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:	Glencorry
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	01 March 2022
Centre ID:	OSV-0002383
Fieldwork ID:	MON-0027862

About the designated centre

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

Glencorry is a designated centre operated by St. Michael's House. It is located in a campus based service for persons with intellectual disabilities located in North Dublin. The centre comprises of one large building and provides full-time residential services to six persons with varying degrees of intellectual disability. The building consists of six resident bedrooms, a large living room, a large dining room, a kitchen and separate pantry space, a staff office, a staff room, a bathroom, a separate shower room, a utility room, and a large entrance hallway. There is an outdoor patio space to the front of the centre with an area for outdoor dining, a seating area, raised planting beds and a water feature. Residents are supported by a person in charge, a clinical nurse manager, staff nurses, social care workers, care workers, a cook, and a household worker.

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 (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 1 March 2022	09:50hrs to 17:10hrs	Amy McGrath	Lead

What residents told us and what inspectors observed

This report outlines the finding of an announced inspection of this designated centre. The inspection was carried out to assess compliance with the regulations following the provider's application to renew registration of the designated centre Glencorry.

The inspector ensured physical distancing measures were implemented as much as possible with residents and staff during the course of the inspection and also wore personal protective equipment (PPE). One resident was self isolating in their bedroom at the time of inspection as a precautionary measure due to a suspected COVID-19 case. The resident was being supported by a staff member and the inspector observed a PPE station at the resident's bedroom door as well as an appropriate waste receptacle. The resident was supported to access the garden and go for drives in the centre vehicle while restricting their movements within their home.

The inspector met three of the residents who lived in the centre. On arrival to the centre, one resident was out at their day service and two others were getting ready to leave to attend their day programmes. The inspector did not spend extended periods of time with residents, and residents did not speak with the inspector. However, the inspector had the opportunity to observe residents in their home throughout the course of the inspection. The inspector used these observations in addition to a review of documentation and conversations with staff members to form judgments on the residents' quality of life.

Overall, the inspector found that residents enjoyed a good quality of life, and the centre was resourced to meet residents' assessed needs. The care provided in the centre was found to be person centered and it was noted that staff were very familiar with residents' needs and preferences. Residents enjoyed activities in their home and in the community, such as trips to the cinema and local restaurants. It was found that quality of life for one resident was impacted by restrictive arrangements in place to manage their finances. This is discussed later in the report.

On arrival to Glencorry, the inspector observed that the premises were clean, spacious and welcoming. The living area had recently been painted and generally the house was in a good state of repair. Each resident had their own room; the inspector saw four of the six bedrooms in the centre, and found they were well furnished and decorated with residents' personal items. There were two bathrooms available for residents use and the necessary assistive aids were available. There was a modest size garden that was well kept with raised beds and bird feeders that residents enjoyed watching from the living area. There was a large living area and separate dining area which were bright and decorated in a homely manner. There was a separate kitchen and a utility room where residents' clothes and linens were laundered.

Residents were supported by a team of nurses and direct support workers. There was a nursing staff vacancy and a part-time housekeeping staff vacancy at the time of inspection. Staff were observed to provide support that was person centred. They were warm and friendly in their interactions with residents and residents appeared relaxed and comfortable in the presence of staff.

Staff in the centre had additional responsibility for housekeeping and cooking. The inspector saw that two residents were having breakfast in the company of staff when they arrived to Glencorry; staff provided support with eating and drinking in a manner that ensured clinical guidance was followed and that promoted residents' dignity. The inspection was carried out on Shrove Tuesday and staff prepared pancakes and various accompaniments for dinner. Staff were seen to cater to residents' preferences, dietary requirements and feeding support needs.

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

The inspector found, that for the most part, the governance and management arrangements within the centre were ensuring a safe and quality service was delivered to residents. It was found that the centre was well resourced and that care and support was delivered in a person centred manner. The inspector found that the provider had not managed a potential safeguarding issue in a timely manner which had resulted in a resident having limited access to their own finances for a prolonged period. This is discussed further later in the report under 'protection'.

