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:	Baldoyle Residential Services
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Short Notice Announced
Date of inspection:	07 July 2020
Centre ID:	OSV-0002340
Fieldwork ID:	MON-0025863

About the designated centre

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

The centre is located in a seaside residential suburb of Co. Dublin and is located on the first floor of a large three storey building. The ground floor of this building comprises of a primary school for children with disabilities, a day care facility for adults and a swimming pool. Administration offices are located on the second floor where outpatient clinics are also held. Access to the designated centre is through a large reception area for the entire building and there is a lift and stairs available to residents. The entire property is owned by St. Michael's House (SMH). The designated centre is divided into two areas, each with their own living areas and kitchen facilities. Thirteen residents reside in the centre. Residents are supported by a team of nurses and care staff. The centre is closed to admissions from external agencies as it is classified as a congregated setting. The provider proposed to de-congregate the centre in line with national policy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
Tuesday 7 July 2020	09:30hrs to 15:30hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what the inspector observed, it was evident that residents had a good quality of life in which their independence was promoted. Although some areas for improvement are highlighted later in this report, overall governance and management systems in place ensured that residents received positive outcomes in their lives and the delivery of a safe and quality service.

The inspector met briefly with six of the 13 residents living in the centre. The residents were met with on the afternoon of the inspection. Two residents had been admitted to the centre in August and December 2019 as emergency admissions but the other residents had lived together for a prolong period. Residents living in the centre required a high level of support from staff with their activities of daily living. The inspector observed elements of their daily lives and their engagement with staff who supported them.

There was an atmosphere of friendliness in the centre and warm interactions between the residents and staff was observed. Staff were observed to interact with residents in a caring and respectful manner. For example, staff were observed to knock and seek permission before entering resident's bedrooms. The residents met with appeared to be in good form and to be comfortable in the company of other residents and staff. The inspector reviewed a log of compliments from a number of residents family members which indicated that they were happy with the care and support that their loved ones were receiving. Residents views were also attained from the centres annual review which detailed a survey of residents' and their family representatives positive views of the care provided in the centre. The inspector did not have an opportunity to meet with the relatives of any of the residents.

The majority of the staff team had worked in the centre for an extended period. This meant that there was consistency of care for residents and enabled relationships between residents and staff to be maintained. The inspector noted that residents' needs and preferences were well known to staff and the person in charge.

Residents were supported to exercise choice and to be involved in decisions about their care and support. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were enabled and assisted to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices.

The centre was found to be comfortable and homely, although some areas were in need of repainting. The centre had abundant space for residents with large communal areas, bathrooms and bedrooms. The centre was located on the first floor of a large three storey building, it also contained a number of flower balconies which could be accessed by residents. Each of the residents had their own bedroom which had been personalised to their own taste and choices. This promoted residents' independence, dignity and recognised their individuality and personal

preferences.

A number of residents spoken with told the inspector that they enjoyed the choice of meals provided to them. However, one resident stated that the meals were not always to her liking or choice but that staff would make her a separate meal or a second choice would be provided from the main kitchen. The centre had two kitchen facilities, although main meals were prepared and cooked in a central kitchen on the ground floor. This meant that residents were not supported to be involved in the preparation and cooking of their main meals. snacks were available for residents in the centre. Menus for meals were discussed with residents.

Residents were supported to engage in meaningful activities in the centre. In line with national guidance regarding COVID-19, the centre had implemented a range of restrictions impacting residents access to the community and their families and friends. An activity schedule for activities each day in the centre was in place. This included activities such as arts and crafts, foot massage, board games and walks. record was maintained of activities residents engaged in. There were formal plans in place, for the lifting of current restrictions in line with national guidelines, so to increase residents access to meaningful activities in a planned and safe manner in the community. Pre COVID-19 restrictions, the majority of residents were engaged in a day service programme which was suitable to meet their needs. Goals had been identified for a number of the residents. However, the achievement of these goals had been impacted by the enforcement of the pandemic restrictions.

