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:	Ardmore
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Short Notice Announced
Date of inspection:	24 September 2020
Centre ID:	OSV-0002353
Fieldwork ID:	MON-0025024

About the designated centre

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

Ardmore is a residential centre which is located in a North County Dublin suburb. The centre is operated by St. Michaels' House and caters for the needs of six male and female adults over the age of 18 years, who have an intellectual disability. The centre comprises one two-storey detached house which offers each resident their own bedroom, shared bathroom facilities, sitting rooms, a kitchen and dining area, utility and garden area. The centre is located close to public transport, shops and amenities. The centre is staffed with a team of social care workers and is managed by a person in charge who in turn reports to a senior manager.

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
Thursday 24 September 2020	09:40hrs to 15:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector met with all six residents living in the designated centre.

In line with infection prevention and control guidelines, the inspector carried out the inspection mostly from one space in the house. The inspector also ensured physical distancing measures and use of personal protective equipment (PPE) was implemented during interactions with all residents and staff and during the course of the inspection.

Residents were keen to talk to the inspector and tell them about their home and the support they received. Overall, residents spoken with expressed they were unhappy with their current living situation. They told the inspector that there was an ongoing incompatibility issue amongst the residents living in the centre, which they were very unhappy about.

They told the inspector that they experienced fear and anxiety on a regular basis in the home. For example, they described some instances where they observed and witnessed incidents of behaviours that challenge exhibited in the house and this made them frightened. Residents described feeling pains in the head, chest and tummy on a regular basis indicating this was how they experienced stress or anxiety. For example, one resident described having a pain in their tummy when they felt nervous.

Residents told the inspector that they were also very unhappy and annoyed with having to leave their home sometimes or having to go to their bedroom for their safety when incidents of behaviours that challenge occurred in the centre. They also described incidents where their personal belongings had been moved or taken from their bedrooms and had logged some complaints in relation to this. They told the inspector they did not know if their complaints were being listened to as the situation was going on a long time.

The inspector also spoke with one family member of a resident and they expressed their concern with regards to the ongoing situation and indicated they wished for all residents in the centre to have their needs met. They also indicated they had raised their concerns to the provider some time back.

During the course of the inspection, the inspector observed staff engage with all residents in a kind and supportive way. Residents told the inspector that staff were good to them and they liked them. They told the inspector that staff worked hard and helped them when they needed support.

Capacity and capability

On this inspection it was not demonstrated the provider had the capacity or capability to provide a good quality service to meet the assessed needs of all residents.

Improvements were required in relation to an incompatibility issue among residents, which in turn had become a safeguarding issue. This had been going on for some time. While it was demonstrated meetings and discussions had occurred in relation to the issue, the lived experience of most residents in the centre was not of a good standard and residents expressed dissatisfaction and concern in relation to their current living environment to the inspector.

It was not demonstrated that complaints were being managed in line with the provider's own complaints process. Staffing resources in the centre required some improvement and six-monthly audits carried out in the centre, on behalf of the provider, did not identify the ongoing safeguarding issue in the audit or identify that some notifications had not been submitted to the Office of the Chief Inspector for a considerable period of time.

As a result of poor compliance findings on this inspection and concerns of a safeguarding nature relayed to the inspector, the provider was required to attend a cautionary meeting with the Office of the Chief Inspector the day after the inspection. At the meeting the provider was informed of the Chief Inspector's concerns regarding the findings of the inspection and required the provider to address non-compliances found on inspection in a timely manner with a time-bound improvement plan for the service required by the Chief Inspector in addition to the compliance plan response for the inspection report. The provider was also required to undertake a look back review of their complaints and notifications, for the centre, to ensure all notifications relating to safeguarding were completed and followed through in line with local and National policy.

Some aspects of the implementation of the provider's complaints policy required improvement. The inspector reviewed a sample of logged complaints made by residents. While these complaints had been logged and a record of them maintained in the centre, it was not clear if they had been responded to in line with the provider's complaints management policy. For example, complaints logged in the centre had not been acknowledged or reviewed by the provider's complaints officer where those complaints could not be addressed at a local level.

