

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Muiríosa Foundation
<b>Centre ID:</b>	OSV-0003959
<b>Centre county:</b>	Westmeath
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Muiríosa Foundation
<b>Provider Nominee:</b>	Brendan Broderick
<b>Lead inspector:</b>	Jillian Connolly
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	10
<b>Number of vacancies on the date of inspection:</b>	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:
23 July 2014 09:30	23 July 2014 17:00
24 July 2014 09:00	24 July 2014 18:00

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 is a unit with a larger campus operated by the Muiriosa Foundation. Residential services can be provided for ten individuals, both male and female. The centre had full capacity of the day of inspection. A monitoring inspection had been completed previously in the designated centre. At this time there were two units in the designated centre. However following on from the findings of that inspection the units were separated into two designated centres. The purpose of the inspection was to assist with informing a decision regarding the registration of the designated centre under the Health Act 2007 of one of these centres.

The inspector observed practice, spoke to relatives and staff and reviewed

documentation. The inspector observed staff to be courteous and respectful to residents. Relatives spoke positively about their experience of the services provided however stated that improvements could be made in regards to consultation from senior management as regards to operational issues which affect their loved one.

On the day of inspection, there was no evidence available of fire compliance or planning compliance, which is required as part of the registration process. The person in charge was also absent for the inspection and the provider nominee was not present. The inspection was facilitated by staff nurses and feedback was provided to a staff nurse, the area manager and the regional director. Since the inspection an application has been submitted to the Authority to change the provider nominee.

As the inspection was part of a decision regarding the registration of the designated centre, eighteen outcomes were inspected. There were five major non - compliances identified relating to privacy and dignity, health and safety, admissions and contracts, governance and management and staffing. A further seven moderate non - compliances were identified in relation to the social care needs of residents, positive behaviour support, records and documentation and the communication needs of residents. There was a minor non - compliance in relation to medication management.

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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

There was evidence that residents and/or their representatives were consulted regarding the day to day care that residents received in the designated centre, through a review of a sample of residents' personal files. There was however inconsistencies in the consultation with residents and/or their representatives as regards to the planning and running of the centre on an operational level. For example, the inspector reviewed correspondence and minutes of engagement with residents and/or their families regarding the transition of residents from the designated centre to another designated centre. The evidence found that residents and/or their representatives were informed of the proposed transition as opposed to being consulted.

Due to the needs of the residents residing in the designated centre, resident meetings were not an appropriate forum for consultation. There were no formal systems in place for representatives of residents to advocate on behalf of residents in the absence of residents' meetings. Whilst there was a policy in place regarding communicating with residents the primary focus was regarding interaction as opposed to consultation with residents. The failings of this inspection demonstrate that a policy is required to guide practice.

The designated centre had a policy in place to inform the process in place for making a complaint. The policy has not been reviewed in four years and did not reference the accountable persons involved in the process, such as the person nominated to manage complaints. Staff had signed the policy. There was a complaints log in place which contained the necessary documentation that individuals required to make a complaint. The log was maintained in an accessible location for stakeholders however inspectors

observed confidential information maintained in the log therefore breaching the privacy of the individuals involved. Regular audits of complaints occurred although the inspector found the audits to be inaccurate. The most recent audit did not account for a complaint which inspectors found in the personal files of a resident.

On a previous inspection, there were failings identified in the privacy and dignity of residents due to the layout of the premises. Whilst the inspector observed that improvements had been made, the findings of this inspection demonstrated that there are still significant factors that impinge on the privacy and dignity of residents. For example, previous findings were that inspectors could see freely into the bedrooms of residents based on glass panelling in doors. On this inspection this had been addressed with the exception of one bedroom. Management ensured that this was rectified prior to the inspector leaving the designated centre. As stated in Outcome 6, there were three toilets in place for residents. However these toilets were in a cubicle format with no privacy locks. As the designated centre provides services to both male and female residents, this was an impingement of the dignity of residents. There was also one bathroom and one shower room available for the use of residents. There was no privacy locks or signage available to indicate that the rooms were in use. The shower room and bathroom could also be accessed by two doors.

