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:	Cill Caisce
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Unannounced
Date of inspection:	04 March 2020
Centre ID:	OSV-0002355
Fieldwork ID:	MON-0026040

About the designated centre

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

Cill Caisce is a designated centre operated by St Michael's House located in North County Dublin. The centre provides a residential service for up to five adults with intellectual disabilities, and can provide support to residents who have additional physical or sensory needs. The centre is a two storey house which comprised of five bedrooms, kitchen/dining room, living room, quiet room, staff room and two shared bathrooms. The centre is staffed by a person in charge and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Wednesday 4 March 2020	09:40hrs to 18:40hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and speak with four of the five residents availing of the service. One resident was visiting family on the day of the unannounced inspection. Some residents spoke with the inspector and other residents engaged with the inspector on their own terms and this was respected. The inspector also observed elements of their daily lives at different times over the course of the inspection.

The inspector spent time in the dining room of the centre and had a coffee with three of the residents who were home as they had an appointment for a home visit with an allied health professional. Residents spoken with discussed recent activities they had participated in, current affairs and subjects they had heard in the news, their day services and plans to attend a show that weekend. Residents also told the inspector about things that were important to them including being involved in dramas, their friends and their family.

The inspector observed residents accessing the community, returning home from day services and relaxing in their home by watching television and enjoying meals. One of the residents showed the inspector their bedroom which had been personalised to their own taste. Some residents chose to have their own keys for the room. Positive interactions were observed between residents and staff as they discussed plans for the day and the purpose of the inspection. Overall, the residents appeared relaxed and content in their home.

While residents appeared relaxed in their own home, there were identified issues with the compatibility of the resident group. For example, one resident told the inspector they were not happy living in a shared living environment and preferred to live on their own. In addition, the inspector reviewed a number of complaints made in 2019 by residents and representatives in relation to the negative impact of the compatibility issues of the resident group.

Capacity and capability

There were management systems in place which ensured the service was consistently and effectively monitored. However, improvements were required in relation to the admission process, staffing arrangements and governance and management of the centre.

There was a clearly defined management structure in place that identified lines of accountability and responsibility which ensured the staff team were aware of their responsibilities and who they were accountable to. The centre was managed by a

suitably qualified and experienced person in charge. The person in charge worked in a full-time role and worked directly with residents. The person in charge reported to the Service Manager who in turn reported to the Director of Adult Services. There were a number of quality assurance audits in place to review the delivery of care and support in the centre. This included six-monthly unannounced provider visits and an annual review for 2019 as required by the regulations. These audits identified areas for improvement and developed action plans.

However, the management systems in place required review so as to ensure the service provided was safe and appropriate to residents needs. For example, the provider had not effectively addressed areas of the premises which required improvement. This non compliance and issue had been ongoing for a prolonged period of time. This issue is further discussed under Regulation 17.

In addition, while the provider had a policy and procedure for the admissions process to the centre, an admission in 2019 did not sufficiently take into account the need to ensure residents were adequately safeguarded and a number of compatibility issues between residents ensued. This led to an increase in adverse incidents occurring in the centre and had a negative impact on quality of life for some of the residents. The inspector also observed that the negative impact on quality of life was subject to a number of complaints from the residents and their representatives.

The person in charge maintained a planned and actual roster. At the time of the inspection, there was one recent whole-time-equivalent vacancy in the staffing complement. The provider was currently in the process of recruitment to fill this vacancy. From a review of a sample of the roster, it was evident that there was an established staff team in place and continuity of care was maintained. However, on the day of the inspection, it was not demonstrated that the current whole-time-equivalent staffing levels for the centre ensured residents' identified needs could be met at all times. For example, a resident's support plan outlined that supporting them with activities may not always possible due to staff issues. This resident had lived in the centre in the centre for an extended period of time.

There were systems in place for the training and development of the staff team. For the most part, the staff team were up-to-date in mandatory training. In addition, there was evidence of some refresher training being booked to ensure the staff team had up-to-date knowledge and skills to meet the residents needs. However, there were some gaps in the booking of refresher training in a timely manner for one area of mandatory training. This is discussed further under the Quality and Safety dimension of the report.