In addition, it was not demonstrated the complaints had been addressed or brought to a conclusion to the satisfaction of the person making the compliant. The inspector was informed some concerns had been logged by family members to the provider however, a record of these concerns were not maintained in the centre and therefore it was unclear in what way they had been responded to, for example, in line with the complaints procedure and policy.

The person in charge was required to improve matters in relation to the quarterly notification of incidents as required by the regulations. No quarterly notification had been submitted by the person in charge to the Office of the Chief Inspector, since July 2019 despite records in the centre demonstrating some residents received chemical restraint, as part of their reactive strategy behaviour support planning, on a number of occasions each month for the previous year, for example.

The inspector noted a number of meetings, in relation to the ongoing incompatibility issues in the centre, had occurred in 2020. The provider had made efforts to review possible alternative arrangements to provide residents with the service they required to meet their needs. However, these arrangements had not come to fruition at the time of inspection and therefore, while it was noted the provider was aware and actively trying to make suitable arrangements to meet the needs of residents, there had been no change to the lived experience of residents in the centre on foot of these meetings.

It was found the provider had ensured a six-monthly audit had been carried out for the centre during COVID-19 pandemic restrictions and a comprehensive annual report of the centre for 2019 had also been completed, which sought feedback from residents, staff and families as part of the review. The annual report of the centre for 2019 had identified residents were unhappy in the centre and had provided this feedback to the provider.

While it was acknowledged that the provider had met the requirements of the regulations in relation to implementing these quality assurances systems, improvements were required. On review of the six-monthly provider led audit, the audit had not identified some key areas which required improvement in the centre. For example, the audit indicated that there were no improvements required in relation to safeguarding and failed to identify the non-compliance in relation to quarterly notifications. Therefore, while an audit had been carried out on behalf of the provider, it did not identify for the provider, key areas that required improvement and as a result was not effectively driving quality improvement in the centre.

Staffing resources for the centre also required improvement. The centre was operating with a whole-time-equivalent (WTE) staffing shortfall of 2.5 WTE. The provider had made arrangements for 1.5 WTE re-deployed staff within the service to fill this staffing deficit. At the time of inspection, however, the centre required an additional 1 WTE staff. The provider was required to address this staffing resource issue.

Regulation 15: Staffing

The provider was required to address the staffing resource issues in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not addressed an ongoing incompatibility issue in the centre in such a way that impacted positively on the lived experiences of residents living in the centre.

A high level of non compliance was found on this inspection.

Some provider-led audits carried out in the centre, failed to identify key quality indicators that required improvement.

Judgment: Not compliant

Regulation 31: Notification of incidents

Quarterly notifications for this centre had not been submitted to the Office of the Chief Inspector since July 2019.

Judgment: Not compliant

Regulation 34: Complaints procedure

It was not demonstrated that where a complaint was logged in the centre it was reviewed and acted upon in line with the provider's complaints policy and procedures.

Judgment: Not compliant

Quality and safety

On this inspection it was not demonstrated that all residents were in receipt of a quality service that met their assessed needs and ensured they had the best possible lived experience in the centre.

Residents spoken with expressed their dissatisfaction with the service they were

receiving. Residents told the inspector they felt anxious and fearful and explained how this made them feel by describing pains in their head, chest and stomach. They told the inspector they were unhappy with an ongoing incompatibility issue in the centre which was impacting on their lives and the opportunities they had to feel relaxed and safe in their home.

They described having to sometimes be quiet and go to their bedrooms or to refrain from laughing or singing loudly in order to maintain a low arousal environment for some of their peers. They also informed the inspector that when they were in their bedrooms their privacy was sometimes impacted upon by others entering their bedroom and in some instances taking or moving their belongings. Residents also described feeling frustrated at having to leave the centre at times when they did not wish to, so as to reduce the noise levels in the house for others or to mitigate an incident of behaviours that challenge from occurring.

It was not demonstrated that all residents living in the centre had the freedom to exercise choice and control in his or her daily life. Residents' rights, privacy and control over their personal possessions were not upheld to an acceptable standard in the centre at all times.

