Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Muiriosa Foundation
Centre ID:	OSV-0003956
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Muiriosa Foundation
Provider Nominee:	Brendan Broderick
Lead inspector:	Jillian Connolly
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 November 2014 10:00	05 November 2014 19:00
06 November 2014 10:00	06 November 2014 16:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The designated centre consists of two community houses on the outskirts of a village in Westmeath. The centre is operated by the Muiriosa Foundation and has the capacity for 8 residents, both male and female. This inspection was conducted following an application by the registered provider to register the centre under the Health Act 2007. It was facilitated by the person in charge, area director and staff employed in the centre. The regional director was present for the feedback.

The inspector reviewed questionnaires submitted to the Authority, met with residents, staff and relatives, observed practice and reviewed documentation. The

feedback obtained from residents and relatives was, in the main, positive and satisfaction was expressed with the services and care provided. The inspector observed staff to engage with residents in a positive and respectful manner and determined the centre to be homely.

Compliance was achieved in seven of the eighteen outcomes. Minor non compliance was identified in relation to the Statement of Purpose and the rights, dignity and consultation of residents. Moderate non compliance was identified in the remaining nine outcomes, which included residents' contracts, the social care needs of residents, premises, health and safety and risk management, safeguarding and safety, notification of incidents to the Chief Inspector, the review of the safety and quality of care of residents, staffing and records and documentation.

Improvements were required in the service contracts between residents and the registered provider, notifications to the Authority, staff training, the review of the quality and safety of care provided and the external grounds. There was one bedroom identified as being only suitable for individuals with specific needs. Whilst individuals had person centred plans in place, the inspector determined that the goals were primarily short term and not fully reflective of involvement from the multi – disciplinary team. Risk identification and laundry facilities also required a review by the provider. There was also an instance were unexplained bruising was not processed through the appropriate procedure.

The action plan at the end of this report identifies the failings identified by the inspector and the actions the provider/person in charge is required to take to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector reviewed a sample of minutes of meetings and determined that residents were met on a monthly basis with the purpose of being consulted in the running of the designated centre and particular issues pertinent to their lives. For example, the weekly menu was discussed in one meeting, re-decoration of bedrooms was discussed in another instance and the role of the Authority was discussed in another meeting. The inspector met with relatives during the course of the inspection who stated that they felt consulted in the care that their loved one received. There was advocacy services available for residents and the details displayed in a prominent position in the designated centre.

The organisation has a policy in place regarding the management of complaints. There was a record of complaints maintained in the designated centre. The inspector reviewed a sample of complaints and confirmed that they were processed in accordance with the policies of the designated centre. Relatives stated that they were satisfied that if they had to make a complaint that it would be dealt with effectively with no adverse effect on their loved one. There were formal and informal complaints included in the record. There was documented evidence that actions arising from a complaint had been implemented in practice for example, the personal plan of the residents was updated to inform staff.

Assessments of capacity had been conducted by the appropriate Allied Health Professional for residents which informed the support that residents received regarding their personal finances. For residents who were deemed not to have capacity, their representatives were consulted regarding their finances. In some instances there was evidence that relatives were content for the staff to manage the finances on behalf of

the resident. There were clear procedures in place to guide staff on the practices regarding the management of residents' finances including daily checks of balances as a safeguard. There was a policy in place regarding the protection of service users' personal possessions, property and finances dated August 2014. An inventory of personal possessions was maintained for residents. There were facilities available for residents to launder their own clothes if they so wished.

Staff were observed engaging with residents in a dignified and respectful manner. Each resident had their own bedroom and therefore were provided with their own private area. Improvements were required as there was no privacy locks or signage on bathroom doors. Residents had access to television and radio.

Residents were supported to attend a formal day service. Additional staff had also been made available three evenings per week so residents could be supported to engage in activities of their choosing. For example, when the inspector was present, they observed two residents being individually supported to go for a walk and to go out for dinner.