The Inspector observed that personal information for residents was easily accessible to any individual present in the designated centre as the office which stored the documentation was unlocked and files were stored on open shelving. There was a key code lock on the main entrance preventing individuals from exiting the designated centre without the knowledge of staff as a result of the risk of residents being absent without leave. There was free access to the designated centre for individuals entering the centre. On numerous occasions the inspector was able to access the designated centre and proceed to area containing residents' bedrooms without staff being aware that they had entered the designated centre as staff were occupied supporting residents. There was also evidence that residents' rights were impinged based on the needs of other residents. For example, there was a resident who was at risk of injury from another resident. The intervention was that the 'at risk' resident was confined to their bedroom for the periods when the other resident was present in the designated centre.

There was a policy in place for the management of residents' finances. Each resident had their own bank account and access to the bank accounts was controlled by management. Whilst the inspector recognised this was a safeguard, there was a restriction in the times in which residents could access their bank accounts based on office hours. There was a clear record maintained of all resident money which was withdrawn and spent, with regular audits occurring. The inspector completed a random check of monies maintained on behalf of residents in the designated centre and was satisfied that the system was robust. Not all residents had their own bed linen and towels resulting in these being a communal resource.

**Judgment:**

Non Compliant - Major

**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):**

No actions were required from the previous inspection.

**Findings:**

Of the sample of individual personal files reviewed, the inspector confirmed that residents had communication assessments in place. Staff also demonstrated a knowledge of the needs and wants of residents based on their experience and time supporting residents. There was an absence of consultation with the relevant Allied Health Professionals within these assessments and were generally conducted by staff employed in the designated centre. The Inspector observed an absence of assistive technology available for residents who experienced challenges with communication or that this had been considered and assessed.

Efforts had been made to utilise pictures and symbols with residents to inform them of the day to day activities within the designated centre. For example, in the entrance hall there were pictures of all staff employed in the designated centre and their role. The inspector also observed staff utilising photographs of meals to ascertain the choice of the resident.

The inspector observed that residents had free access to media such as televisions and radios.

**Judgment:**

Non Compliant - Moderate

**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):**

No actions were required from the previous inspection.

**Findings:**

There was a policy in place regarding visitors to the designated centre. Signage stated

that it was in the best interest of visitors to contact the designated centre in advance to avoid disappointment in the event of a resident not being at home. The inspector spoke with family members who stated that they were always welcome at the designated centre. There was a visitors' log in place as a safeguarding measure. As the designated centre had three communal rooms and with the exception of two residents each resident had their own room, there were areas available for residents to meet visitors in private.

Each resident had an activity schedule in place which included activities both conducted in the designated centre and activities within the community. Relatives reported that staff were happy to facilitate parties and family gatherings within the designated centre. They further reported that staff will try within the resources available to support residents to be actively involved in family events.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were no written agreements as required in Regulation 24 (3) in place between the service provider and the resident which outlined the fees to be paid and the services that are received for that agreed fee. As stated in Outcome 1, the inspector reviewed the systems in place regarding residents' finances and confirmed that residents pay a fee on a monthly basis to the service provider. The inspector discussed this with management at the feedback meeting, stating that a contract is required and must include the services that are included in any fee paid by the resident and any additional costs which may be incurred outside of the agreed fee.

As stated in Outcome 13 the Statement of Purpose and function did not comply with the matters stated 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. The admissions criteria for the designated centre refer to the organisational policy which is in place for the admissions, discharge and transitions of residents. The inspector determined that this policy is generic and does not inform of the actual criteria required for admission to the designated centre. As of the day of inspection there had been no admissions to the designated centre since the commencement of regulation in November 2013.

**Judgment:**

Non Compliant - Major

**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):**

No actions were required from the previous inspection.

**Findings:**

Of the sample of residents personal plans reviewed, the inspector confirmed that residents had an assessment in place for both their health and social care needs. The assessment was reviewed annually or more frequently if the needs of the residents were to change. Whilst there were plans of care in place, the actual supports required to meet the needs were insufficient. Specific goals had been identified, which included actions to be taken and the person responsible for supporting the resident to achieve the goal. However there was an absence of the actual resources required to achieve that goal, such as staffing required. This was as the assessment of need did not account for the dependency levels of residents. As stated in Outcome 1, this was evident in the restriction placed on one resident who had to remain in their bedroom when another resident was present in the designated centre. This intervention resulted from an incident which had occurred between the two residents. The inspector could not determine if the intervention was as a result of insufficient resourcing or the choice of the resident and/or their representative. There was evidence of input from Allied Health Professionals in the personal plans of residents.