The inspector reviewed the matters in relation to the provider's implementation of National Safeguarding Vulnerable Adults policies and procedures. While safeguarding plans were in place, they were not effective, as residents informed the inspector that they remained fearful and anxious in their home.

Staff informed the inspector that on foot of raising a recent allegation, made by a resident, where they said that they felt afraid and scared, they were told to document this as a complaint as this was deemed an organisational issue. On review of a sample of complaints recorded in the centre, it was not clear that these complaints, which were of a safeguarding nature, had been consistently responded to through a safeguarding framework and that safeguarding policies and procedures, in line with National Safeguarding policies, had been followed in response to them being made.

In summary, it was not demonstrated, in a documented way, that all reports or allegations of a safeguarding nature were reviewed and screened as required in line with National Safeguarding Policies and procedures. On foot of these findings, and in line with the Memorandum of Understanding between both offices, the Office of the Chief Inspector referred these matters to the National Disability Safeguarding Office, raising concerns in relation to the safeguarding matters expressed by residents to the inspector and the lack of evidence to demonstrate the consistent and effective implementation of National Safeguarding Vulnerable Adults policies and procedures in the centre.

While it was demonstrated positive behaviour support planning was in place for residents with identified assessed needs for behaviour support, it was not demonstrated these plans could be implemented in the centre in such a way that did not impact on other residents. For example, behaviour support assessments outlined the necessity for some residents to be afforded a low arousal, quiet environment

with minimal transitions.

The restrictions imposed by the recent COVID-19 pandemic had supported the implementation of these environmental accommodations for some residents and were found to be having a positive impact for them. It was noted the requirement for the administration of PRN (as required) medication to mitigate a behavioural incident, had reduced significantly during the recent restrictions. For example, in January 2020, prior to restrictions this medication had been administered over 30 times, while in September 2020 it had only been required two times. This demonstrated, for some residents, a low arousal environment, with reduced transitions and a different day activity model provision, was required to support their assessed behaviour support needs.

However, other residents living in the centre expressed their frustration with living in a low arousal environment and explained how it had negatively impacted on their lives. For example, residents told the inspector sometimes they had to be quiet, not play music, sing or laugh too loud in order to maintain a low arousal environment for others. Therefore, it was not demonstrated the provider could implement behaviour support planning requirements in this centre in a way that could ensure all residents had optimum lived experiences in their home. In addition, while the intensity and severity of behavioural incidents had reduced in recent times, there remained ongoing behavioural support needs in the centre which which continued to impact on residents. Behaviour support planning arrangements required improvement.

As referred to previously, some PRN (as required) medications formed part of residents' overall positive behaviour support planning and as a behaviour risk reduction strategy when all other de-escalation measures had failed. While it was demonstrated there were clear and informative criteria for it's administration, this restrictive measure had not been reviewed through the provider's human rights framework.

The inspector reviewed matters in relation to infection control management in the centre. The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required. The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in procedure relating to this. There was a folder with information on COVID-19 infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment was in good supply and hand washing facilities were available in the centre with a good supply of hand soap and alcohol hand gels available also. Each staff member and resident had their temperature checked daily as a further precaution. Residents were knowledgeable in how to implement public health guidance while in and outside of their home.

Regulation 27: Protection against infection

There was evidence of the implementation of Public Health Guidelines in relation to infection control management in this centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

It was not demonstrated the provider could implement environmental requirements, from a behaviour support perspective, to support one resident without negatively impacting on other residents that did not require this type of environment.

While the severity and intensity of behavioural incidents had reduced, there were still ongoing behavioural support needs occurring in the centre which impacted on residents.

While it was demonstrated there were clear and informative criteria for administration PRN (as required) medications for the purposes of behaviour management. This restrictive measure had not been reviewed through the provider's human rights framework.

Judgment: Not compliant

Regulation 8: Protection

Residents reported feeling afraid and anxious living in the centre.

It was not clearly demonstrated that National Safeguarding Policies and Procedures were implemented on foot of allegations, complaints and reports of a safeguarding nature.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' right to exercise freedom and choice in their daily lives was not upheld to an adequate standard.

