



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

## Issued by the Chief Inspector

Name of designated centre:	Grangemore Rise
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Short Notice Announced
Date of inspection:	27 April 2021
Centre ID:	OSV-0002341
Fieldwork ID:	MON-0028998

## About the designated centre

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

Grangemore Rise is a designated centre operated by St Michael's House. The centre is located in North County Dublin. It provides community residential services for up to seven residents, over the age of 18 years, with intellectual disabilities and with support needs. The designated centre consists of a house and a detached apartment located to the rear of the house. The house is a two storey building and provides accommodation for up to six residents and consists of a storage room, toilet, utility room, kitchen, dining room/living room, two bathrooms, two offices and six individual bedrooms. The apartment is home to one resident and consists of a kitchen, living/dining room, utility room, staff room, bathroom and bedroom. The designated centre is located close to local shops and transport links. The centre is staffed by a person in charge and social care workers.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	6
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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 27 April 2021	09:55hrs to 16:00hrs	Andrew Mooney	Lead
Tuesday 27 April 2021	09:55hrs to 16:00hrs	Ciara McShane	Support

## What residents told us and what inspectors observed

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

The inspectors found that ongoing compatibility issues between residents had adversely impacted residents' quality of life. Residents told inspectors that they were very unhappy with their living arrangements. There had been a very high number of recorded safeguarding incidents in the centre and these were seriously impacting residents' quality of life. For instance, a resident told inspectors that their life was made a misery but they had to live with it, as there was nothing they could do about it. This resident was visibly upset telling the inspector how unhappy they were. They said, they had made complaints but nothing could be done to make the situation better.

The inspectors also spoke with two residents' representatives. Both were very complimentary about how the staff and management had supported their family members during the COVID-19 pandemic. They noted that the staff team kept them informed regularly and that the provider had increased support arrangements within the centre, to respond to an outbreak. However, a resident's representative also highlighted their concerns relating to the compatibility of residents. They outlined that their family member was very unhappy as a result of negative peer to peer interactions. They said that the frequency and severity of incidents had escalated despite the best efforts of staff and this was impacting their family members physical and mental health.

The inspectors observed some residents spending time in the kitchen doing table top activities and watching TV. Others were supported to access their local community and some went for walks and shopping. There was a requirement for staff to carefully supervise residents' interactions with each other due to known compatibility issues. The inspectors also observed some environmental restrictions in place in part of the centre. These restrictions, limited residents access to the kitchen, presses and a fridge. While assessed as necessary by the provider, this led to residents not having access to all aspects of their home. Inspectors found the high level of supervision and use of environmental restrictions, did not contribute to a homely environment but these arrangements were necessary to protect residents.

Staff appeared to know residents very well and they supported residents in a gentle and supportive manner. Staff supported residents to communicate with the inspectors in line with their assessed communication needs and this enabled

meaningful interactions with the inspectors.

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 certain community activities but was in keeping with current public health guidance. Residents told the inspector they understood the reasons behind these restrictions but were looking forward to when they could get back out doing the things they loved in the community. The provider had arrangements in place so that when appropriate, and in line with public health guidance, visitors could meet residents in a safe manner. Alternative visiting arrangements were facilitated, which included garden visits. The provider had also facilitated the roll out of COVID-19 vaccinations for staff and residents, in line with their preferences.

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

This centre was last inspected 15 January 2020. Due to the length of time since that inspection and the receipt of a significant number of notifications of a safeguarding nature, a risk based inspection was completed. This inspection found high levels of non compliance in key areas such as safeguarding, governance and management, complaints and individual assessment and personal plans. Inspectors found the provider had failed to ensure that all residents living at the centre felt safe and secure in their home. The provider also failed to ensure that residents' assessed needs, such as their emotional and psychological well being, were supported appropriately.

Subsequent to this inspection the provider was required to attend a warning meeting with the Office of the Chief Inspector, warning the provider if they failed to come back into compliance with the regulations, further escalation activity would be initiated, including but not limited to the potential issuing of a notice of proposal to cancel the registration of the centre.