The person centred plans were reflective of both short and long term goals of residents inclusive of with who and where they would like to live. Each resident also had an activity schedule in place. There were inconsistencies however in the action taken as a result of the information documented. In one instance it was clear that efforts had been made to contact individuals identified in the person centred plan of a resident, however there was no formal transition plan in place. There were also instances where residents and their representatives had been informed of a transition, however this was not completed in consultation with the resident and/or their representative. The inspector directed management to Regulation 25 (4) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)

Regulations 2013, in the feedback meeting.

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

The designated centre is a unit within a larger campus operated by the Muiriosa Foundation. Whilst the centre has its own entrance it is contained in the same building as another designated centre and services which are not under the remit of the Health Act 2007. As per the Statement of Purpose and Function, the designated centre has the capacity to provide services for ten adults, both male and female. The premise consists of eight single bedrooms and one double bedroom. An action identified in the previous inspection was that there was insufficient control measures in place in the double room to ensure the privacy and dignity of the two residents residing there. The provider responded by providing additional screening between the personal spaces of each resident.

The designated centre also consists of two sitting rooms and a smaller recreational room, a dining room which contained some kitchen appliances, a bathroom, a shower room and three cubicle style toilets. There is also a toilet for use by visitors and staff and an internal garden. There is one main entrance to the designated centre which restricted access out of the designated centre however there was no restrictions for individuals entering the designated centre. There was also an entrance at the back of the designated centre which had the same system. A risk was present at both entrances. The back entrance is linked to a day service area. This allows any individual utilising this facility to walk directly into the area of the bedrooms of residents. As stated in Outcome 1, the inspector also had the opportunity to enter the main entrance of the designated centre on numerous occasions and proceed to the private rooms of residents without meeting staff.

The inspector was not satisfied that the premises were fit for purpose and meeting the intended purpose of the designated centre. As stated previously, male and female residents were sharing cubicle toilets and there was multiple accesses to the shower

room and bathroom. The Inspector observed mealtimes in the designated centre and observed the dining room to be of an inadequate size for the number of residents accessing same. This is further discussed in Outcome 11. The dining room contained a fridge, microwave, dishwasher, sink and portable grill however there was no cooker in place and all main meals were delivered from a central kitchen on the campus. Staff did state that they try to provide alternative meals such as a cooked breakfast to residents despite the absence of a cooker.

Although efforts had been made to personalise the bedrooms and communal areas, there was areas where maintenance was required due to flooring being worn and paint work chipped and marked. Bedrooms were partitioned from the main corridor by frosted glass resulting in similarities with an acute setting and reducing the homeliness of the designated centre. Residents' beds were those that were appropriate for an acute setting as opposed to that of an individual's home. There were no assessments to support that this was an identified need for a resident. Bedrooms were furnished with appropriate storage however some of the furniture was in disrepair.

The two sitting rooms and smaller recreational room were of an adequate size and there was also a sensory room available for residents to access off one of the sitting rooms. There was storage area for household chemicals however there was insufficient hand washing facilities and ventilation in the room. There were laundry facilities available which were primarily used for small items such as dish towels or residents' aprons. The inspector was informed that the majority of laundry is completed outside of the designated centre. The washing machine and dryer were maintained in a sluice room. The inspector was informed that the sluice room was no longer operational. Notwithstanding this, the inspector informed management that a decision had to be made for the actual purpose of the room and any unnecessary equipment removed to ensure appropriate infection control management.

The inspector reviewed the evidence of maintenance of equipment and confirmed that the appropriate servicing occurred.

**Judgment:**

Non Compliant - Major

**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):**

No actions were required from the previous inspection.

**Findings:**

The organisation had a corporate safety statement in place, with a centre specific safety

statement for the designated centre. There was a policy in place regarding the management of risk and a centre specific risk register in place. The inspector reviewed the risk register and recognised that although assessments were occurring a review was required to ensure that the information contained in the assessment was accurate and reflective of the actual risk within the designated centre. For example, whilst the risk of infection was assessed there was no reference to the laundry facilities being located in the sluice room. Despite the inspector being informed that the sluice room was no longer operational. The communal cubicle style toilets were also not risk assessed. The inspector reviewed records of the monthly health and safety audits and were satisfied that actions identified were addressed in a timely manner.