Residents' right to have privacy and control over personal possessions were not upheld to an adequate standard.

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
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Protection against infection	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ardmore OSV-0002353

Inspection ID: MON-0025024

Date of inspection: 24/09/2020

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 WTE for this designated centre is filled with permanent staff. • Additional staff required for special project is 1.5 WTE – currently 1.66 WTE is in place and the remainder of shifts will be allocated to one relief staff member during Day Service closures. • Additional relief staff is in place to cover any gaps on the roster while still providing consistency.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A further 6 Monthly Review was completed on 6th October 2020. • Meeting with HSE CHO 09 to discuss compatibility issues within centre took place 29th September 2020. • DisMat submitted 28th December 2019 reviewed and all information re assessments completed forwarded again to Disability Manager on the 29th September 2020. • Forms have been completed and submitted to PAMG Committee to review possible restrictive practices. • A Look Back review of all NF06's took place with the Service Manager, Director of Adult Services, Designated Officer, Principal Social Worker and Head of Social Work on the following dates: 29th September 2020 & 2nd October 2020. • All identified required PSF's were completed and submitted to the HSE Community Safeguarding Team. • Meeting with HSE Community Safeguarding Team took place Wednesday 7th October.	

• A comprehensive tracker document to include details of all incidents will be completed and reviewed with the HSE Community Safeguarding Team on a monthly basis – the next scheduled meeting is the 13th November 2020. • SMH Complaints Policy pathway document in place and accessible version in place for residents.

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Referral made to the PAMG regarding restrictive practice. • All notifications will be submitted to the Authority as required.	

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Meeting with PIC, Service Manager, and Risk and Incident Officer took place on the 8th October 2020. • The Provider has identified a person to oversee complaints as per regulation 34 (3) (a). • Service Manager and PIC completed review of complaints for last 12 months. • All staff have been asked to refresh themselves of the complaints process by 28th October. • Complaints Tracker now in place to support the recording and action of complaints in the DC.	

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Residents have a PBS plan in place. • Psychology support in place to support staff and residents in implementing positive behaviour strategies.	

• Compatibility issues with resident group were discussed at the HSE CH09 IMR Meetings on the following dates: 25/10/2019, 9/12/2019, 24/1/2020, 19/2/2020, 13/5/2020, 15/9/2020 and the 13/10/2020. • Discussions with HSE CH09 to discuss additional support requirements took place on the 24th and 28th of September 2020. • Referral for alternative placement resubmitted to HSE on the 29th September 2020. • A detailed Time Bound Plan was submitted to the Authority on the 9th October 2020.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • A Look Back review of all NF06s took place with the Service Manager, Director of Adult Services, Designated Officer, Principal Social Worker and Head of Social Work on the following dates: 29/9/2020 & 2/10/2020. • All identified required PSF's were completed and submitted to the HSE Safeguarding Team. • Meeting with HSE Safeguarding Team took place on Wednesday 7th October. • The HSE Formal Safeguarding Plans for five residents will be completed by 6/11/2020 • Proportional Review Process will be implemented in line with HSE Community Safeguarding Meeting actions - a comprehensive tracker document to include details of all incidents will be completed and reviewed with the HSE Community Safeguarding Team on a monthly basis.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The Designated Officer and the Servicer Manager met with each resident, observing all relevant Covid 19 safety measures, on Tuesday 13th October 2020 and discussed their safeguarding plans. • Service Manager emailed SMH Advocacy Officer re further supports for residents. • Relevant documentation relating to environmental restrictive practices will be submitted to the PAMG by the 31st October 2020.

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	30/11/2020
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	31/12/2020
Regulation 23(2)(a)	The registered provider, or a person nominated	Not Compliant	Orange	31/12/2020

	by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	20/10/2020
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	28/10/2020

Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to.	Not Compliant	Orange	20/10/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	15/11/2020
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	31/12/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	06/11/2020
Regulation 08(3)	The person in charge shall	Not Compliant	Orange	02/10/2020

	initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/12/2020