There was evidence that residents and their family representatives were consulted with and communicated with about decisions regarding the resident's care and support, and the running of their house. Residents were supported as required to maintain connections with their families during the pandemic through video and voice calls. In line with national guidance, the centre had recommenced facilitation of visits under strict controls. As mentioned previously, the inspector did not have an opportunity to meet with the families of any of the residents but it was reported that they were happy with the level of care and support that their loved one was receiving 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 contracts of care, the directory of residents, the complaint management process and staff training and development.

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 and the requirements of the regulations. The person in charge had only taken up the post in the preceding four week period and was in a full-time position. The person in charge

was not responsible for any other centre. She/ he was a registered nurse in intellectual disbilities and held a degree in nursing, a masters in ethics and law and a certificate in quality initiative and management. At the time of inspection the person in charge was in the process of completing a post grad diploma in advanced leadership. She/ he had more than three years management experience and had been working in the centre as deputy manager for the preceding 11 month period. Staff members spoken with told the inspector that the person in charge supported them in their role.

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 had been completed for 2019 and involved consultation with residents and their families. 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.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were in place and the majority of the staff team had been working in the centre for a prolonged period. This meant that there was consistency of care for the residents in the centre.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. However, a number of the staff team were over due to attend mandatory training and none of the staff team had attended positive behaviour support training. It was acknowledged that some of this training had been scheduled for staff but due to COVID - 19 had been cancelled. There was a staff training and development policy in place and a training programme was coordinated by the provider's training department. There were no volunteers working in the centre at the time of inspection.

There were staff supervision arrangements in place. However, a significant number of staff were not receiving supervision in line with the frequency stated in the providers policy. It was identified that a number of staff had not received formal supervision in more than 12 months.

Contracts of care were found to be in place for the majority of residents which detailed the services to be provided and fees payable. However, contracts of care which met the requirements of the regulations were not in place for a small number of residents.

A directory of residents was in place and found to contain the majority of the information required by the regulations. However, a date of admission was not

recorded for two of the residents and the name and address of the authority or organisation which arranged the service users admission to the centre was not always recorded as per the requirements of the regulations.

There was a complaint management process in place. However, a number of complaints were found to be open for an extended period and it was unclear if time frames in the provider's complaint management process were being adhered. For example, communicating progress and updates with the complainant.

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.

Judgment: Compliant

Regulation 16: Training and staff development

A number of the staff team were over due to attend mandatory training and none of the staff team had attended positive behaviour support training. A significant number of staff were not receiving supervision in line with the frequency stated in the providers policy.

Judgment: Not compliant

Regulation 19: Directory of residents

A date of admission was not recorded for two of the residents and the name and address of the authority or organisation which arranged the service users admission to the centre was not always recorded as per the requirements of the regulations.

Judgment: Substantially 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 24: Admissions and contract for the provision of services

Contracts of care were found not to be in place for a small number of the residents contrary to the requirements of the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A number of complaints were found to be open for an extended period and it was unclear if time frames in the provider's complaint management process were being adhered. For example, communicating progress and updates with the complainant.

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 to ensure that personal plans were put in place for all residents within 28 days of admission and in relation to fire management arrangements.

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support. However, a personal plan had not been put in place for one of the residents who had been admitted to the centre in the preceding six month period. Comprehensive assessments of needs had been completed for the majority of residents. 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. Goals for a number of the residents had been identified but some of these were not specific or individualised to the resident.

The residents' healthcare needs appeared to be met. Specific health plans were in place for residents identified to require same. This was a nurse led service with a staff nurse on duty 24/7 to meet the residents' healthcare needs and residents were seen by general practitioners at regular intervals.

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. Risk assessments for COVID-19 had been completed. A local risk register was maintained in the centre. An analysis of all incidents occurring in the centre were completed on a regular basis. Overall, there were a relatively small number of incidents in the centre.

There were procedures in place for the prevention and control of infection. However, there was chipped paint on the walls and woodwork in a number of areas. This meant that these areas could be more difficult to effectively clean. A COVID-19 decision pathway had been put in place which was in line with the national guidance. The inspector observed that all areas were clean. A cleaning schedule was in place which was overseen by the person in charge. Colour coded cleaning equipment was in place. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to COVID-19, proper use of personal protective equipment and effective hand hygiene had been provided for staff. A guidance document on easing restrictions which were in line with national guidance were being implemented in the centre. Staff and resident temperature checks were being taken at regular intervals. Disposable surgical face masks were being used by all staff whilst in the centre. At the time of inspection none of the residents in the centre had contracted COVID-19.