There was a policy in place regarding the control of infection and the inspector observed personal protective equipment readily available for staff. There was a colour coded mop system in place. The risk assessment in place for the control of infection stated that all staff had received training in appropriate hand hygiene practices and adhere to best practice. The inspector observed deficits in the hand hygiene practices of staff at mealtimes and the staff training records available on the day of inspection did not evidence that all staff had received training. Management had not conducted audits to review the practices of staff. The centre had material data sheets in place for all chemicals utilised in the designated centre. However as stated in Outcome 6 there was no ventilation in the room in which the chemicals were stored.

As the designated centre is contained within a larger structure, a staff member involved in the operations of the wider organisation is appointed as the fire officer and is responsible for the prevention and management of fire in the designated centre. On the first day of inspection, the inspector was not assured that the systems in place for the detection and management of fire was robust. Therefore contacted the provider nominee to notify him of same. On the second day of inspection, the inspector met with the fire officer who assured the inspector that the fire alarm system was accurate and specific to the designated centre. Two staff present on the days of inspection had not received training in the prevention and management of fire. The findings of day one further evidence that refresher training was required for other staff to ensure that they were fully informed. The designated centre is divided into three zones, with fire doors in place. The emergency plan did not reflect the zoning of the designated centre and although fire drills were conducted they were not reflective of the zoning. For example, one record of a fire drill stated that it took twenty seven minutes to evacuate residents when one staff was on duty. One staff member was the standard staffing level from 22.30 hours to 08.00 hours. However the records did not inform if the fire evacuation was a staged evacuation or a full evacuation of the building. For security reasons the designated centre is locked at night with the staff on duty containing the keys. The three fire exits were key operated. Risk assessments had been conducted regarding the staffing levels at night. In March 2014 the risk was identified as high and in April 2014 it had been reduced to medium. The additional control measure was that wheelchairs were placed in residents rooms at night, however there was no referencing to staffing levels and the actual supports required by residents.

All residents had a personal evacuation plan in place, however evidence stated that eight residents require the assistance of one staff with four residents requiring full physical assistance. Two residents required the assistance of two staff. There was also

no assistive equipment available for residents as the beds did not facilitate same, therefore hoists or duvets were required to evacuate.

The records of maintenance and servicing of fire equipment was up to date. There were also contingency plans in place in the event of a full evacuation of the building required and a location identified for residents to be transferred.

As of the day of inspection there was no certification from a competent person available to confirm that the building was in compliance with statutory requirements relating to fire safety and building control as stipulated in Regulation 5 (3) (d) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Judgment:**

Non Compliant - Major

**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):**

No actions were required from the previous inspection.

**Findings:**

The designated centre had a policy in place regarding the prevention, detection and response to abuse. Staff spoken to were able to demonstrate the appropriate actions to be taken in the event of a suspicion or allegation of abuse. From the sample of staff training reviewed, staff had received the appropriate training. Relatives spoken to stated that they were assured that their loved one was safe. There had been no allegation or suspicions of abuse reported since the commencement of regulation. Improvements were required in specifying the reporting structures and identifying who the designated officer for the management of suspicions or allegations of abuse was.

From the sample of personal plans reviewed, the inspector observed inconsistencies in the positive behaviour support provided to residents. Whilst residents who were identified as presenting with behaviours that challenge had been referred to the relevant allied health professionals there were inconsistencies in the use of proactive and reactive strategies. There was also a requirement for more regular reviews. For example there was evidence that a resident had injured a staff member in May 2014, however their last

review was March 2013. There was no evidence that the resident had been re-referred to the relevant allied health professionals. There were also instances where the documented strategies were not specific and did not adequately inform staff of the actions to be taken. The inspector reviewed one document which stated that the lives of other residents were being negatively impacted by the behaviours of one resident. However there was no evidence of the actions that had been taken to support the resident and reduce the negative outcomes for others.

**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):**

No actions were required from the previous inspection.

**Findings:**

There was a record of all incidents occurring within the centre. The centre adheres to the legislative requirement to submit relevant notifications in a timely manner to the Chief Inspector. There had been no accidents or incidents which required notification to Chief Inspector within three working days. The inspector was assured that the information reported on a quarterly basis was accurate.

