangements in the centre. At the time of the inspection the provider was managing a significant safeguarding concern. It was found that this safeguarding risk had been reported to the relevant statutory agencies.

During the course of the inspection the provider did not supply the records requested during the course of the inspection in relation to safeguarding risks, and as such the inspector was not was not assured that all allegations of abuse had been investigated appropriately, or that residents were being protected from all forms of abuse.

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Riverside Residential OSV-0003600

Inspection ID: MON-0032363

Date of inspection: 20/04/2021

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The registered provider identified that the existing systems relating to Schedule 2, in particular staff disciplinary hearings/ employee relations required review. An updated procedure for the management of employee relations documentation was agreed at a Safeguarding Committee meeting on 20th May 2021. Minutes of this meeting are available for inspection. The updated trust in care procedure includes access to employee relations/ disciplinary hearings documentation for the PIC and PPIM's in the centre. The updated procedure has been implemented in the designated centre and all documentation is available to the PIC and PPIM's. A copy of the updated procedure is available for inspection in the designated centre. The HR department will complete audit of staff files for the designated centre to ensure all documentation as prescribed in schedule 2 of the regulations is in place.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In response to the area of non-compliance found under Regulation 16 • The Person in Charge has implemented a schedule for staff support meetings for the year, with each staff member to receive quarterly support meetings as per provider policy.	

• The agenda will include Key working duties, staff training and development, and staff wellbeing. Clear actions will be set for the PIC and staff member from these meetings.

• Minutes will be taken at each support meeting. Staff will be provided with a copy of their support meeting minutes.

• Minutes of support meetings will be kept in a secured press in the centre that only the PIC and PPIMs will have access to. The location of staff support meeting minutes will be documented in the centre's essential guide so as to ensure that if there is a change in the Person in Charge the new PIC will have access to them.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
n response to the area of non-compliance found under Regulation 21 (1) (a)

• The Registered Provider completed a thorough review of the circumstances relating to records not being available on the day of inspection. The review was discussed with the Regulator and submitted as part of the follow up to this inspection. The review concluded that one set of documents relating to Schedule 2 was not available on the day of inspection due to a systems failure. All other documentation was provided to the inspector.

• The registered provider identified that the existing systems relating to Schedule 2, in particular staff disciplinary hearings/ employee relations required review. An updated procedure for the management of employee relations documentation was agreed at a Safeguarding Committee meeting on 20th May 2021. Minutes of this meeting are available for inspection. The updated trust in care procedure includes access to employee relations/ disciplinary hearings documentation for the PIC and PPIM's in the centre. The updated procedure has been implemented in the designated centre and all documentation is available to the PIC and PPIM's. A copy of the updated procedure is available for inspection in the designated centre.
In response to the area of non-compliance found under Regulations 21 (1)(c) and 21 (4)

• The registered provider will review schedule 4 to ensure that all documentation is available in the designated centre. The Registered Provider will as part of the review ensure that documentation is retained for a period of at least four years from the date of the record being met.
In response to the area of non-compliance found under Regulation 21(2)

The HR department has a system in place to ensure that all schedule 2 documentation is retained for a period of no less than 7 years after the staff member ceases to be employed in the designated centre. The HR department will complete audit of staff files for the designated centre to ensure all documentation as prescribed in schedule 2 of the

regulations is in place.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
n response to the area of non-compliance found under Regulation 23(1) (b)

• The Registered Provider appointed a new Person in Charge to the centre on the 29.3.2021. The PIC is aware of their lines of authority and accountability and specific responsibilities' for all areas of service provision and is supported by the centres Service Manager (PPIM) and the Director of Adult Services (PPIM) in implementing all areas of responsibility.

• The Director of Adult Services established a Governance and Management Committee with Terms of Reference on the 24.4.2021. The Panel consists of the PIC, Service Manager, Administration Manager, Director of Quality Improvement and Safety Development, Director of HR & Organisational development and the Director of Adult Services. The Committee will ensure all actions from the recent HIQA inspection and internal audits/reviews are supported and implemented within the agreed timeframe

In response to the area of non-compliance found under Regulation 23(1)(c)

• A Governance and Management committee has been established for the centre, with clear lines of accountability and identifying the roles and responsibilities of the PIC, PPIMs and organisational representatives in ensuring that the management systems in the designated centre are safe and in meeting the needs of the residents and are effectively monitored.

• The PIC and Service Manager have reintroduced the Monthly Data reports to the centre and are reviewed and discussed during their supervision meetings.

• The Centre's Quality Enhancement Plan (QEP) has been introduced by the PIC and Service Manager. The QEP is updated quarterly and all agreed actions from the HIQA inspection and internal audits/ reviews will inform this document and will be monitored regularly by the PIC.

In response to the area of non-compliance found under Regulation 23(2)(a)

• An unannounced 6 monthly audit is carried out by the provider twice annually, in line with regulations. This was completed twice last year and an Annual report was also

completed for the centre

• The Registered Provider will nominate a person to carry out the unannounced visits to the centre in line with the regulations and will undertake an additional audit to ensure the systems that are operational in the centre are being effectively monitored, consistent and meeting the safety and quality of care and support requirements of the residents.

• The Registered Provider will provide a written report from these visits with actions required and will address and report any concern regarding the standard of care and support in the centre.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In response to the area of non-compliance found under Regulation 8(2)

• The Registered Provider submitted a Provider Assurances report to HIQA on the 11.5.2021 and they will continue to implement the agreed actions identified in the report

• The PIC and PPIMs of the centre will continue to notify HIQA of any allegation, suspected or confirmed of abuse of a resident.

• The PIC will continue to submit Preliminary Screening Forms to the Local Safeguarding Team, in line with National and SMH policy.

• A multi-disciplinary team was commission by the Director of Adult Services to ensure that all residents emotional wellbeing is being addressed and appropriate therapeutic intervention and support is provided. Safeguarding plans will be reviewed and amended as required and the Designated officer will continue to provide oversight in relation to this.

In response to the area of non-compliance found under Regulation 8(3)

• The Registered Provider convened a safeguarding committee meeting on the 20.5.2021 to discuss the recent HIQA inspection in the designated centre and actions required to come in compliance with regulation 8(3). The PIC and PPIMs of the centre will continue notify HIQA and the local safeguarding team of any allegation, suspected or confirmed of abuse of a resident and going forward the PIC will be included in Trust In Care screenings where possible and appropriate.

• The TIC panel for the screenings will include the PIC of the centre, the Director of HR & Organisational Development or HR Manager, Head of Social Work or the Principal Social Work, Service Manager (PPIM) and Director of Adult Services (PPIM) or the

Administration Manager. The panel which includes the PIC will initiate and put in place an investigation where it is deemed necessary from the screening process to ensure the resident is safe from harm or abuse.

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(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.	Not Compliant	Orange	30/06/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/12/2021
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/06/2021
Regulation 21(1)(c)	The registered provider shall ensure that the additional records	Not Compliant	Orange	30/06/2021

	specified in Schedule 4 are maintained and are available for inspection by the chief inspector.			
Regulation 21(2)	Records kept in accordance with this section and set out in Schedule 2 shall be retained for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.	Not Compliant	Orange	30/06/2021
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Not Compliant	Orange	30/06/2021
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.	Not Compliant	Orange	30/07/2021
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/06/2021

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	02/06/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take	Not Compliant	Orange	02/06/2021

	appropriate action where a resident is harmed or suffers abuse.			