While the provider was aware and acknowledged there was an ongoing and sustained issue with compatibility of residents, they failed to address these matters in a timely way that offered support, reassurance and respite to residents and/or their representatives who advocated on their behalf.

The provider had a clear governance structure in place and at the time of inspection an experienced person in charge was in post and demonstrated the capacity to oversee the day to day running of the centre. The person in charge was supported by a service manager who in turn was supported by a director of service. The inspectors reviewed evidence and spoke to staff which demonstrated that staff were

supported and supervised appropriately. There was also evidence that the provider had systems in place to monitor and review the quality of services provided within the centre. However, these systems failed to resolve ongoing issues relating to the compatibility of residents in a timely manner. For example, the provider was aware of the significant impact resulting from compatibility issues as detailed in statutory notifications, safeguarding plans and as outlined in complaints but the issues persisted in the absence of a specific time bound improvement plan.

Residents and staff spoken with outlined the difficult living arrangements that residents had been, and at the time of inspection, continued to experience as a result of poor compatibility of residents and the lack of swift response to the changing needs of residents. The inspectors also reviewed the compliments and complaints folder and while family members were greatly appreciative of the support the provider gave their loved ones during the COVID-19 pandemic it was overshadowed by the complaints that were logged in relation to residents' negative experiences while residing in their home.

Complaints detailed how residents were fearful, upset and felt stressed by situations which occurred at the centre. Residents' outlined in their complaints how they were kept awake at night time because of behaviours of concerns displayed by fellow residents' at untimely hours during the night. Residents also outlined in their complaints that it was futile to complain as nothing was ever done about it. The provider, at the time of the inspection acknowledged the situation was complex and stated they were committed to putting a plan in place however there was no clear time bound plan developed for the inspectors to review. On the day of the inspection the provider had submitted a funding request to their funding agency and had also told the inspectors of how they were trying to seek alternative arrangements to alleviate the situation. However, as outlined in the complaints and as told to the inspectors, residents continued to be negatively impacted. The complaints, which residents made, were not at all times dealt with in line with the provider's complaints policy and were not resolved to the satisfaction of the resident and or their representatives. In addition due to the nature of the complaints and the stage at which the complaints had reached, in line with the provider's policy, it was also not evident that independent stakeholders had been engaged with.

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 clear that there was 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 inspectors observed staff supporting residents in a caring and dignified manor during the inspection.

## Regulation 15: Staffing

There was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times.

Judgment: Compliant

### Regulation 23: Governance and management

Despite the provider self identifying a significant area of concern, that was ongoing and consistent, they failed to demonstrate they had the capacity to rectify the concern and to make changes in a timely manner. For example, there was an ongoing compatibility issue that was having a significant impact on the lived experience and quality of life for all residents at the centre. At the time of inspection this remained a key concern that had not been resolved.

Judgment: Not compliant

### Regulation 34: Complaints procedure

The provider's complaint procedure was not effective and did not bring about positive change. For example, a resident told the inspectors there was no point in making a complaint as nothing ever happened as a result.

The provider had failed to address numerous complaints made by residents and/or their representatives to the satisfaction of the complainant and also failed to follow the stages of dealing with a complaint as outlined in their policy.

The provider failed to maintain a full record of the complaint where the investigation into the complaint was outlined and any action taken on foot of the complaint.

Complaints were not at all times investigated promptly and were left at the status 'ongoing' for lengthy periods of time.

Judgment: Not compliant

### Quality and safety

As outlined previously in this report, ongoing compatibility issues within the centre negatively impacted the quality and safety of the centre. These compatibility issues resulted in negative peer to peer interactions which adversely impacted residents

quality of life, this required urgent review.

The provider's safeguarding practices required urgent review to ensure residents were free from all forms of abuse. All incidents, allegations and suspicions of abuse at the centre were investigated. However, safeguarding measures put in place were not sufficient to prevent on-going negative peer to peer incidents. Since October 2020, 41 safeguarding incidents had occurred within the centre. Documentation reviewed by inspectors noted that the frequency and reoccurring pattern of these incidents led to the National Safeguarding Office not being able to agree with the provider's interim safeguarding plans. Inspectors acknowledge that the provider had endeavoured to put a plan in place that would resolve these compatibility issues. However, this plan had not been enacted in a timely manner. This resulted in residents' quality of life being adversely impacted.

