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:	Glenanaar
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	05 July 2023
Centre ID:	OSV-0002380
Fieldwork ID:	MON-0036707

About the designated centre

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

Glenanaar is a designated centre operated by St. Michael's House located within a campus setting in North County Dublin. It is a residential home for six adults with an intellectual disability and additional needs which require nursing care. The centre is a bungalow which consists of a kitchen, dining room, sitting room, staff office, staff sleepover room, sensory room, shared bathroom and shower room and six individual bedrooms for the residents. The centre is located close to local shops and transport links. The centre is staffed by a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff.

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
Wednesday 5 July 2023	10:30hrs to 18:00hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor ongoing regulatory compliance in the designated centre. The inspector used observations, in addition to a review of documentation, and conversations with staff to form judgements on the residents' quality of life.

The centre consisted of one residential bungalow situated on a congregated campus setting in North Dublin. The designated centre has a registered capacity for six residents, at the time of the inspection there was no vacancies.

The person in charge was on leave at the time of the inspection but a staff member was present to facilitate the inspection. The service manager was contacted and made themselves available later in the day.

Overall, the centre was found to be clean, bright, homely, nicely furnished, and the lay out was appropriate to the needs of residents living there.

There was a large living area and a separate dining area which was connected to a modest sized kitchen. The house benefited from the use of domestic staff including a cook. This arrangement was Monday to Friday and staff took over cooking duties at the weekend with night duty assigned general cleaning duties as per cleaning schedule.

The sitting room had an activity board with pictures to support residents routine management. The couches in the sitting room were tired and worn looking and starting to fray in parts.

The centre had a large garden with garden furniture covered with a parasol so residents could sit outside.

There were three bathrooms with bathing facilities (one of which was en-suite). The premises had the necessary equipment, such as ceiling hoists, to support residents to receive safe care and to access all areas of their home.

Each resident had their own bedroom. All the bedrooms were personalised to the resident's tastes with art-work, photos of family and of residents attending events and activities on display.

The utility room was appropriately fitted out with a washing machine and dryer and a small sink. Staff were aware of correct procedures for laundry management and there was further guidance on the wall.

The wall in the hall had the house floor plans clearly displayed alongside the centre's fire evacuation plan. The hall also had the centre's safeguarding statement, residents' guide, visitors policy, complaints procedure and residents paintings,

artwork and photos on display.

The centre had a sensory room which staff informed the inspector that some residents actively used the space and it had been identified as part of one of their goals.

The inspector spoke with the service manager, a nurse and a social care worker on duty on the day of inspection. They all spoke about the residents warmly and respectfully, and demonstrated a rich understanding of the residents' assessed needs and personalities and demonstrated a commitment to ensuring a safe service for them.

Residents were observed receiving a good quality person-centred service that was meeting their needs. The inspector observed residents coming and going from their home during the day. Staff were observed to interact warmly with residents. They were observed to interact with residents in a manner which supported their assessed communication and behaviour support needs.

The inspector met with three of the residents who lived in the centre. One resident proudly showed their newly decorated bedroom off and talked to the inspector about what they liked to watch on TV. Some of the residents were unable to provide verbal feedback about the service, therefore the inspector carried out observations of residents' daily routines and of their home and support arrangements. On observing residents interacting and engaging with staff, it was obvious that staff could interpret what was being communicated to them by the residents. During conversations between the inspector and residents, staff members supported the conversations by communicating some of the non-verbal cues presented by the residents. For example, a resident, who was in the living area of the premises took the inspector by the hand and started to walk through the centre. Staff accompanied the resident on the walk and supported them in their interactions with the inspector.

The provider's most recent annual review of the centre had consulted with residents and their representatives. It reported that families were extremely happy with the support that residents received, with one family member commenting that they are always made to feel welcome. Both staff and family members felt that central transport to day services was an ongoing issue that impacted on the provision of activities for the residents. Residents views were obtained by staff through key-working, personal plans and house meetings to ensure their voices were heard. The consensus from the review showed that residents were generally comfortable living here and welcomed the return of day services but would like to engage in more activities in the community like going on holiday or day trips.

In summary, the inspector found that the residents enjoyed living in the centre and had a good rapport with staff. The residents' overall wellbeing and welfare was provided to a reasonably good standard. However, the premises required some upgrading in particular the bathrooms.

The next two sections of this report will 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 care in the centre.

Capacity and capability

The purpose of this inspection was to monitor levels of compliance with the regulations. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The registered provider had implemented governance and management systems to ensure that the service provided to residents was safe, consistent, and appropriate to their needs and therefore, demonstrated, they had the capacity and capability to provide a good quality service. The centre had a clearly defined management structure, which identified lines of authority and accountability.

There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage the service.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents including annual reviews and six-monthly reports, plus a suite of audits had been carried out in the centre.

There was a planned and actual roster maintained for the designated centre. Rotas were clear and showed the full name of each staff member, their role and their shift allocation. However staff vacancies were impacting on the consistency of care provided to residents.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge provided support and formal supervision to staff working in the centre.