**Judgment:**

Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

Each resident had an activity timetable in place with one resident having access to a formal day service. The residents residing in the designated centre had complex needs and the majority of activities were sensory based. There was a sensory room on site in the designated centre and residents observed residents having regular access to this. As previously reported, relatives stated that they felt residents were supported to maintain personal relationships and links with the wider community. Due to the collective needs of residents, there was evidence that residents were not provided with the appropriate supports due to resources. As stated in Outcome 1, it was documented that the nature and extent of one resident's disability and assessed needs negatively impacted on the ability of other residents to receive appropriate care and support.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed a sample of residents' files and in the main was satisfied that the healthcare needs of residents were being met. There was evidence that residents were regularly reviewed by the general practitioner and were seen within an appropriate time frame when the need arose. Residents did not have a choice of general practitioner however there was no evidence that residents were dissatisfied with this. There was evidence of referrals to appropriate Allied Health Professional when a need was identified and care plans were reviewed annually or sooner if the need arose. There was evidence based tools utilised for the assessment of health care needs. Of the sample of files reviewed there was evidence that residents were supported at the end of their life, and that consultation had taken place between the resident and/or their representative.

The inspector reviewed the mealtimes of residents and observed them to be rushed. There was a choice of two meals available and pictures were utilised to ascertain the choice of residents. However, as stated in Outcome 12, the dining room was inadequate to support the number of residents in the designated centre. As a result mealtimes were staged, however a number of residents were in the dining room for less than fifteen minutes. Staffs supporting residents were observed speaking in a dignified and respectful manner. There were appropriate assessments in place for individuals requiring nutritional or food modification. These assessments were in conjunction with relevant members of the multi - disciplinary team.

**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):**

No actions were required from the previous inspection.

**Findings:**

The organisation had a policy in place regarding the practices and procedures in place for the management of medication. The policy was out of date and had not been reviewed since 2010. Medication was stored in a secure location and access to same was restricted to personal with the relevant training and skill set. The inspector observed the administration of medication and found a risk present. The medication was administered at mealtimes, and as stated in Outcome 11 residents were in the dining room for short periods of time. The inspector observed the administrator to dispense medication, however place to one side as the resident was not ready to receive same. The administrator then proceeded to dispense and administer the medication of a second resident in the interim. This practice is not in line with best practice recommendations.

On the day of inspection, there were residents prescribed controlled drugs. The inspector reviewed the system in place for storing and checking the stock and was satisfied that the system was in line with best practice. From a review of the prescription and administration records, medications were administered at the prescribed time. There was a signature for the administering staff present. There was a record of staff signatures present in the designated centre, this was not maintained with the medication records. Not all of the relevant information was maintained on the prescription sheet with the name of the prescriber omitted in some instances and the signature of the prescriber was not present for all medications.

The policy of the organisation states that a protocol must be in place for all medication prescribed for as required. The inspector found that there were policies in place however the effectiveness of the protocols was reduced as the information contained did not inform of when the medication should be administered. For example, the protocol in place for medication to be administered to assist a resident sleeping did not inform of the circumstance in which it should be administered or how the resident presents.

There was evidence of monthly medication audits occurring.

**Judgment:**

Non Compliant - Minor

**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):**

No actions were required from the previous inspection.

**Findings:**

Prior to the commencement of the inspection, the inspectors reviewed the Statement of Purpose and Function of the designated centre and determined that it did not contain all of the necessary information 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. For example the person in charge and the provider were not included. There was no clear admissions criteria stated in the Statement of Purpose and Function. The fire precautions and associated emergency procedures in the designated centre were not included.

**Judgment:**

Non Compliant - Moderate

**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):**

No actions were required from the previous inspection.

**Findings:**

On the two day inspection the person in charge was absent from the designated centre. The provider nominee was also not present. Therefore the inspection was facilitated by

the area manager and staff nurses. Feedback was provided to the regional manager, the area manager and nursing staff. Subsequently the organisation submitted documentation to alter the provider nominee from the Chief Executive Officer to the regional manager. At the time of this report the application was in process. The inspector was not in a position to assess the fitness of the person in charge due to their absence.

There was a management structure in place and there was evidence that audits occurred regularly to review the quality of care provided to residents, inclusive of health and safety audits, regular review of restrictive practices and medication. However there was no written report on the safety and quality of care and support provided in the designated centre as stipulated in Regulation 23 (2).

**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):**

No actions were required from the previous inspection.

