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:	Grattan Lodge
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	18 November 2019
Centre ID:	OSV-0003599
Fieldwork ID:	MON-0024536

About the designated centre

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

Grattan Lodge is a designated centre operated by St. Michael's House. It is a community based home with the capacity to provide full-time residential care and support to six adults both male and female. It is currently home for six residents with varying degrees of intellectual and physical disabilities. Residents in the centre are supported with positive behaviour support needs, augmentative communication needs, emotional support needs, specialised diet and nutritional needs, and physical and intimate care support needs. The house is situated on a quiet cul de sac with a large green area opposite the house. It is located in a suburban area of Co. Dublin with access to a variety of local amenities such as a local shopping centre, cinema, bowling alley, dart station, bus routes, and churches. The centre has a vehicle to enable residents to access day services, local amenities and leisure facilities in the surrounding areas. The centre consists of a large two-storey house with seven bedrooms and an accessible front and back garden. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, social care workers, and a care assistant.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
18 November 2019	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

As part of the inspection, the inspector met with four of the six residents living in the centre. These residents told the inspector that they enjoyed living in the centre and spending time with the other residents and staff members. Three of the residents showed the inspector their bedrooms which had been personalised to their own individual tastes. One of the residents played the key board and was an avid music fan. The inspector observed warm interactions between the residents and staff caring for them. Two of the residents were wheelchair users and had their bedrooms on the ground floor which was fully accessible for them.

There was evidence that residents and their family representatives were consulted with and communicated with about decisions regarding their care and the running of their house. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspector did not have an opportunity to meet with the relatives of any of the residents to attain their views of the quality and safety of care provided. However, it was reported by staff, that residents' family representatives were generally happy with the care their loved ones received in the centre.

Capacity and capability

There were management systems in place to promote the service provided to be safe, consistent and appropriate to the residents' needs. However, some improvements were required in relation to staffing arrangements and staff supervision systems.

The centre was managed by a suitably qualified, skilled and experienced person who had an in-depth knowledge of the needs of each of the residents. The person in charge was in a full-time position and was not responsible for any other centre. The person in charge held a certificate in management and a degree in applied social studies. She had been working with the provider for more than 18 years and had more than eight years management experience. She was found to have a sound knowledge of the requirements of the regulations and standards. Staff members spoken with told the inspector that the person in charge supported them in their role and encouraged a culture of openness where the views of all involved in the service were sought and taken into consideration.

There was a clearly defined management structure in place that identified lines of accountability and responsibility which ensured staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the service manager who in turn reported to the director of adult services. There

was evidence that the service manager visited the centre at regular intervals. This demonstrated clear lines of reporting and accountability systems for the operational management of the centre.

An annual review of the quality and safety of care and unannounced visits on a six-monthly basis to assess the quality and safety of the service had been completed. There was evidence that actions were taken to address issues identified on these visits. A limited number of other audits had been undertaken and included finance, hygiene, medication and health and safety. A quality enhancement action plan was in place and included actions from various audits and actions proposed to address same. The person in charge completed quality and governance data reports at regular intervals which were submitted to senior management. These reports included data on matters such as incidents, complaints and other operational issues.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. However, the full complement of staff was not in place at the time of inspection, with one whole time equivalent staff vacancy and one other staff member who was on extended leave. A number of relief, and on occasions agency staff, covered these vacancies and also staff leave. This provided some consistency of care for the residents living in the centre.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. However, there were a small number of staff overdue to attend positive behaviour support training and one staff member was due to attend fire safety training.There was a staff training and development policy, dated May 2019. A training programme was in place which was coordinated by the provider's training department. Training records available on the day of inspection indicated that the majority of staff had attended mandatory training requirements. There were no volunteers working in the centre at the time of inspection.

Staff supervision arrangements were in place. However, of a sample of three staff supervision records reviewed, it was identified that supervision for the three members of staff had not been undertaken in more than eight months which was not in line with the frequency proposed in the providers policy. This meant that some staff may not have been appropriately supported to perform their duties to the best of their abilities.

A directory of residents was maintained in the centre and found to contain all of the information required by the Regulations.

There were systems in place for the recording and management of all incidents. However, the inspector identified that there had been an incident in the preceding period which had not been notified to the Chief Inspector of Social Services as per the requirements of the regulations.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff team were considered to have the required skills and competencies to meet the needs of the residents living in the centre. However, the full staff complement was not in place at the time of inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, there were a small number of staff overdue to attend positive behaviour support training and one staff member was due to attend fire safety training. Staff supervision arrangements were in place. However, of a sample of three staff supervision records reviewed, it was identified that supervision for the three members of staff had not been undertaken in more than eight months which was not in line with the frequency proposed in the providers policy.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was in place and found to contain all of the information required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Regulation 31: Notification of incidents

There were systems in place for the recording and management of all incidents. However, the inspector identified that there had been an incident in the preceding period which had not been notified to the chief inspector as per the requirements of the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, the residents living in the centre received care and support which was of a good quality and person centred. However, some improvements were required in relation to fire safety, medication management and the premises.