Judgment:
Non Compliant - Minor

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The designated centre had communication guidelines specific to residents which had been completed by a Speech and Language Therapist in September 2014. There was also an organisational protocol for communicating with residents dated August 2014. Residents had plans of care in place regarding their communication needs and residents were supported to communicate utilising methods which promoted their independence and autonomy. For example, the inspector was informed by one resident utilising pictures of their plans for the evening. There were pictures of staff who were working on the day of inspection on a communication notice board in the kitchen. The choices available on the menu were also available for residents in a photograph or word format.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Relatives spoken to stated that they always felt welcome in the designated centre. There was a policy in place regarding visitors to the designated centre and a record of all visitors was maintained in the designated centre. Residents also had their own bedrooms so that they could meet visitors in private if they wished.

As stated previously, residents were supported to engage in activities in the wider community, with the inspector being informed of plans to support residents to become members of local community groups based on their interests such as farming.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a policy in place regarding the admissions of residents in the designated centre. However there had been no admissions to the designated centre since the commencement of regulation in November 2013. Each resident or their representative, depending on the assessment of capacity previously mentioned, had retrospectively been provided with a written contract on the terms that the resident shall reside in the designated centre. As of the day of inspection not all contracts had been returned. The contract stated that residents are liable for a rental charge, 'as set out by government in its annual budget statement,' and residents were also responsible for fees payable in respect of utility bills and food which are aligned with rates that are set out by houses managed by a government body and could be subject to change. However it was not clear what the actual fees paid by residents were and the services to be received. For example, the contract stated that food was included in the 'kitty' expenses however there was documented evidence of residents paying for a take away. The inspector was verbally informed by management that this was not included in the fees however this was not stipulated in the agreement.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Assessments had been completed of residents' needs on an annual basis and relevant personal plans had been developed following on from this assessment of need. For example, residents were assessed regarding the support they required to maintain a safe environment, the supports required to manage their financial affairs, residents' health care needs and their social care needs. Residents also had goals developed as part of their annual review which were derived from a personal planning meeting, in which residents were present. The progress towards the achievement of these goals was reviewed on a monthly basis. The personal plans and progress towards the goals were recorded in an accessible format, for example photographs of residents achieving the goals.

Residents had access to Allied Health Professionals however it was not always apparent that they had been present and involved in the creation of the personal plan rather reactively providing a service based on an identification of a specific need by residential staff and a subsequent referral. The inspector observed that the majority of goals were short term and had been achieved such as re-decorating a bedroom or going to a pet farm. The plans did not account for the vision of residents inclusive of where and with whom they would like to live. Therefore not addressing the vision or long term goals of the resident and the skills required by the resident to achieve that vision.

There was a policy in place regarding the temporary absence, transition or discharge of residents from the designated centre, however there had been no absence, transition or discharge of a resident from the designated centre since the commencement of regulation in November 2013.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working

order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The designated centre consists of two neighbouring bungalows which are located on the outskirts of a village in Co. Westmeath. Each bungalow consists of five bedrooms and is the home of four residents. The fifth bedroom in each house is utilised by staff. Each house also has an open plan kitchen and dining room and a separate sitting room. One bedroom in each house is en suite and there is a main bathroom in each house. The inspector observed the houses to be clean and homely, suitably heated and ventilated and of sound construction. Bedrooms were personalised and reflective of the residents that reside there. However one bedroom was only suitable to meet the needs of a resident who did not require assistive equipment such as a hoist or a wheelchair due to the limited space available in the room. This was not reflected in the Statement of Purpose and Function of the centre. Communal areas were homely and contained photographs of the residents.

The inspector observed that there was appropriate adaptive equipment available for residents including hand rails, hoists and ramps however determined that the external grounds were not suitable to meet the assessed needs of residents. There was evidence that equipment was serviced and maintained at appropriate intervals. The bungalows are both located on a road in which the inspector observed considerable traffic. Each garden had a front gate and wall separating from the main road. There was no fence separating the front garden from the back garden. As some residents were assessed as requiring support to maintain a safe environment both the front and back door were locked at all times. Therefore limiting the access residents had to access the external grounds independently and safely. Access between the two bungalows also required walking out onto the road which had no path.