There were systems in place for the recording and management of all incidents. The inspector reviewed a sample of adverse incidents which had occurred in the centre and found that incidents were notified as appropriate to the Office of the Chief Inspector.

Regulation 15: Staffing

The person in charge maintained a planned and actual roster for the designated centre. However, it was not demonstrated that the current whole-time-equivalent staffing levels ensured that the residents' identified needs could be met at all times.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. There were a number of quality assurance audits in place to review the delivery of care and support in the centre. However, some improvement was needed in the management systems in place to ensure the service provided was safe and appropriate to residents needs.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There was an admission policy and procedure in place. However, a recent admission to the service did not sufficiently take into account the need to ensure residents were adequately safeguarded. A number of compatibility issues between residents had occurred following the admission.

Judgment: Not compliant

Regulation 31: Notification of incidents

All adverse incidents were notified as appropriate to the Office of the Chief Inspector

in line with Regulation 31.

Judgment: 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, improvements were required in the premises to ensure residents' needs could be met appropriately, safeguarding, risk management documentation and positive behaviour support plans.

The inspector completed a walk though of the premises accompanied by a staff member. The centre was well-maintained and decorated in a homely manner with pictures of residents located throughout the centre. In addition, the person in charge showed the inspector some decorations the residents were working on to display in the house. The inspector found that residents bedrooms were decorated in line with their personal preferences and tastes. However, some areas of the house required upkeep for example the carpet on the stairs. This had been self-identified by the provider in their annual review.

In addition, as identified in the previous inspection, there were insufficient shower facilities available to meet residents' needs. Two residents used a shower on the ground floor, which was a en-suite in one resident's bedroom. The bathroom was also accessible from another door via a shared living space, and such arrangements did not ensure that the privacy and dignity of each resident was maintained. While there was evidence that this had been reviewed by appropriate allied health professionals and the provider's maintenance team, it remained an ongoing area for improvement.

There were systems in place to safeguard residents. The inspector reviewed a sample of incidents and found that they were appropriately managed and responded to. Staff spoken to were clear on what constituted abuse and what to do in the event of a concern or allegation. As noted under Regulation 24: Admissions, there were identified compatibility issues in the resident group which impacted negatively on residents' quality of life. This resulted in the development of a number of safeguarding plans and environmental changes (second sitting room) to safeguard residents. The inspector was informed that the provider was currently exploring alternative placements. In addition, there were some gaps in mandatory refresher training in safeguarding vulnerable adults for the staff team. The provider informed the inspector post inspection that this refresher training had been scheduled for April 2020.

The inspector reviewed a sample of residents' personal plans and found that each resident had an up-to-date comprehensive assessment of need in place. The assessment identified residents needs in areas including communication, social supports and health. This informed the development of personal support

plans which appropriately guided the staff team in supporting residents with identified needs.

The inspector reviewed a sample of healthcare plans and found that they were up to date and suitably guided the staff team to support residents with identified healthcare needs. There was evidence that residents had regular access to appropriate allied health professionals. The staff team were supported by a nurse manager on call system if required.

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The positive behaviour support plans reviewed were up to date and guided staff in supporting residents to manage their behaviour. However, some improvement was required in a positive behaviour support plan to suitably guide the staff team on the use of a PRN (as required) medication. There were some restrictive practices in use in the designated centre. These had been identified by the person in charge and were reviewed by the provider's Positive Approaches Management Group (PAMG). However, one restrictive practice in place, which was recently referred to the PAMG, had yet to be reviewed and approved.

There were systems in place for the assessment, management and ongoing review of risk. The person in charge maintained a risk register which identified general risks and the controls in place to mitigate or remove the risk. In addition, individual risk assessments were in place which included risk of choking, falls and behaviour that challenges. While, the inspector found that overall risk was well managed in the designated centre, the documentation required improvement. For example, there were some gaps in risk assessment documentation identified during the inspection. This was also identified as an area for improvement at the last inspection.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place which outlined the supports for each resident to evacuate the designated centre. There was evidence of regular fire drills occurring in the designated centre.