The inspector spoke with staff members on duty throughout the course of the inspection. The staff members were knowledgeable on the needs of each resident, and supported their communication styles in a respectful manner.

An up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

The person in charge had submitted all required notifications of incidents to the Chief Inspector of Social Services within the expected time frame.

The provider had a complaints policy and associated procedures in place as required by the regulations. The inspector reviewed how complaints were managed in the

centre and noted there were up-to-date logs maintained.

Overall, the inspector found that the centre was well governed and that there were systems in place to ensure that risks pertaining to the designated centre were identified and progressed in a timely manner.

Regulation 14: Persons in charge

The designated centre was managed by a suitably qualified and experienced person in charge. The person in charge was full-time and had oversight solely of this designated centre.

There were suitable arrangements for the oversight and operational management of the designated centre at times when the person in charge was or off-duty or absent.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual roster maintained for the designated centre. A review of the rosters found that staffing levels on a day-to-day basis were generally in line with the statement of purpose. The centre had three staff vacancies at the time of inspection. These vacancies were filled by a panel of regular relief and agency staff. However, there was a lack of consistency regarding the recruitment and retention of the same familiar agency staff. Furthermore, the inspector was informed that the staff vacancies were impacting on the ability of staff to fully implement some of the residents' care plans. For example, required one-to-one staffing for some residents at times meant a reduction in outings in the community for other residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. All staff have completed mandatory training including refreshers when required. The person in charge had highlighted training programmes for all staff including relief to attend to ensure the staff team were up to date and informed in their day to day practice.

The inspector found that staff were receiving regular supervision as appropriate to

their role. Supervision records reviewed were in line with organisation policy, with a provision for staff to request early supervision if they have any concerns arising.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance structure which identified the lines of authority and accountability within the centre and ensured the delivery of good quality care and support that was routinely monitored and evaluated.

There was suitable local oversight and the centre was sufficiently resourced to meet the needs of all residents.

The provider had a Quality Enhancement Plan in place, with local audits, risk assessments and training to guide staff practice and development.

The designated centre had a clear action plan and audits carried out in the centre were up to date, with actions identified progressed in a timely manner. Audits carried out included six-monthly unannounced visit reports, an annual review of the quality and safety of the service, and audits on risk management, fire safety, infection prevention and control (IPC), finance, and medication.

Judgment: Compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place which met the requirements of Schedule 1, and clearly set out the services provided in the centre and the governance and staffing arrangements.

A copy of the statement of purpose was readily available to the inspector on the day of inspection. It was also available to residents and their representatives with an easy-to-read version displayed in the hall.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifiable incidents, as detailed under Schedule 4 of the regulations, were notified to

the Chief Inspector of Social Services within the required time frame.

The inspector reviewed a sample of incident logs during the course of the inspection, and found that they corresponded to the notifications received by the Chief Inspector

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy in place. There was an up-to-date complaints log and procedure available in the centre. This was in easy-to-read format, with a visual guide on the stages of the complaints process.

The inspector reviewed a sample of these logs and found that complaints were being responded to and managed locally.

The person in charge was aware of all complaints and they were followed up and resolved in a timely manner.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents who lived in the designated centre. The inspector found that the governance and management systems had ensured that care and support was delivered to residents in a safe manner and that the service was consistently and effectively monitored.

The premises was found to be designed and laid out in a manner which met residents' needs. There was adequate private and communal spaces and residents had their own bedrooms, which were being decorated in line with their tastes. However, improvements were required particularly to the bathrooms in relation to the infection precautions and control, to ensure that the service was safe and of a good quality.

There were fire safety systems and procedures in place throughout the centre. There were fire doors to support the containment of smoke or fire. There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting provided. The fire panel was addressable and there was guidance displayed beside it on the different fire zones in the centre.

Positive behaviour support plans were developed for residents where required. The plans were up to date and readily available for staff to follow. Staff had also completed training in positive behaviour support to support them in responding to behaviours of concern.

The inspector reviewed several of the residents' files. It was found that residents had an up-to-date and comprehensive assessment of need on file. Care plans were derived from these assessments of need. Care plans were comprehensive and were written in person-centred language. The inspector saw that residents had access to health care in line with their assessed needs. Residents' needs were assessed on an ongoing basis and there were measures in place to ensure that their needs were identified and adequately met. Support plans included communication needs, social and emotional well being, safety, health and rights.

There were comprehensive communication plans in place that gave clear guidance and set out how each person communicated their needs and preferences.

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 feeding, eating and drinking support needs had been well assessed. There were plans in place to guide staff in supporting residents in this area.

The registered provider had safeguarding policies and procedures in place including guidance to ensure all residents were protected and safeguarded from all forms of abuse.

Overall, the inspector found that the day-to-day practice within this centre ensured that residents were receiving a safe and quality service.

Regulation 10: Communication

The inspector saw that residents in this designated centre were supported to communicate in line with their assessed needs and wishes. Some residents' had communication care plans in place which detailed that they required additional support to communicate. The inspector saw that staff had received training in communication and were familiar with residents' communication needs and care plans.