As part of the application to register, the registered provider submitted confirmation from a suitably qualified person with experience in planning and construction stating that the premises is in compliance with all statutory requirements relating to the Planning and Development Act 2000 – 2006.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:
The organisation has an overarching Health and Safety Statement which was dated August 2014 which addresses the management of risk and the roles and responsibilities of certain personal in respect of health and safety. The safety statement addresses generic risks which are present in the designated centre and the organisational control measures in place to address same. For example, the control measure in place regarding staff that completes lone working is documented in the organisational policy. There was also a centre specific risk register which addressed both communal risks and individual risks such as slips/trips and falls and the risk of burns and scalds from household equipment. However the inspector found that the risk register did not address all the necessary control measures in place to mitigate or reduce risk and therefore was risk adverse. For example, as stated in Outcome 6, the front and back door was locked at all times due to residents requiring support to maintain a safe environment. However there was no evidence that alternative strategies had been addressed to reduce the limitation that this placed on residents ability to access the outdoors independently.

There was evidence that the equipment in the house such as beds, baths and hoists had been serviced in an appropriate timeframe.

There was a policy in place regarding the management and control of infection, which included standard precautions such as hand hygiene, the use of personal protective equipment and waste management. There was a policy in place regarding the handling of laundry, however it did not address the specific arrangements in place for the management of soiled or infected laundry in the designated centre. Staff spoken to stated that clothes which were extremely soiled were disposed of, which is not guided by policy and results in residents' clothes potentially being unnecessarily discarded. The designated centre maintained cleaning logs, there was evidence of audits being undertaken in respect of same and the house was visibly clean.

As part of the application to register, the registered provider submitted confirmation from a suitably qualified person with experience in fire safety design and management stating that all statutory requirements in relation to fire safety and building control have been complied with. The centre had emergency plans in place in the event of a fire/flood/water failure or suspected gas leak. Fire orders were displayed in the designated centre however they were not reflective of the fire doors within the designated centre and the additional protection they can provide. Residents had personal evacuation plans in place which were reflective of both their physical and cognitive needs. One member of staff on duty did not have training in the equipment documented as required to evacuate some residents in the event of fire. This training was completed prior to the inspector leaving the premises on the first day of inspection. Fire drills were completed on a monthly basis and demonstrated that the maximum number of residents could be evacuated with the minimum number of staff in an appropriate time frame. There was documentary evidence that fire equipment such as the alarm, extinguishers and emergency lighting were maintained and serviced at appropriate intervals. Staff spoken to was able to inform the inspector on the actions to be taken in the event of a fire.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The designated centre has a policy in place regarding the protection of vulnerable adults. Staff had received training in the prevention, detection and response to abuse. Residents spoken to stated that they felt safe and their relatives concurred with this. Staff were able to inform the inspector of the actions to be taken in the event of an allegation or suspicion of abuse and the appropriate reporting mechanisms. There had been one incident of unexplained bruising identified by the inspector in the accident/incident log which had not been investigated in line with the policy of the organisation. The rationale for this was as staff judged the bruising to be as a result of behaviours that the resident can exhibit regularly. It was addressed from this perspective and the relevant allied health professionals were consulted. However as it was un witnessed, the inspector determined that it should have been in line with the policy on the protection of vulnerable adults.

There was a system in place regarding supporting residents who require support as a result of exhibiting behaviours that challenge. However the inspector determined that improvements were required to ensure consistent support was offered for all residents. For example, one resident had a very clear plan in place regarding the proactive and reactive strategies to be implemented to ensure positive behaviour support. However some of the strategies were reliant on training in de-escalation techniques and crisis intervention training which had not been completed by all staff. In another instance a resident was documented as requiring a physical restraint by staff in the event of receiving necessary health interventions. However the information regarding the type of restraint, staff training, and duration was inadequate. Staff had also not received training in how appropriately support the resident.

The centre maintained a restrictive practice record, however it did not adequately meet the requirements of regulations as stated in Outcome 18.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector reviewed the incident/accident log and observed inconsistencies in the notifications which had been submitted to the Authority since the commencement of regulation in November 2013. The provider omitted to submit the written report for the first quarter of 2014 as required by Regulation 31(3).This had been addressed by the inspector and all of the appropriately quarterly notifications had been submitted following on from this. As stated in Outcome 8, an incidence of unexplained bruising had not been investigated in line with the organisation policy on the protection of vulnerable adults. Therefore it had not been notified to the Chief Inspector as required by Regulation 31 (1) (f) of the Health Act 2007(Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulation 2013.

