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

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Seanna Cill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>St Michael's House</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Dublin 5</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>14 March 2018</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0002356</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0021317</td>
</tr>
</tbody>
</table>
About the designated centre

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

Seanna Cill is a residential service based in Dublin 5, which is run by St. Michael's House. The centre provides accommodation to a maximum of six male and female residents, who are over the age of 18 years and who have an intellectual and physical disability. The service can cater for a broad spectrum of needs, including, low to high support needs, behaviour support, medical needs and emotional and environmental needs. The centre comprises of one house which is located close to local amenities such as shops, cafes and recreational facilities. Each resident has their own bedroom and shares communal spaces such as sitting rooms, kitchen and dining areas and bath and shower rooms. Staff are on duty both day and night to support residents who live in this centre.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>13/09/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>5</td>
</tr>
</tbody>
</table>
How we inspect

To prepare for this inspection the inspector or 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 March 2018</td>
<td>10:30hrs to 18:30hrs</td>
<td>Anne Marie Byrne</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

The inspector met with two residents who live in this centre. Although both residents spoke directly with the inspector, they did not communicate with the inspector about the care and support they received.

During the inspection, the inspector observed staff to communicate effectively with residents and residents appeared to be comfortable in the company of staff. On the day of the inspection, some residents were supported to stay at home in accordance with their wishes, while other residents were observed to take part in household chores and meet with their visitors upon their arrival back to the centre in the afternoon.

Staff supported residents to complete a questionnaire on the service they receive, in which they stated that they were happy with the supports provided in areas such as the facilities available to them, social care opportunities, staff support and in the promotion of their rights.

Capacity and capability

Governance and management arrangements ensured that a good quality and safe service was provided to the residents living in this centre. Furthermore, the inspector found the provider had put measures in place to address the improvements required from the previous inspection.

Effective leadership and management arrangements were in place, which had a positive impact on ensuring clear lines of authority and accountability within the service. A suitably qualified and experienced person in charge had the responsibility for the centre and he held an administrative role, which gave him the capacity to visit the centre regularly each week to meet with residents and staff. Regular management meetings were occurring to discuss areas such as contingency and strategic planning. The person in charge also held regular staff meetings in the centre, which allowed for issues arising to be formally reviewed and discussed with staff.

The provider ensured that all aspects of the service were subject to on-going monitoring, review and development, which had a positive impact on the care and support provided to residents. The annual review of the service and six monthly provider-led visits were occurring and where improvements were identified, plans
were in place to address these. Systems were also in place to ensure staff were aware of the findings of these audits and reviews. The provider had also ensured that where adverse incidents occurred, these were recorded, reviewed and responded to in a timely manner.

The provider had an effective complaints procedure in place for residents, which was in an accessible format and included an appeals procedure. Residents were regularly informed of this procedure through weekly meetings and staff were aware of their responsibility in the local resolution of complaints received. A system was in place to ensure the management and outcome of complaints was clearly recorded.

Policies and procedures were in place in this designated centre to guide staff practice and the provider had arrangements in place to ensure these were reviewed in line with the regulations. Since the last inspection, improvements were made to the directory of residents, ensuring it contained all information as required by the regulations.

**Regulation 19: Directory of residents**

Since the last inspection, improvements were made to the directory of residents and the inspector observed it now detailed the name and address of any authority or organisation, which arranged residents' admission to the centre.

**Judgment:** Compliant

**Regulation 23: Governance and management**

The person in charge had the overall responsibility for the centre and he was supported by persons participating in management and by the provider's representative in the management of the centre. He had the capacity to visit the centre regularly each week and he told the inspector that he had the resources available to him to fulfill his role. Regular staff and management meetings were occurring, ensuring that all staff had the opportunity to discuss issues relating to the service. The annual review and six monthly unannounced provider-led visits were completed in line with the requirements of the regulations and copies of these reports were available in the centre. Residents had completed satisfaction surveys, which gave them the opportunity to be involved in, and provide feedback towards the annual review of the service. The person in charge also ensured additional oversight of the service delivered to residents through an auditing programme and regular review of incidents occurring within the centre.
Judgment: Compliant

**Regulation 3: Statement of purpose**

The provider had prepared a written statement of purpose, which contained all information as set out in Schedule 1 of the regulations.