The inspector saw that visual supports required by residents were readily available in the designated centre. Folders containing pictures to support residents to understand and make decisions in areas such as menu planning were available to all residents.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises was homely and suitable to meet the assessed needs of residents. There was adequate private and communal accommodation for the residents, including a sitting room and a kitchen/dining area and spacious garden area.

However, some repair works and improvements were required:

- The keypad on the kitchen door was broken and awaiting repair, and a hole in the counter top in kitchen was waiting to be fixed.
- In one of the shower rooms, storage presses were chipped and damaged, the inspector was informed that these presses were not in use for the last six weeks and residents' toiletries were being stored in their bedrooms instead. A weighing scales stored in the shower room was discoloured and rusting and it was not clear if it was in use. Grout on the tiles needed cleaning and the handrail was dirty with grime, a few cracked tiles were also observed. The drain hole of the shower hole was rusty. A wood panel on the wall was chipped and was beginning to show signs of mould. The second shower room was clean however there was yellow staining on the floor.
- Parts of enclosed garden space path/patio was uneven.
- Walls throughout out the premises were scuffed from general wear and tear and required painting.
- One bedroom was particularly small and staff said it causes difficulty using equipment such as a hoist for the resident.
- The skirting and sink in one bedroom was chipped and cracked.

These issues had been already been identified prior to the inspection through the provider's own audits and notified to the provider's maintenance department, and had been prioritised on the provider's wait list.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' nutritional needs were considered in meal planning and meals were prepared and served in accordance with residents' assessed feeding, eating and drinking support plans.

The designated centre had its own cook Monday to Friday and at weekends staff on duty provided meals for the residents. The kitchen was well equipped and had guidance on daily food duties, temperature checks and transportation of food and a food safety folder.

There was guidance for each resident regarding their meal-time requirements

including food consistency, cutlery and plates used, and each residents' likes and dislikes.

All residents had assessed needs in the area of feeding, eating, drinking and swallowing (FEDS). Residents had up-to-date FEDS care plans on file. Staff spoken with were knowledgeable regarding these. The inspector observed staff preparing food and drinks which were in line with residents' FEDS care plans.

In line with residents care plans, some residents were referred for a dietetic assessment and guidance around specific conditions and how to eat well to support their specific healthcare needs.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety systems including fire detection, containment and fighting equipment.

There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting arrangements.

The fire panel was addressable and there was guidance displayed beside it on the different fire zones in the centre.

The exit doors were easily opened to aid a prompt evacuation, and the fire doors closed properly when the fire alarm activated.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were suitable care and support arrangements in place to meet residents' assessed needs.

A sample of residents' files were reviewed and it was found that comprehensive assessments of need and support plans were in place for these residents.

Easy-to-read documents were included for each resident's assessment of need and they were consulted in all goal setting.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured, where residents required positive behaviour support, appropriate and comprehensive arrangements were in place. Clearly documented de-escalation strategies were incorporated as part of residents' behaviour support planning. All staff had completed positive behaviour support training.

Restrictive practices were regularly reviewed with clinical guidance and risk assessed to use the least restrictive option possible.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented measures and systems to protect residents from abuse. There was a policy on the safeguarding of residents that outlined the governance arrangements and procedures for responding to safeguarding concerns.

Each resident had an interim safeguarding plan.

Staff spoken to on the day of inspection reported they had no current safeguarding concerns and training in safeguarding vulnerable adults had been completed by all staff.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially 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
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glenanaar OSV-0002380

Inspection ID: MON-0036707

Date of inspection: 05/07/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Relief/agency staff will be block booked to cover gaps in the roster caused by parental leave and haddington road hours. • Roster review scheduled with Admin manager, HR Business Partner, PIC and Service Manager for 07/09/2023.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Request has been sent to SMH TSD to organize repair of the keypad on the kitchen door. • Old weighing scales in the bathroom has been discarded. • Grout on the tiles in the bathroom have been cleaned and will be added to the centre's cleaning schedule. • Handrail in the bathroom was cleaned and has been added to the centre's cleaning schedule. • Request for the wood panel on the wall of the bathroom to be replaced has been sent to SMH TSD. • TSD will get 3 quotes for the bathroom flooring. PIC will complete a capex to apply for funding. • TSD will get 3 quotes to have the house painted. PIC will complete capex to apply for funding. • TSD will get 3 quotes to replace the skirting and sink in one bedroom. PIC will complete capex to apply for funding. • One residents bedroom is quite small. As such a few options are being considered and priced (where needed) to establish the best solution for the resident, staff and those living in the house. • The bathroom storage and cracked tiles have been escalated to SMH housing association and have been scheduled for action in the first quarter of 2024.	

• TSD will get 3 quotes to replace the kitchen counter top. PIC will complete Capex to apply for funding.

• Request has been sent to TSD to replace the drain hole in the shower room.
• In relation to the uneven patio Technical Service Department manager has been contacted and advised the area needs to be fully assessed to determine the works required. Once reviewed and agreed, quotes/ funding will be sought for the works to be carried out as per Estates Procedural process.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/10/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/03/2024

	are of sound construction and kept in a good state of repair externally and internally.			