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
As stated previously each resident had access to a formal day service. On the days of inspection, the inspector observed residents to leave the house at 9.30 hours and return at 16.30 hours. As stated previously, additional staffing were available three evenings a week to support residents to meet their social care needs. The activities that were completed were in line with the personal short term goals and reflective of their interests.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector was assured that the health care needs of residents were being met. From reviewing the record of appointments maintained in the designated centre, it was evident that residents had access to their local general practitioner regularly and when a need arose. There was evidence that residents also had access to the appropriate Allied Health Professionals when the need arose for example residents had personal exercise programmes in place from physiotherapists. Residents also attended chiropody, speech and language therapy, occupational therapy and psychology. Residents were also supported to attend appointments with specialists following a referral from their general practitioner. Plans of care for specific health needs were created, such as epilepsy or constipation and documentation evidenced that staff supported residents as per their personal plans. For example, there were clear guidelines in place to instruct staff on the action to be taken in the event of a seizure including the administration of medication as required. Residents were also proactively supported to maintain good health such as being offered the vaccine for Influenza.

There was a policy in place regarding supporting residents' nutritional needs. Residents needs were assessed utilising an evidence based tool and referred to an Allied Health Professionals if a need was identified for residents who required food fortification. There were also recommendations in place for residents who required food modification and required support to eat a meal. The inspector observed staff preparing a meal and found that appropriate food hygiene practices were in place. However not all staff involved in the preparation of food had received the appropriate training. Residents reported that they enjoyed the food and staff were observed supporting residents in a dignified and respectful manner.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a policy in place to inform staff of best practice in relation to medication management. The policy addressed the procedures in place for the administration, prescribing, recording and disposal of medication. Medication was stored securely in the designated centre with each resident's medication segregated from other residents. There was a separate refrigerator in place dedicated for the storage of applicable medications. Of the sample of prescription and administration records reviewed, the inspector found that all of the pertinent information was available, inclusive of a photograph of the resident and a signature for each individual medication prescribed. The times medications were prescribed for correlated with the times of administration documented. The maximum dosage for medication as required was documented on the prescription record. There was additional information maintained with the medication informing staff of the name of the medication, a description of the medication and the potential side effects of each medication. The inspector observed staff administering medication to residents and found that the staff adhered to best practice guidelines and utilised good hand hygiene procedures. The staff engaged with residents in dignified manner.

There was a procedure in place for returning unused or out of date medication to the pharmacist. There had been a medication error identified in September 2014. It was reported and investigated as per the policy of the organisation. The person in charge had reviewed the findings with staff in a team meeting and had reviewed best practice.

Judgment:
Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The statement of purpose and function describes the aims and objectives and ethos of the designated centre and the services provided to residents. However as stated in Outcome 6, it did not identify the specific needs that one bedroom could accommodate.

Judgment:
Non Compliant - Minor

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There is a management structure in place in the designated centre. The provider nominee is the CEO of the organisation. They are supported by a regional director who in turn is supported by an area director. The area director is responsible for six designated centres. The person in charge reports to the area director and is the person in charge for two designated centres. The organisation has developed systems in place to ensure that the care provided to residents is safe and positive outcomes are experienced by residents. This is supported by the person in charge meeting with the area manager on a monthly basis. The area manager in turn meets with the regional director on a monthly basis who reports any matters arising to senior management. There is also a quarterly forum in which all persons in charge meet with area management and regional management. The inspector reviewed a sample of minutes from these meetings and confirmed that it is a forum for shared learning.

There was evidence that audits had been undertaken however there were inconsistencies in the effectiveness of these audits. For example, in one instance an audit of personal plans identified that goals identified were not measurable and person centred. This had been auctioned and subsequently reviewed by management. The improvement was also confirmed by the inspector. However in other instances audits were a checklist style and there was no evidence of action plans being developed following on from the audits and learning obtained from same. For example, there was a record maintained of all restrictive practice utilised however the audits were not reflective of Regulation 7 (5) (c) that a review had been undertaken to ensure that the least restrictive procedure was utilised for the shortest period of time.