Judgment: Compliant

**Regulation 34: Complaints procedure**

The provider had a nominated person in place to manage complaints and the complaints procedure was found to provide clear guidance on how complaints were responded to, managed and resolved within the centre. It included details of the appeals process available to residents and the procedure was prominently displayed within the centre. An easy-to-read version of the procedure was also available to residents within their bedrooms. No complaints were being actively managed at the time of this inspection; however, a system was in place to ensure that where complaints were received, details of the complaint, investigations into the complaint, the outcome of the complaint and the satisfaction level of the complainant was clearly recorded. The complaints procedure was regularly discussed with residents at weekly meetings.

Judgment: Compliant

**Regulation 4: Written policies and procedures**

The provider had written policies and procedures in place on the matters as set out in Schedule 5 of the regulations. Some of these policies were in the process of review and the provider had plans in place for revised policies to be available to staff in the weeks subsequent to the inspection.

Judgment: Compliant

**Quality and safety**

Overall, the inspector found arrangements were in place which ensure residents
Residents received the care and support they required.

Improved health care arrangements ensured residents now had personal plans in place which gave staff clear guidance on how they were required to support residents with specific health care needs. Arrangements were also in place to ensure these plans were regularly reviewed and updated to reflect changes to residents’ needs. The provider had effective communication arrangements in place which enabled residents to communicate their wishes to staff.

Residents were supported to live their lives as they wished, with all activities planned around residents’ choice. For example, some residents did not wish to engage with day-care services and these residents were supported to spend their time doing activities of interest to them. Residents had opportunities for employment and education, with some residents in the process of completing training courses. The person in charge told the inspector that an emphasis was being placed on supporting residents who wished to take part in positive risk-taking to ensure that arrangements were being put in place to facilitate this choice for residents.

The provider had fire safety precautions in place, which ensured that the risk of fire was regularly monitored. Regular fire drills were occurring within the centre, which ensured residents could be safely evacuated. Residents had up-to-date evacuation plans in place to guide staff on the support residents' would require in the event of an evacuation. Regular fire checks were completed by staff and all staff had received up-to-date training in fire safety. Staff who spoke with the inspector were familiar with the procedure to adhere to in the event of a fire in the centre. Fire exits were available to residents throughout the centre and these were maintained clear. Although a fire procedure was displayed on the day of the inspection, it did not clearly guide staff on what to do in the event of a fire. This was brought to the attention of the person in charge, who put measures in place to rectify this before the close of the inspection. In response to the needs of some residents with behaviours that challenge, the provider had implemented additional measures to support these residents in the event of an evacuation. Although the provider demonstrated a proactive approach to fire safety, deficits were still found to emergency lighting and fire containment measures. Since the last inspection, a fire risk assessment of the centre was completed by a competent person, which identified improvement works to be completed to emergency lighting, fire containment and fire detection within specific time frames. Subsequent to the inspection, the provider provided written assurances to the inspector on the interim fire safety arrangements that were being put in place until this work was complete.

Risk management arrangements ensured that residents were protected from identified risks and that organisational risks were regularly reviewed and discussed with senior management. Staff who spoke with the inspector were aware of residents' specific risks and of their responsibility in keeping these residents safe. However, improvements were required to the risk management policy, to ensure it clearly guided staff on the assessment process to be adhered to in the management
of residents’ specific risks.

Improved medication management systems ensured that safe practices were now in place for the administration of as-required medicines. Well-maintained prescription and administration records ensured that staff could clearly identify the medicines that were to be administered to residents. Restrictive practices were regularly reviewed and staff who spoke with the inspector knew how to apply these restrictions in accordance with the guidance documentation available to them.

Behaviour support arrangements ensured that residents with behaviours that challenge had an appropriate assessment completed, received regular reviews and had a behaviour support plan in place. Safeguarding systems were found to promote residents’ safety and provide staff with clear guidance on how they were required to keep residents safe. Staff who spoke with the inspector were aware of how to detect, respond and manage safeguarding concerns.

Regulation 10: Communication

Some residents living in the centre had assessed communication needs, and clear guidance was in place for staff to know how to effectively communicate with these residents. Where required, residents also had the support of speech and language services. Easy-to-read information and pictorial references were readily available throughout the centre for residents to reference. Internet, television and radio was also available in the centre to residents.

Judgment: Compliant

Regulation 13: General welfare and development

The provider had arrangements in place to ensure residents had access to facilities for occupation, education and recreation. At the time of inspection, some residents were attending courses, while others were being supported to seek employment. Residents had opportunities to participate in activities in accordance to their interests, capacities and developmental needs. They were supported to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Judgment: Compliant

Regulation 26: Risk management procedures
The provider had systems in place to ensure residents' specific and organisational risks were assessed, managed and monitored on an on-going basis. Although the provider had a risk management policy in place, it was unclear from this policy the procedure staff were to adhere to in the assessment of residents' specific risks. A risk register was in place which monitored the controls in place to mitigate organisational risks and this was regularly reviewed by the person in charge. However some improvements were required to ensure that organisational risk assessments clearly demonstrated all controls in place to mitigate against some risks. For example, although the fire risk assessment was regularly reviewed, it did not clearly identify all the fire containment measures that were in place.