**Findings:**

As stated in Outcome 14, the person in charge was absent from the designated centre for the duration of inspection. However the absence was not expected to exceed 28 days therefore notification was not required to the Chief Inspector as stated in Regulation 32 (1). However the inspector determined that there were no arrangements in place in the event of this occurring unexpectedly. When asked, staff were not able to state who the deputy person in charge was and who took responsibility for the statutory role of the person in charge in their absence. For example, who would notify the Authority of an event in three working days as stipulated in Regulation 31 (1).

**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):**

No actions were required from the previous inspection.

**Findings:**

The failings identified on this inspection demonstrate that the designated centre is not resourced to ensure effective delivery of care and support. Examples identified by the inspector include residents being confined to their room as a result of being 'at risk' from other residents and that the documented evacuation needs of residents did not correlate with the staffing levels at night. The minimal time residents also spent in the dining room were indicative of insufficient resources.

Whilst there was a clearly defined organisational structure, the individuals responsible for the statutory requirements were not clear. As stated the person in charge was absent from the designated centre, however it was not clear who was taking responsibility in their absence on the day of inspection as stated in Outcome 15. There was no evidence that the management systems in place in the designated centre supported services which were appropriate to the residents needs, were consistent and effectively monitor, as stated in Outcome 1 and 10. As stated in Outcome 5, goals created did not account for the actual resources required and there was no evidence that staffing levels were reflective of the actual needs of residents.

Whilst there were staff meetings held, minutes demonstrated that they primarily focused on specific resident issues as opposed to the quality and safety of services. There were instances where a risk was identified with the staffing levels as night, consistent with the findings of this inspection, however there was no evidence of a follow up by management or further consultation with staff.

The inspector found that the practices were not in line with the Statement of Purpose and Function of the designated centre. For example, the Statement of Purpose of Function states that when residents are transitioning this occurs in consultation with the resident and their family. As reported in Outcome 1, the evidence on this inspection did not substantiate same. The Statement of Purpose also states that individuals who require behaviour support plans have them in place and they were reviewed regularly. This was not in practice as stated in Outcome 8. As reported in Outcome 1, records of complaints was stored in an accessible location which is in contradiction to the Statement of Purpose and function, which states that all complaints will be treated with confidence.

**Judgment:**

Non Compliant - Major

**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):**

No actions were required from the previous inspection.

**Findings:**

The findings of this inspection evidence that the staffing levels were not sufficient to meet the documented needs of the residents. The inspector reviewed a sample of rosters and confirmed that the standard staffing level is six staff during the day, two nursing staff and four care staff and one nurse and one care staff from 20.00 hours to 22.30 hours. From 22.30 hours there is one nurse on duty. As stated previously, residents who required more intensive supports resulted in a negative impact on other residents. Also the personal evacuation plans on residents stated that two residents required the support of two staff in the event of an emergency despite there being one staff on duty. There was an arrangement in place with another designated centre in the same building for support from their one staff. However as the arrangement worked both ways, there was a risk that ten residents could be unsupervised if the night staff was required in the other designated centre.

The training records available on the day of inspection were incomplete and did not evidence that staff had received the appropriate training. The inspector completed an additional field work day in the central office of the Muiriosa foundation to review staff files and training records. Of the sample of files reviewed, staff had received training in manual handling and the protection of vulnerable adults however two staff who were on duty on the day of inspection did not have training in the prevention and management of fire.

Of the sample of staff files reviewed all of the records were held in respect of staff as stipulated in Schedule 2 of the regulations. There was no evidence available of the supervision and support provided to staff appropriate to their role. There was a record maintained of the current registration status of nursing staff.

Agency staff were utilised in the event of staff shortages and the central offices held documentation in respect of same. There were no volunteers involved in the designated centre at the time of inspection.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector reviewed the policies listed in Schedule 3, 4 and 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Not all of the policies listed in Schedule 5 were present in the designated centre and a review of other policies were required to ensure that they were still relevant and reflective of the actual policies in place in the designated centre. For example the complaints policy and medication management policy had not been reviewed and there was an absence of a policy in relation to the provision of information to residents. There was also a need to review the policy in relation to the admissions, discharge and transfer of residents as it was not reflective of the actual procedure for the designated centre and the legislative requirement.