The person in charge is a registered nurse. They commenced their role within the organisation in July 2014. The person in charge demonstrated sufficient knowledge of their statutory responsibilities and the systems in place to ensure that they are in a position to meet them. For example, the person in charge had identified that additional staffing was required one evening a week to ensure that the social care needs of residents were being met. This had been escalated through the management systems within the organisation and subsequently approved and implemented, which resulted in positive outcomes for residents as observed by the inspector.

There was no annual review of the quality and safety of care available on the day of inspection. The inspector was verbally informed that this was in progress.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There has been no instances where the person in charge has been absent from the designated centre for more than 28 days. The provider is aware of the requirement to notify the Chief Inspector one month prior to an expected absence or within three working days in the event of an emergency. In the event of the person in charge being absent there are two other managers nominated to deputise in their absence.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector reviewed a sample of rosters and confirmed that the staffing on the day was reflective of the regular staffing levels. As stated previously additional staffing had been allocated to one evening a week to support residents achieving their personal goals. Staff spoken to stated that the staffing levels available were suitable to meet the needs of residents. Relatives stated that they felt that the staffing levels were adequate however additional staff would be beneficial to enhance the quality of life of residents. There was transport available to support residents to engage in activities in the wider community.

Judgment:
Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

As stated in the previous outcome, there was sufficient staffing available to meet the needs of residents. From the sample of staff records reviewed, staff had received mandatory training in the prevention, detection and response to abuse, fire prevention and management and manual handling. Additional training had also been provided in the management of complaints, the safe administration of medication and the administration of medication as required in the event of a resident experiencing a seizure. There were some staff who had not received training in supporting residents who experience behaviours that challenge and the administration of medication as required in the event of a resident experiencing a seizure and food safety. The inspector identified this with the person in charge on the day of the inspection as the assessed needs of residents required staff to have this knowledge. The person in charge verbally assured the inspector that this would be addressed immediately.

Of the sample of staff records reviewed, the information maintained was as required by Schedule 2 of the regulations.

The person in charge had commenced supervision of staff which were titled 'performance conversations.' The purpose of these conversations were to identify the training needs of staff and to highlight areas of improvement. The person in charge is responsible to identify the training needs of staff and contacts the relevant personal at a regional level to organise this training.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)

Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a residents' guide in place in the designated centre. It required a review as it did not reflect the actual persons participating in the management of the designated centre. The policies as required by Schedule 5 were maintained in the centre. Of the sample reviewed the inspector determined that in the main they are reflective of practice. For example, staff were able to inform inspectors of the procedure to be taken in the event of a complaint, or in the event of an allegation or suspicion of abuse. As stated previously the supports provided to residents in the event of residents experiencing behaviours that challenge were not always conducted in line with policy. Staff had also not received all supplementary training as per policy.

Improvements were required in residents' personal records as the following was omitted:
- A directory of residents was maintained in the designated centre. Improvements were required in the admission dates of residents as it stated the date they were admitted into residential care as opposed to the date of admission to the designated centre.
- There was a record of restrictive procedures in place however it stated the restrictive practice that residents were generally assessed for but did not state the actual duration that bed rails for example were utilised as required by Schedule 3 Part 3 (m).

The records as required under Schedule 4 of the regulations were present.

As part of the application to register the register provider provided evidence that the organisation was adequately insured against accidents or injury to residents, staff and visitors.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Muiriosa Foundation
Centre ID:	OSV-0003956
Date of Inspection:	05 November 2014
Date of response:	08 January 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of privacy locks or signage on bathroom doors.

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
• Privacy locks have been fitted to all bathroom doors.

Proposed Timescale: 07/11/2014

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract in place between the provider and the resident did not stipulate the actual fees to be charged.

Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
• The contracts of care have been amended to include an appendix which details the fees to be charged where appropriate.
• The updated information will be sent to each individual and their representative and a copy will placed on each individual's file.

Proposed Timescale: 09/01/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The reviews of personal plans did not evidence multi -disciplinary involvement.

Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
• Members of the relevant multidisciplinary team will be formally invited to input into the review process in line with the organisation's policy "Involvement of multidisciplinary practitioners" August 2014.

