Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Kilbarrack
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	04 September 2019
Centre ID:	OSV-0002358
Fieldwork ID:	MON-0026365

About the designated centre

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

Kilbarrack is a designated centre based in a North Dublin suburban area which supports six residents with intellectual disabilities. The designated centre is comprises a bungalow with an enclosed garden space to the rear. It contains an entrance hallway, six resident bedrooms, one staff sleep over room which contains an en-suite and also acts as a staff office, two sitting rooms, a kitchen and dining space, a large bathroom, and a smaller shower room with toilet facilities. The designated centre provides 24 hour residential supports to residents by a staff team of social care workers and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
04 September 2019	11:00hrs to 18:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the four residents living in the designated centre during the course of the inspection. Some residents communicated verbally while others used non verbal methods to communicate. In addition, the inspector observed care practices and staff interactions with residents over the course of the inspection.

Overall, residents appeared relaxed in their home and were also seen to be comfortable in the presence of staff. The inspector observed residents preparing meals and engaging in activities of preference and interests. Throughout the course of the inspection, positive interactions were observed between residents and staff.

Capacity and capability

Overall, the governance and management arrangements in place provided effective oversight and ensured that the service provided was of a good quality.

There was a defined management structure in place. The centre was managed by a full-time person in charge who reported to the Service Manager, who in turn reported to the Director of Adult Services. The person in charge was suitably qualified and experienced and demonstrated good knowledge of the residents and their needs. The person in charge who worked directly with residents and also had protected administrative time of 32 hours a month. The person in charge was supported in their role by a social care worker, who formed part of the local management structure for the centre. Quality assurance audits were in place to monitor and evaluate the quality of care provided to residents. These included annual reviews, six monthly unannounced provider visits, hygiene audits and medication management audits. These audits identified areas for improvement and developed action plans to address these areas.

The person in charge maintained planned and actual staffing rosters for the centre. From a review of a sample of rosters, the inspector noted there were a sufficient number of staff in place to meet the assessed needs of residents. At the time of the inspection, the centre was operating with one whole-time-equivalent vacancy. The provider was in the process of recruitment to fill this vacancy. In addition, due to planned leave, it was observed that there was some reliance on relief and agency in the previous months. However, the provider ensured continuity of care through covering shifts with familiar staff and the use of a small number of regular relief and agency staff.

There were systems in place for training and development of the staff team. From a review of the training records, the inspector found that for the most part, all of the staff team had up-to-date mandatory training. Some members of the staff team were on planned leave at the time of refresher training. However, there was evidence that refresher training had been scheduled to ensure all of the staff team had up-to-date training.

The inspector reviewed a sample of incidents and accidents and found that they were notified as appropriate to the Office of the Chief Inspector of Social Services as required by the Regulation 31.

The provider maintained a statement of purpose dated September 2019 which contained all of the information as required by Schedule 1 of the regulations.

Regulation 14: Persons in charge

The designated centre was managed by a person in charge who was employed on a full-time basis, suitably qualified and experienced. The person in charge demonstrated good knowledge of the residents and their support needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained planned and actual staffing rosters for the centre. There was a sufficient number of staff in place to meet the assessed needs of residents. At the time of the inspection, the centre was operating with one whole time equivalent vacancy.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for training and development of the staff team. For the most part, all of the staff team had up-to-date mandatory training and refresher training had been scheduled for members of the staff team which were on planned leave.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined management structure in place. Quality assurance audits were in place to monitor and evaluate the quality of care provided to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose dated September 2019 contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and accidents were notified as appropriate to the Office of the Chief Inspector for Social Services as per the matters of Regulation 31.

Judgment: Compliant

Quality and safety

The inspector found that there were systems in place to ensure that residents received a safe, quality and person-centred service. However, improvements were required in personal plans, premises, fire containment and risk management.

The inspector and the person in charge completed a walk-through of the centre. The centre was decorated in a homely manner. The residents rooms were decorated in line with their individual tastes. The centre consisted of an entrance hallway, six resident bedrooms, one staff sleep over room which contains an en-suite and also acts as a staff office, two sitting rooms, a kitchen and dining space, a large bathroom, and a smaller shower room with toilet facilities. However, there was some areas of improvement in relation to a shower room and painting in some areas of the centre. This had also been identified by the provider through their quality audit systems. The inspector was informed that approval was granted

to upgrade the shower room and painting would begin after the shower room works were completed.

There was an up-to-date assessment of need completed for each resident. The assessment of need identified residents' health and social care needs and informed residents' personal support plans. However, some personal plans required review to take into account changes in circumstances and new developments in order to suitably guide staff team in supporting residents with their identified needs. For example, several personal plans, for one resident, referred to PRN (as required) medication which had been recently discontinued. It is noted, those plans were updated during the course of the inspection. In addition, while there was evidence that residents were engaged in activities they enjoyed and were planning events such as birthday parties and concerts. However, there were no identified goals in place for 2019 in some personal plans reviewed. This was not in line with the provider's personal planning process.