The designated centre maintained records in relation to residents however improvements were required in relation to the communication needs of residents and occasions in which restrictive practices were used in respect of a resident, the reason for its use, the interventions tried to manage the behaviour, the nature of the restrictive procedure and its duration. As stated in Outcome 12, improvements were also required in the records maintained for each drug and medicine administered to the resident. The designated centre had a guide for residents however the inspector found that it did not inform residents of the operations of the designated centre and the services received by the resident. There was a directory of residents maintained inclusive of date of admission.

As part of the process for registration the designated centre provided evidence of adequate insurance against injury to residents.

**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:***

Jillian Connolly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Muiríosa Foundation
<b>Centre ID:</b>	OSV-0003959
<b>Date of Inspection:</b>	23 July 2014
<b>Date of response:</b>	14 October 2014

### 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 evidence that residents and/or their representatives were informed regarding the running of the centre as opposed to being consulted.

**Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

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

Actions taken:

- Each individual has a key worker who makes contact with family members on a monthly basis, or more frequently if required, to ascertain the individual's and family member's views of the service provided by the designated centre. This communication also allows the family members to highlight issues which they would like to discuss further. Date action implemented: 22nd September 2014
- Each key worker provides a documented quarterly update, or more frequently if required, to the person in charge to ensure that he/she is confident in the status of family involvement in the support which their family member receives. Date action implemented: 22nd September 2014

Actions Planned:

- A piece of work has been commissioned within the region to ascertain what supports/training are required to ensure that key workers within the designated centre are confident to undertake the above. Date for completion: 31st December 2014.

**Proposed Timescale:** 31/12/2014

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were numerous breaches in the privacy and dignity of residents:

- Personal information of residents was easily accessible both in the complaints log and in the office
- The toilets and bathrooms did not promote the privacy or dignity of residents
- There was free access into the designated centre from outside

**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 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:**

Actions Taken:

- All personal information is stored securely in a locked office. The staff member in charge carries the key to the office and access is restricted. Action completed: 25th July 2014.
- Privacy thumb locks have been added to each toilet door to promote privacy and dignity of each individual. Action completed: 3rd September 2014.
- Signage is in place to show when the room is in use. Action completed: 1st August 2014.
- Quotations for the cost of installation of electronic key pads for each entrance to the centre have been requested. Action completed: 22nd September 2014

Actions Planned:

- Quotations for works to convert the current toilet area into two separate toilet

facilities, each with its own entrance will be requested. Date for completion: 3rd October 2014

- Once costs have been received for the conversion of the toilet area and the installation of key pads, work on same will be prioritised in line with other works required in the designated centre. Date for completion: 31st October 2014

**Proposed Timescale:** 31/10/2014

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Access to residents' monies was restricted to office hours.

**Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Action taken:

- Each individual holds a maximum amount of €200 on site, the staff member in charge can facilitate access to same, without restriction, should an individual so require it.

Action completed: 20th September 2014

**Proposed Timescale:** 20/09/2014

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was evidence of negative outcomes for some residents based on the needs of others.

**Action Required:**

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

Actions taken:

- A person centred support plan is in place for each individual which outlines their needs and identifies supports required.

Actions planned:

- The risk assessment, in relation to an individual whose behaviour of concern impact negatively on another individual, is currently being reviewed by the local manger and the senior psychologist.

- The risk assessment will clearly identify the pertinent control measures and the subsequent risk ratings. Date for completion: 3rd October 2014

**Proposed Timescale:** 03/10/2014

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was a record of complaints in place however it was inaccurate as the inspector found evidence of complaints which had not been logged.

**Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Actions taken:

- The local manger will conduct a monthly review of complaints received to ensure that the designated centre is complying with the organisation's updated policy document "Policy & Procedure for the Management of Complaints" August 2014.
- As part of this review the local manager will ensure that each complaint logged is addressed in an appropriate manner. Date for implementation: 22nd September 2014
- Complaints received and their resolution is a standing item for all staff team meetings.

Actions planned:

- In order to ensure that the staff team are competent in the process of receiving and logging complaints, the person in charge will undertake a refresher with the team in relation to the organisation's updated policy document "Policy & Procedure for the Management of Complaints" August 2014. Date for completion: 1st October 2014.

**Proposed Timescale:** 01/10/2014

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no evidence that assistive technology had been considered or assessed for residents who experienced challenges communicating.