Some arrangements were in place for the management of fire. However, improvements were required in relation to the fire drill procedures and a number of fire safety works were identified as required. There was evidence that fire drills had been undertaken in March and December 2019. However, these fire drills had only involved one resident at each and no fire drill had been completed in the last six month period. In addition a fire drill involving the two most recent admissions to the centre in August and December 2019 respectively had not been completed. This meant that residents and staff who support them, may not be sufficiently practiced so as to enable the safe evacuation of residents as safely and quickly as possible. A number of fire safety works were identified as required in the centre. These included the upgrading and replacement of fire doors to the required standard and the maintenance of an identified fault in a fire door in the centre. This meant that fire containment measures were not adequate to protect residents. A specific fire evacuation plan was in place which was based on specialist advice to meet the

needs of residents and the size and layout of the premises. Each resident had a personal evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff had received appropriate training.There was documentary evidence that fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. A fire risk assessment had been completed.

There were safeguarding measures in place to protect residents from suffering from abuse. Safeguarding plans were in place for residents identified to require same. There were safeguarding policies in place to guide staff practice. A staff member spoken with was knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. As referred to above a small number of staff were overdue to attend safeguarding training.

Residents were provided with appropriate emotional and behavioural support. Assessment of need in relation to behaviours and emotional well being support plans, and psychology support plans were in place for residents identified to require same. 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.

Regulation 26: Risk management procedures

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

Judgment: Compliant

Regulation 27: Protection against infection

There was chipped paint on the walls and woodwork in a number of areas. This meant that these areas could be more difficult to effectively clean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A fire drill had not been completed in the preceding six month period. Prior to that, a fire drill in August and December 2019 had only involved one resident at each of the drills. A number of fire safety works were identified as required in the centre. These included the upgrading and replacement of fire doors to the required

standard and the maintenance of an identified fault in a fire door in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A personal plan had not been put in place for one of the residents who had been admitted to the centre in the preceding six month period. Goals for a number of the residents had been identified but some of these were not specific or individualised to the resident.

Judgment: Substantially compliant

Regulation 6: Health care

The residents' healthcare needs were being met.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional support.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Baldoyle Residential Services OSV-0002340

Inspection ID: MON-0025863

Date of inspection: 07/07/2020

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • PIC has completed a review of training and all identified needs are now being addressed. • All staff will have completed online mandatory training by 31st October 2020. • TIPS' training will commence in August 2020 and will be completed by December 2020. • All required supervision will be provided to all staff in line with the organizations policy by the 30/09/2020. • Priority staff are being identified for PBS training and will be nominated for same when it is scheduled.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: • The Directory of Residence has now been completed in line with regulatory requirements since the 9/8/20.	

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• All identified Contracts of Care will be in place with required information by 30/9/2020.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Updates are being provided to all residents regarding complaints made, with the exception of one resident, where to do so will cause the resident anxiety. Updates provided by the 20/8/2020.

• All outstanding issues have been escalated where they cannot be addressed at a local level, for example, an external internet service provider. Escalated by 20/8/2020.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• A quotation will be sought for the painting of identified areas and works will commence by 30/9/2020.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• There are regular fire checks completed in the centre, and, regular maintenance of all fire fighting equipment. A phased horizontal Fire Walk was completed with all residents on the 9th August 2020.

• Upgrading of outstanding fires doors has been identified as required in the Fire Safety Feedback Report completed on the 23/4/2020. These works will be completed within one year of the report as per the organizations medium priority timeframe.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

- Two residents will have a reviewed Assessment of Need completed by 21/8/2020

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 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.	Not Compliant	Orange	31/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Yellow	30/09/2020
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	09/08/2020
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the	Substantially Compliant	Yellow	30/09/2020

	terms on which that resident shall reside in the designated centre.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/12/2020
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	30/04/2021
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably	Not Compliant	Orange	09/08/2020

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	20/08/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	21/08/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	21/08/2020
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal	Substantially Compliant	Yellow	21/08/2020

	plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			