Residents were supported to enjoy their best possible health. Residents' assessment of need identified health-care needs and health-care plans which clearly guided staff in supporting residents to manage their health. There was evidence of regular access to General Practitioners and allied health professionals as required.

There were positive behaviour support plans in place for residents who required some support to manage their behaviours. The inspector reviewed a sample of behaviour support plans and found that they were up-to-date and contained comprehensive information to guide the staff team. Residents had access to allied professionals such as psychiatry and psychology as required. The centre promoted a restraint-free environment and at the time of the inspection no restrictive practices were in use in the centre.

There were systems in place to safeguard residents. The inspector reviewed of a sample of incidents and found that they were appropriately reviewed and responded to. Staff spoken with were clear in what constituted abuse and what to do in the event of an allegation or concern. The inspector observed that residents appeared content and relaxed in their home.

There were effective risk managements systems in place to identify, assess, manage and review risk in the designated centre. The centre maintained a local risk register which outlined measures in place to control identified risks including recent staff shortages, manual handling and changing needs of residents. In addition, individual risk assessments were also in place in relation to management of behaviours that challenge and absconding. However, some risk assessments were not reviewed in a timely manner to ensure that they accurately guided staff on the to mitigate the risk. For example, some individual risks were dated March and April 2018 and had not been reviewed. These particular risk assessments were updated by the person in charge during the course of the inspection.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a Personal

Emergency Evacuation Plan (PEEP) in place which outlined the supports for each resident to evacuate the designated centre.

However, some improvement was required to demonstrate that all persons could be evacuated in the case of a fire. Centre records demonstrated that one day-time fire evacuation drill had been completed in 2019. Two fire evacuation drills, one day-time and one simulated night-time drill, had been completed in 2018. It was noted the simulated night-time fire evacuation drill was completed due to the changing needs of a previous resident and was overseen by the provider's fire prevention officer, to ensure best fire safety procedures were practiced. The simulated night time drill had not included residents as active participants due to the risk of injury to residents and staff. The inspector was also informed that a night time fire drill was scheduled to take place before the end of 2019.

From a review of records however, it was not clearly demonstrable that all persons could be evacuated in the case of a fire and while simulated drills had occurred, further assurances were required in this regard. Some improvements were also required to ensure adequate fire containment measures were in place. The provider's fire prevention officer outlined to the inspector, in writing, that the provider had plans in place to address this issue.

There were suitable practices in place in relation to the ordering, storage, administration and disposal of medicines. Medication was found to be stored in a secure locked press. A sample of prescription and administration sheets were viewed and found to contain appropriate. information. The last inspection identified that capacity assessments and risk assessments had not been completed for residents to self administer medication. There was evidence that the provider consulted each resident in relation to self administering medication and they expressed the preference for the staff team to continue to provide support in the administration of medication.

Regulation 17: Premises

The centre was decorated in a homely manner. The residents rooms were decorated in line with their individual tastes. However, there was some areas of improvement in relation to general upkeep of a bathroom and painting in some areas of the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were effective risk managements systems in place to identify, assess, manage and review risk in the designated centre. The centre maintained a local risk register

and individual risk assessments which outlined measures in place to control identified risks. However, some risk assessments were not reviewed in a timely manner to ensure that they accurately guided staff on the to mitigate the risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required.

Centre records demonstrated that fire drills had been completed.
However, improvement was required to ensure that there were adequate measures in place for the containment of fire and in demonstrating that all persons could be evacuated in the case of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable practices in place in relation to the ordering, storage, administration and disposal of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need completed for each resident. The assessment of need identified residents' health and social care needs and informed residents' personal support plans. However, some personal plan documents required review to suitably guide staff team in supporting residents with their identified needs.

Judgment: Substantially compliant

Regulation 6: Health care

Health care plans clearly guided staff in supporting residents manage their identified health care needs. There was evidence of regular access to General Practitioners and allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behavioural support plans in place for residents who required some support to manage their behaviours. The plans were up-to-date and guided the staff team. Residents had access to allied professionals such as psychiatry and psychology as required. At the time of the inspection no restrictive practices were in use in the centre.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Kilbarrack OSV-0002358

Inspection ID: MON-0026365

Date of inspection: 04/09/2019

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: In response to the area of non-compliance found under regulation17(1)(b) Work has been scoped out and approved for the upgrade of the bathroom facilities. The designated centre will be painted once this work is completed.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: In response to the area of non-compliance found under regulation26(2) The PIC has reviewed and updated all risk assessments	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: In response to the area of non-compliance found under regulation 28(3)(a) Free swing door closers to all doors that open onto a means of escape corridor will be	

installed in 2020.
In response to the area of non-compliance found under regulation 28(3)(d)

A daytime and night time fire drill has been completed in the designated centre.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
In response to the area of non-compliance found under regulation05(6)(d)

Personal plans have been updated to reflect changes in circumstances

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/08/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	05/09/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Substantially Compliant	Yellow	31/12/2020

	extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	19/09/2019
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.	Substantially Compliant	Yellow	05/09/2019