Proposed Timescale: 07/01/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans primarily focused on the short term goals of residents as opposed to long term goals therefore not demonstrating that the residents' independence have been maximised.

Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:

• The person in charge and area director will undertake a review of all person centred support plans in conjunction with each individual, their key workers, families, and members of multidisciplinary team as required.
• Once the review is completed individuals will be supported to achieve their identified long term goals through the development of short term goals with a long term view, thus increasing independence, confidence and contribution to community.
• Date for completion: Reviews will be completed by the 31st January 2015.

Proposed Timescale: 31/01/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose and Function did not address the unsuitability of one room for residents who require mobility devices.

Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:

• The Statement of Purpose and Function document has been updated to include information regarding the unsuitability of one room within the centre for individuals who require assistance of mobility devices/aids.
A copy of the updated Statement of Purpose and Function has been submitted to the Health Information and Quality Authority.

Proposed Timescale: 06/01/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The external grounds were not independently accessible to residents.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:

• All necessary ground works to ensure accessibility for individuals to the grounds will be completed. by 31st January 2015.

Proposed Timescale: 31/01/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all control measures in the risk management plan were proportionate to the risk involved.

Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:

• A review of the local risk register will be undertaken by the person in charge and area director in conjunction with the staff team, this review will involve members of the multidisciplinary team and/or Operations Manager where required.
• The purpose of the review will be to ensure that all control measures in place are proportionate to the level of risk identified and that any adverse impact such measures might have on the resident's quality of life have been considered.

Proposed Timescale: 31/01/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The guidelines in place for the procedures to launder residents' clothes were

inadequate.

Action Required:
Under Regulation 27 you are required to: 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.

Please state the actions you have taken or are planning to take:

• A Local protocol has been developed by the Person in Charge in consultation with the Infection Control Nurse to guide staff to launder effectively.
• The protocol has been implemented in the designated centre with effect from the 19th November 2014.
• The local protocol has been submitted to Chairperson of Nursing Policy and Procedure Committee for inclusion in Organisational policy which is currently being reviewed by Nursing Policy and Procedure Committee.

Proposed Timescale: 19/11/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in the management of behaviours that challenge.

Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:

• All staff have attended a briefing session on the organisation's policy document "Listening to and Responding to Behaviours of Concern", 2014. Date action completed: 6th January 2015.
• The Person In Charge and Senior Clinical Psychologist met on the 16th December 2014 to discuss training needs of the staff team in relation to the management of behaviours of concern.
Actions planned:
• The Senior Clinical Psychologist will undertake a review to identify staff training needs in relation to providing support to individuals who display behaviours of concern.
• Staff training needs will be identified and a timetable for training devised. Date for completion: 15th April 2015

Proposed Timescale: 15/04/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were documented as requiring physical restraint however the information and training provided to staff was not in line with national policy.

Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

• Following consultation with the individual, their representative and relevant multi disciplinary team members if physical restraint is required during medical intervention this will be documented in the person centred support plan.
• The Senior Clinical Psychologist is undertaking a review to ensure that staff have the training required to safely support people who require physical restraint during medical interventions.
• On completion of the review, a training and development programme will be deployed and all staff will have completed by 15th April 2015.

Proposed Timescale: 15/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in the supports available for residents who exhibit behaviours that challenge.

Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:

• Each individual who displays behaviours of concern has a Positive Behaviour Support Plan developed in conjunction with Behavioural Support Team, the staff team and the Person in Charge. These are reviewed regularly.
• Relevant staff have attended training in Crisis Prevention Intervention. Date action completed: 17th December 2014.
• All staff have attended a briefing session on the organisation's policy document "Listening to and Responding to Behaviours of Concern", 2014. Date action completed: 6th January 2015.
Actions Planned:

• The Senior Clinical Psychologist is undertaking a review to ensure that staff have the training required to safely support people who require physical restraint during medical interventions.
• On completion of the review, a training and development programme will be deployed and all staff will have completed by 15th April 2015.

Proposed Timescale: 15/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An incident of unexplained bruising was not investigated in line with the policy of the organisation.

Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:

• Staff have been informed in writing, through the local staff meetings and supervision that all incidents of unexplained bruising must be reported to the person in charge. Date action completed: 6th November 2014
• Any allegation of abuse suspected or confirmed will be dealt with through the relevant organisational policy ie Trust in Care Policy or Adult Protection and Welfare Policy and Procedure.
• Staff have been informed of the requirement to report any allegation of abuse suspected or confirmed to HIQA via the completion and submission of the NF06 form through the Person in Charge.

Proposed Timescale: 06/11/2014

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An incidence of unexplained bruising had not been investigated in line with the organisation policy on the protection of vulnerable adults. Therefore it had not been notified to the Chief Inspector.

Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:

• Staff have been informed of the requirement to report any allegation of abuse suspected or confirmed to HIQA via the completion and submission of the NF06 form through the Person in Charge.

Proposed Timescale: 06/11/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose did not identify the specific needs that one bedroom could accommodate.

Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

• The Statement of Purpose and Function document has been updated to include information regarding the unsuitability of one room within the centre for individuals who require assistance of mobility devices/aids.
• A copy of the updated Statement of Purpose and Function has been submitted to the Health Information and Quality Authority.

Proposed Timescale: 06/01/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inconsistencies in the learning obtained from the audits conducted to ensure the care provided is safe and effective.

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
• Locally an audit review tool has been devised and implemented by the Person In

Charge and Area Director.
• The tool aims to facilitate learning by identifying any recurring themes or patterns in remedial actions required. It is reviewed on a monthly basis by the Person In Charge and Area Director.
• Outcomes and subsequent learning are shared and discussed at monthly staff team meetings and individual staff supervision meetings where necessary.
• Any learning from audits or inspections are shared at the quarterly regional PIC's meeting to ensure dissemination of learning.

Proposed Timescale: 22/12/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review of the quality and safety of care was not available on the day of inspection.

Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:

• The annual review of quality and safety was undertaken by the regional director and the report will be made available by the 14th January 2015.

Proposed Timescale: 14/01/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were some staff who had not received training in supporting residents who experience behaviours that challenge, the administration of medication as required in the event of a resident experiencing a seizure and food safety.

Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:

• All staff have attended a briefing session on the organisation's policy document "Listening to and Responding to Behaviours of Concern", 2014. Date action completed: 6th January 2015.

• Staff member attended training in the Administration of Buccal Midazolam. Date action completed: 7th November 2014.
• Staff attended training in Food Safety. Date action completed: 4th December 2014.
• The Person in Charge will identify training needs and ensure that staff attend all relevant training including refresher training on a continuous basis as required.

Proposed Timescale: 06/01/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all of the policies were implemented in practice.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

• The Person in Charge has ensured that all Schedule 5 policies are available to staff in the designated centre, that staff are familiar with the policies, and that all staff have attended or are scheduled to attend relevant training in order to ensure that staff implement policies in practice.
• The person in charge will ensure that all schedule 5 policies remain on the agenda of local staff team meetings to facilitate discussion on a rolling basis.

Proposed Timescale: 06/01/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not accurately reflect the admission date of residents to the designated centre.

Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:

• The directory of residents has been reviewed and admission dates of individuals to

designated centre have been updated.

Proposed Timescale: 20/11/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents' guide did not accurately reflect the persons participating in management.

Action Required:
Under Regulation 20 (2) (c) you are required to: Ensure that the guide prepared in respect of the designated centre includes arrangements for resident involvement in the running of the centre.

Please state the actions you have taken or are planning to take:

• An updated resident's guide was furnished to each individual and also sent to the Health Information and Quality Authority on 13th November 2014.

Proposed Timescale: 13/11/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a record of restrictive procedures in place however it stated the restrictive practice that residents were generally assessed for but did not state the actual duration that bed rails for example were utilised as required by Schedule 3 Part 3 (m).

Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:

• Local staff meetings and supervision meetings have been used to ensure staff are aware of the requirement for proper documentation.
• The duration of use of bedrails is documented daily in each individual's progress notes.
• The Person In Charge will review progress notes at least weekly, to ensure staff are documenting appropriately.
The person in charge will ensure that records are maintained and are available for inspection in relation to each resident as specified in Schedule 3.

Proposed Timescale: 06/01/2015