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Care plans and personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal, communication and social needs and choices. Each of the personal plans had been reviewed with the involvement of the resident's multidisciplinary team, the resident and family representatives within the last year. A number of the residents had goals set for the year ahead which were focused on skills teaching for aspects of their daily lives and safeguarding regarding social media usage.

A number of the residents were independent and required minimal support from staff. Five out of the six residents attended a formal day service and or work placement. The sixth resident was not engaged in a formal day service and an individualised programme, was established and coordinated by staff for this resident within the centre. Residents were each supported to engage in meaningful activities in the centre and within their local community. Activities residents enjoyed included, beauty treatments in a nearby beauticians, massage, cinema, shopping, overnight hotel stays and day trips, shows and meals out. One of the residents was involved with the special Olympics for running whilst another two residents were members of a local social club. One of the residents was a choir member within the local community. All six of the residents were due to go for a day trip together to Galway on the week of the inspection. A number of the residents told the inspector that they were looking forward to the trip.

The centre was found to be accessible, comfortable and homely. However, chipped paint was observed on walls and woodwork in the hallway and a number of rooms.

Each of the residents had their own bedroom which had been personalised to their tastes and choices. This promoted residents' independence, dignity and recognised their individuality and personal preferences. There was only one sitting room and a separate kitchen come dining room area in the centre. This meant that residents might not always be able to entertain visitors in private but the provider had identified an area for development into a visitors room. Works had not yet started on same.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified. A risk register was in place and maintained as a contemporaneous document.

Overall, suitable arrangements were found to be in place for the management of fire. However, the provider had identified a number of fire containment measures which were required. These included fire detection equipment in the laundry area which was located in a separate building the the rear of the centre. There was documentary evidence that the fire alarm system and fire fighting equipment was serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. However, the fire alarm system was overdue for a service at the time of inspection. A fire risk assessment had been completed. There was a fire safety management policy, dated March 2019. There were adequate means of escape and a fire assembly point was identified in an area to the front of the centre. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training.

There were safeguarding measures in place to protect residents from suffering from abuse and residents were provided with appropriate emotional and behavioural support. Overall there were low levels of behaviour that challenges presented in the centre. Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual resident. There was evidence that plans in place were regularly reviewed by the provider's psychologist. Safeguarding plans were also in place.

There were systems in place to ensure the safe management and administration of medications. However, assessments had not been completed for all residents to determine if individual residents had the ability to self manage and administer their own medications as required by the regulations. Otherwise, the processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. A medication management policy was in place. There was a secure cupboard for the storage of all medicines. All staff had received appropriate training in the safe administration of medications. Individual medication management plans were in place. There were systems in place to review and monitor safe medication management practices which included medication audits and counts.

Regulation 17: Premises

The centre was found to be accessible, comfortable and homely. However, chipped paint was observed on walls and woodwork in the hallway and a number of rooms.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, suitable arrangements were found to be in place for the management of fire. However, the provider had identified a number of fire containment measures which were required. These included fire detection equipment in the laundry area which was located in a separate building the the rear of the centre. The fire alarm system was overdue for a service at the time of inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications. However, assessments had not been completed for some residents to determine if individual residents had the ability to self manage and administer their own medications as required by the regulations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate behavioural and emotional support.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Grattan Lodge OSV-0003599

Inspection ID: MON-0024536

Date of inspection: 18/11/2019

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Organization has in place a procedure to ensure that the recruitment of staff is appropriate to the number and assessed needs of the residents in the designated centre. • The PIC ensures that the monthly staff roster is in place, and reflects the needs of the residents. In response to the area of non-compliance found under regulation 15(1); • At present there is an ongoing recruitment campaign in the Organization. The Service Provider continues to whenever practicable; employ familiar relief staff to provide as much continuity for residents as possible. • One new full time staff member will commence in the Designated Centre in January 2020	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff in St Michael House have access to appropriate training, relevant to their position. In response to the area of non-compliance found under regulation 16; • Completion of Positive Behavior Support training has been scheduled for February 2020 • Fire Safety training has been scheduled for February 2020 • Supervision has been completed for all staff and scheduled supervision dates are in	

place for 2020	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: In response to the area of non-compliance found under regulation 31(1)(g) ; • All notifications will be forwarded to the chief inspector in the allocated time frame.	
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 regulation 17 (1)(b); • Painting/ touch up of areas to be completed throughout the centre.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The organization will ensure that effective fire safety management systems are in place to provide adequate precautions against the risk of fire in the Designated Centre. In response to the area of non-compliance found under regulation 28(3)(a); • Additional fire containment measures that are required in the designated centre form part of the SMH Fire Safety Plan for 2019 and will be completed in order of priority in quarter 4 2020. • Fire Alarm was serviced on the 06/11/19	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: In response to the area of non-compliance found under regulation 29(5); • Assessment completed for all residents to determine if each individual had the ability to administer their own medication	

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	31/01/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	29/02/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2020

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	30/04/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	30/11/2019
Regulation 31(1)(g)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the	Substantially Compliant	Yellow	19/11/2019

	registered provider or by staff.			