The centre had a clearly defined management structure, which identified lines of authority and accountability. There were reporting mechanisms in place, with various monitoring systems to oversee the quality and safety of the service provided to residents. Staff spoken with were aware of how to raise any concerns.

The provider had carried out an unannounced visit to the centre every six months and prepared a report on the findings. There was also an annual review of the quality and safety of the service carried out, and there were quality improvement plans in place where necessary.

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting residents' assessed needs. Residents were supported by a team of nurses and direct support workers on a 24-hour basis. There was a planned and actual roster maintained by the person in charge. There were a number of vacancies in the centre at the time of inspection which were covered by relief or agency staff.

The staffing resources in the designated centre were well managed to suit the needs and number of residents. Residents were afforded with staff support from familiar staff who knew them well. The inspector reviewed a number of staff files and found that the provider had ensured all records required to be maintained under Schedule 2 were available, such as Garda vetting reports and employer references.

Staff received training in areas determined by the provider to be mandatory, such as safeguarding and fire safety. Refresher training was available as required and staff had received training in additional areas specific to residents' assessed needs.

There were formalised supervision arrangements in place. The person in charge provided supervision to the staff team on a quarterly basis. The person in charge was supervised by a service manager.

There was a directory of residents available that contained the information required in Schedule 3 of the regulations, which was kept up-to-date. The provider had prepared a statement of purpose that was updated on a regular basis and was an accurate reflection of the service provided in Glencorry.

Regulation 15: Staffing

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting residents' assessed needs. There was a planned and actual roster maintained by the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. Training was made available in areas specific to residents' assessed needs. There were established supervision arrangements in place for staff.

Judgment: Compliant

Regulation 19: Directory of residents

There was a directory of residents available that contained the information required in Schedule 3 of the regulations, which was kept up-to-date.

Judgment: Compliant

Regulation 23: Governance and management

There were effective management systems in place in the centre. The provider and person in charge were ensuring oversight through regular audits and reviews. There was an audit schedule in place in the centre and the provider had completed unannounced visits every six months. An annual review of care and support in the centre had been completed for 2021.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place that was reviewed and updated on a regular basis.

Judgment: Compliant

Quality and safety

The governance and management arrangements in the centre were found to facilitate good quality, person centred care and support to residents. Residents were supported to direct their own care plans, contribute to the running of the centre and engage in meaningful activities that maximised their potential. Action was required to ensure that all potential safeguarding concerns were reported and acted upon in accordance with national policy.

The inspector found that while some residents were supported to maintain ownership of their own finances, the arrangements in place for one resident were restrictive in nature and limited the resident's access to their own money. A resident's finances were found to be managed by a third party. The resident received sums of their own money at planned intervals and did not have a bank account. The arrangements in place meant that the resident did not have enough money to pay some of their weekly accommodation charges and there were periods of time where they had very little money available for day to day expenses. The resident did not have access to information about their payments or financial affairs.

On review of records it was found that this was a longstanding issue which had been escalated by the person in charge in accordance with the provider's own

policy. The issue had not been appropriately screened or reported to the relevant statutory agencies. It was found that minimal follow up had occurred despite the persisting nature of the issue, and there was no evidence of a safeguarding plan.

Residents were supported to communicate using preferred methods. Residents' communication support needs were comprehensively assessed and at the time of inspection there were detailed plans in place that utilised the most current assessment, and staff and family knowledge.

There were arrangements in place that ensured residents were provided with adequate nutritious and wholesome food that was consistent with their dietary requirements and preferences. Residents were supported to buy, prepare and cook their own meals in accordance with their abilities. Residents contributed to meal planning and also enjoyed meals out in local cafés and restaurants.

Residents were supported to receive visitors in their home, and also to have visits with family outside of the designated centre. There was a visitor's policy in place. Residents were supported to maintain and develop relationships with friends and family.