The inspector reviewed medication management within the centre and found that there was suitable systems in place for the ordering, receipt, prescribing, storing disposal and administration of medication. There was suitable secure storage of medication in the centre. The inspector reviewed a sample of medication administration sheets and found that medication was administered as prescribed. The previous inspection identified that an assessment of their capacity to take responsibility for their own medication was not in place for each resident. This had been addressed by the provider and assessments were in place for each resident.

Regulation 17: Premises

The centre was homely, clean and maintained to a good standard. However, the number of showers to meet the needs of residents was insufficient and some areas of the centre required upkeep.

Judgment: Not compliant

Regulation 26: Risk management procedures

The centre had a risk management policy and appropriate practices in place for the assessment, management and ongoing review of risk. However, there were some gaps in documentation.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were suitable systems in place for fire safety management. The centre had suitable fire safety equipment in place and there was evidence of regular fire drills occurring in the designated centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There was suitable systems in place for the ordering, receipt, prescribing, storing disposal and administration of medication.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date comprehensive assessment of need in place for each resident. The personal plans were up-to-date and guided the staff team in supporting residents with their assessed needs.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to manage their identified healthcare needs. The healthcare plans were up to date and suitably guided the staff team to support residents. There was evidence that residents had regular access to appropriate allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place for residents where required. The plans were up to date and guided staff in supporting residents to manage their behaviour. However, some improvement was required in a positive behaviour support plan in the use of a PRN (as required) medication.

There were some restrictive practices in use in the designated centre. These were identified by the person in charge and were reviewed by the provider's Positive Approaches Management Group (PAMG). However, one restrictive practice had yet to be reviewed and approved.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. The inspector reviewed a sample of incidents and found that they were appropriately managed and responded to. Staff spoken to were clear on what constituted abuse and what to do in the event of a concern or allegation. However, there were some gaps in mandatory refresher training in safeguarding vulnerable adults for the staff team.

Judgment: Substantially 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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Cill Caisce OSV-0002355

Inspection ID: MON-0026040

Date of inspection: 04/03/2020

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: • Recruitment of staff commenced prior to staff resigning position on the 28.2.2020 • Consultation process for alternative residential placement for one resident is at the final stage of approval.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Plans for an alternative placement of resident is in the final stages of consultation • Modifications required within that setting have been undertaken to provide secure access for the resident. This has been completed as of the 26th March 2020	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • Consultation process for alternate residential placement for one resident is at the final stage of approval • Compatibility issues have been recognized and will be resolved with the transfer of one resident to alternate placement. • All Residents have been supported to meet with service manager and where required clinical supports have been made available	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • All downstairs showering facilities have been reviewed within the DC. • This review has been undertaken by OT, TSD and architect.	

• Further review will be considered for long tern solution to providing alterative facilities in the centre. • New covering for stairs has been approved and arrangements are being made to replace same.

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • The organization has in place a risk management policy • All staff are instructed in the identification of risk • All risks assessments and documentation have been reviewed and assigned proportionate risk allocation. There are now reflected on risk register.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • A Review has been completed with Psychiatrist and Psychologist , PRN medications for one resident in the support of Behaviours that Challenge has been removed from the MAS. • All restrictive practices are identified on the Restrictive Practice log, and reviewed annually or sooner if needed • Referral has been sent to PAMG for approval and all documentation re: same are available for review in the DC	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: On line safeguarding training for staff through the Open training college to be completed on the 10/4/2020	

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	30/08/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2021
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	Substantially Compliant	Yellow	30/07/2020

	and effectively monitored.			
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	30/07/2020
Regulation 26(2)	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.	Substantially Compliant	Yellow	06/03/2020
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.	Substantially Compliant	Yellow	06/03/2020
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the	Substantially Compliant	Yellow	10/04/2020

	prevention, detection and response to abuse.			