The current arrangements in the designated centre were not suitable to meet the assessed needs of all residents. Long standing compatibility issues within the centre resulted in persistent adverse incidents. As the centre was not suitable to meet all residents' assessed needs, residents were required to spend long periods outside of the centre. This arrangement was necessary to protect residents but was not conducive to providing appropriate individualised person centred care. These arrangements required urgent improvement to enhance residents' lived experience within the centre.

Supports were in place to respond to residents' assessed behaviour 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.

The provider had adopted a range of infection prevention and control procedures to protect residents from the risk of acquiring a healthcare associated infection. The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. There were appropriate hand washing and hand sanitising facilities available throughout the centre. There were suitable arrangements for clinical waste disposal. The provider had devised a contingency plan in the event of an outbreak of COVID-19 however, they failed to individually risk assess each resident in terms of their ability to self isolate should they become symptomatic of COVID-19. This required enhancement to ensure the overall effectiveness of the contingency plan.

## Regulation 27: Protection against infection

For the most part the provider had good arrangements in place to prevent and control healthcare associated infections and to ensure they were appropriately managed. The inspectors observed adequate hand hygiene gel available in the centre, an allocated area for donning and doffing PPE should it be required in addition to staff wearing the appropriate PPE in line with National guidance.

The provider had also completed contingency plans in the event of an outbreak of

COVID-19 however they failed to individually risk assess each resident in terms of their ability to self isolate should they become symptomatic of COVID-19.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

The centre was not suitable to meet the assessed needs of each resident within the centre. Known compatibility issues within the centre led to a negative lived experience for residents.

Judgment: Not compliant

### Regulation 7: Positive behavioural support

Staff received training in the management of behaviours that is challenging, including escalation and intervention techniques. Where required therapeutic interventions were implemented in line with the providers policies and reviewed in line with residents' personal planning process.

Judgment: Compliant

### Regulation 8: Protection

Incidents, allegations and suspicions of abuse within the centre were investigated. However, the safeguards put in place were not effective. This led to a reoccurring pattern of negative peer to peer incidents which led to residents not being adequately protected. For instance there had been 41 NF06 notifications submitted since October 2020.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
<b>Quality and safety</b>	
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

# Compliance Plan for Grangemore Rise OSV-0002341

Inspection ID: MON-0028998

Date of inspection: 27/04/2021

## 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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider had identified significant concerns regarding the compatibility of the residents residing in the designated centre. The provider was in the process of exploring other avenue's in order to alleviate the concerns. The provider was successful in sourcing alternative accommodation for one resident and this transition was completed on the 4th of June 2021.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The provider will ensure that all complaints going forward will be addressed in line with the organisational complaints policy.  A record of complaints requiring investigation and the outcomes will be maintained. This record will be accessible to the Person in Charge of the designated centre upon request.  All complaints in the designated centre will be reviewed and managed in a timely manner.  Person in Charge will review all current complaints (open/ongoing) this will be completed by 09/07/2021.	

Regulation 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>The Person in Charge has assessed each individual residing in the designated centre in relation to their ability to self isolate should they become symptomatic of Covid-19.</p>	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>Due to the change of residents residing in the designated centre all Assessment of Needs will be reviewed to ensure all their needs are met in a safe manner. This will be completed by 14/07/2021</p>	
Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <p>The provider was in the process of exploring avenues to alleviate the safeguarding concerns in the designated centre. The provider was successful in sourcing alternative accommodation for one resident, this transition was completed on 4th June 2021 therefore reducing safeguarding concerns.</p>	

## 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.	Not Compliant	Orange	04/06/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	04/06/2021

	published by the Authority.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	04/06/2021
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.	Not Compliant	Orange	10/05/2021
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	09/07/2021
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 complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	04/06/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet	Not Compliant	Red	04/06/2021

	the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	04/06/2021