There was a risk management policy and associated procedures in place. There was an accurate risk register in place that reflected the risks identified in the centre. The processes in place ensured that risk was identified promptly, comprehensively assessed and that appropriate control measures were in place.

There were arrangements in place to prevent or minimise the occurrence of a healthcare-associated infection. There were control measures in place in response to identified risks and there were clear governance arrangements in place to monitor the implementation and effectiveness of these measures. For example, a hygiene audit had been carried out in February 2022 and an action plan had been developed with time-bound actions to address any areas requiring address. It was found that most of these issues had been addressed at the time of inspection, for example, torn bed bumpers had been replaced to facilitate effective cleaning.

The provider had developed a range of policies and procedures in response to the risks associated with COVID-19, and these were well known to the person in charge and communicated to staff. Staff had received training in infection control and hand hygiene. There was adequate and suitable personal protective equipment (PPE) available and guidance was provided to staff in relation to its' use.

There were fire safety management systems in place in the centre, which were kept under ongoing review. Fire drills were completed regularly and learning from fire drills was reflected in residents' evacuation plans. There were suitable fire safety arrangements in place, including a fire alarm system, emergency lighting and fire fighting equipment. Staff had received training in fire safety. A review of fire doors in the house found that one door was wedged open and two others did not close when tested.

Regulation 10: Communication

There were communication support plans in place for each resident that were based on their assessed needs and supported residents in communicating their needs and making choices.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to receive visitors in their home and to maintain relationships with friends and family. The centre had sufficient space and facilities for residents to receive visitors.

Judgment: Compliant

Regulation 12: Personal possessions

The inspector found that not all residents had ownership of their own finances, and that support provided was not in line with residents assessed needs and preferences.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was adequate and nutritious food available to residents that was consistent with their dietary requirements and preferences. Residents were supported to buy, prepare and cook their own meals in accordance with their abilities.

Judgment: Compliant

Regulation 26: Risk management procedures

There were risk management arrangements in place, including a risk management policy and procedures. Risk in the centre was assessed and there were

comprehensive control measures in place.

Judgment: Compliant

Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19. The centre was found to be clean and hygienic and there were a range of hygiene checklists and audits in place to ensure that this was maintained.

Judgment: Compliant

Regulation 28: Fire precautions

A review of fire doors in the house found that one door was wedged open and two others did not close when tested.

Judgment: Substantially compliant

Regulation 8: Protection

While there was a safeguarding policy in place, it was found that not all incidents of a potential safeguarding nature were appropriately screened. The arrangements in place did not ensure that when potential safeguarding risks were raised by staff or the person in charge, that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements.

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 (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 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Glencorry OSV-0002383

Inspection ID: MON-0027862

Date of inspection: 01/03/2022

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 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • The organisations Finance Department are working with The Department of Social Welfare to ensure the resident will have access to personal finance taking into consideration Assistant Decision Making Legislation • The PIC and organisations Finance Manager are in the process of final completion to set up alternative banking arrangements for Resident to facilitate residents financial accessibility and autonomy of all personal funds • The Register Provider has not been in receipt of RSMAC payments for identified Resident while aforementioned actions are outstanding as a means of ensuring resident has access to disposable finances available to them.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Additional service to fire doors have been completed to ensure that all fire doors close when tested • Door wedge has been removed from the Centre • Environment checklist has been added in addition to allocation list to ensure that no wedges or obstructions are in place within the centre.	

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• The Registered provider has completed capacity assessment for Resident in relation to capacity and will and preference in regards to the vaccination administration in line with ADM

• The Register Provider has scheduled a second capacity assessment for resident in relation to capacity and best interest as recommended by the organisations director of clinical services, directory of psychiatry and external advocate

• The register provider will review the capacity assessment for resident and progress based on the findings.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/01/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	02/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/01/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in	Not Compliant	Orange	30/01/2023

	relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			