Judgment: Substantially compliant

**Regulation 28: Fire precautions**

The provider had various fire safety arrangements in place such as regular fire drills, up-to-date fire safety training and regular fire checks. The findings of the last inspection identified deficits to external emergency lighting and to fire containment measures. The provider had sought a fire risk assessment to be completed by a competent person, which identified improvements to emergency lighting, fire detection and fire containment arrangements to be completed within specified time frames. Subsequent to the inspection, the provider provided written assurance to the inspector of the interim safety arrangements that were being put in place to mitigate against the risk of fire until these improvement works were completed.

Judgment: Compliant

**Regulation 29: Medicines and pharmaceutical services**

Since the last inspection, improvements were made to the labelling of as-required medicines, in accordance with residents' prescriptions. Prescription and administration records were found to be clear, legible and well-maintained. Suitable storage arrangements were in place for medicines and all staff had received up-to-date training in the safe administration of medicines. Although no residents were self-administering their own medicines at the time of inspection, the provider had arrangements in place to conduct capacity assessments with residents who have an interest in taking responsibility for their own medicines.

Judgment: Compliant

**Regulation 6: Health care**
The provider had made improvements towards the personal plans in place for residents with specific health care needs. Personal plans were found to now clearly guide staff on how they were required to support these residents. Personal plans were regularly reviewed and updated by staff as required. Staff who spoke with the inspector were aware of residents' assessed health care needs and of their responsibility in supporting these residents each day. Where residents wished to independently manage their own health care needs, these residents were supported to do so. Residents also had access to a variety of allied health care professionals.

Judgment: Compliant

**Regulation 7: Positive behavioural support**

Where residents presented with behaviours that challenge, they received regular assessment and review. Behaviour support plans were in place to guide staff on how to support these residents. All staff had received up-to-date training in the management of residents' behaviours. There were some restrictive practices in place and these practices were regularly reviewed. Since the last inspection, activities were carried out by the person in charge to identify opportunities for the reduction in the use of restrictive practices. Although restrictive practices were regularly assessed, it was unclear from the records in place how this assessment was completed. This was brought to the attention of the person in charge, who rectified this before the close of the inspection.

Judgment: Compliant

**Regulation 8: Protection**

There were no active safeguarding plans in the centre at the time of this inspection. However, the provider had a policy in place to guide staff on how to identify, respond and manage any safeguarding concerns. Staff who spoke with the inspector were aware of their responsibility in safeguarding residents and all staff had received up-to-date training in safeguarding. The provider had appointed a designated person to support the centre in the management of safeguarding concerns.

Judgment: Compliant
Regulation 9: Residents' rights

The provider ensured residents participated and consented in decisions around their care and support. Each resident was supported to exercise choice over how they wished to spend their time. Advocacy services were available to residents and information about these services was available in the centre to residents. Residents were consulted in the running of the centre through daily interaction with staff and through regular resident meetings.

Judgment: Compliant
### Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 19: Directory of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 10: Communication</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 13: General welfare and development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
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</tbody>
</table>
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. **Specific to that regulation, Measurable** so that they can monitor progress, **Achievable** and **Realistic**, and **Time 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:**

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

There is a Risk Management policy is place. St Michaels House are updating the Risk Management Policy to reflect changes in assessment of risk including methodology, updating of risk assessment template and risk register template to ensure that significant risks are sufficiently managed, tracked and reviewed for effectiveness. Revised policy will be brought at Quality Safety Executive Committee for approval May 2018

Review risk management section (section 11) in the corporate Safety Statement and take into consideration the feedback received in relation to support plans linking to risk assessments where applicable.

PIC and Health & Safety Manager will meet to review the local risk management arrangements including accident/Incident management procedures in the centre and review of the site specific risk assessments, any amendments will be addressed and update risk assessments where appropriate on the 16th May 2018.

The PIC is trained in the management of risk and will continue to develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies.
**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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31st May 2018</td>
</tr>
<tr>
<td>Regulation 26(2)</td>
<td>The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31st May 2018</td>
</tr>
</tbody>
</table>