**Action Required:**

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

Action taken:

- A referral has been sent to the speech and language therapist to assess each individual's communication needs and to identify if any individual requires assistive technology. Action completed: 18th September 2014

Actions planned:

- The review of individual's needs in relation to assistive technology will be completed by the speech and language therapist. Date for completion: 28th November 2014
- If assistive technology is seen to be required by an individual the speech and language therapist will provide a report on the requirement to the local manager.
- If assistive technology is to be purchased the individual will be supported on same.

**Proposed Timescale:** 28/11/2014

**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:**

There was no contract between the resident and/or their representative in place, stating the fee to be paid, the services received and any additional charges to be incurred.

**Action Required:**

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

Actions taken:

- A contract of care has been devised by the organisation which states the terms on which the individual will reside within the designated centre. Date action completed: 5th September 2014.

Actions planned:

- The signed contract of care will be available on each individual's personal file and a copy will be issued to the individual's family member where appropriate. Date for completion: 31st October 2014

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The policy regarding admissions was generic and did not inform of the actual criteria or

process of admission to the designated centre.

**Action Required:**

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

Actions taken:

- The organisation's policy document "Policy & Procedure on Access, Discharge and Transfers to and from Muiriosa Foundation Services" has been updated and re-issued in March 2014.
- o Admission requests to residential services are routed via the funding body.
- o Requests for admissions to residential services are made to the Muiriosa foundation rather than named designated centres.
- o On receipt of a referral for admission, the first set of issues that need to be considered in the context of processing the admissions request are set out in the generic admissions criteria of the policy.
- o There is then a follow-on phase in relation to specific designated centres which involves:
  - a) Confirmation of a vacancy
  - b) Application in the context of statement of purpose and function
  - c) Consideration in context of compatibility of the person who is subject to the application and the residents living in the designated centre.

**Proposed Timescale:** 30/03/2014

**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 assessments did not inform of the actual supports residents required.

**Action Required:**

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

Action taken:

- The person in charge will ensure that all individuals have an assessment of need based on a comprehensive assessment by an appropriate health care professional (which in most instances will be a social care worker or a registered nurse) prior to admission as required by regulation 05 (1) (a).

**Proposed Timescale:** 13/09/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was evidence that a resident was planned to be discharged from the designated centre contrary to the wishes of the resident and/or their representative.

**Action Required:**

Under Regulation 25 (4) (d) you are required to: Ensure the discharge of residents from the designated centre is discussed, planned for and agreed with residents and, where appropriate, with residents' representatives.

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

Actions taken:

- Following communication with family, a suggested transfer/discharge which had been previously explored in relation to one individual was not pursued any further in line with the family's wishes. The area director confirmed this with the family representative. Action completed: 8th October 2014.

- In line with the organisation's policy document "Policy & Procedure on Access, Discharge and Transfers to and from Muiríosa Foundation Services" 30th March 2014, all future transitions and discharges will be undertaken in consultation with each individual and their representative and in respect of each individual's personal preferences and wishes. Action completed: 30th March 2014.

Actions Planned:

- Future planning in relation to the individual has commenced in consultation with the individual's family representative.
- Area Director and key worker met with the individual and parents to explore the individual's vision and preferences.
- Parents visited a possible alternative accommodation.
- Following from these meetings a transition plan specific to the individual will be developed.
- The individual's contract of care will be reviewed with the individual and their family member at this time.
- Action commenced: 9th October 2014

**Proposed Timescale:** 09/10/2014

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were numerous areas in the designated centre which were in disrepair.

**Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

Actions taken:

- A formal meeting took place between operations manager, maintenance manager, area director and person in charge to ascertain general maintenance works required.

Action completed: 18th September 2014

Actions planned:

- Required works identified will be prioritised in order of urgency. Date for completion: 10th October 2014
- Prioritised works required will be carried out in line with the organisation's available resources. Date for completion: 30th April 2015
- A report detailing the general maintenance works required and the proposed time line for completion of same will be made available to HIQA as requested by the 14th October 2014.

**Proposed Timescale:** 30/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The dining room was not of an adequate size.

**Action Required:**

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

Actions taken:

- Each individual has their own preference at meal times, as documented in their personal care plan. For example, one individual prefers to take their meal when the dining room is quiet, as such, meals are staggered in accordance with individuals wishes.
- A meeting has took place between operations manager, maintenance manager, area director and person in charge to review options available in relation to providing additional dining room space. Date action completed: 10th October 2014
- Following the above meeting it was seen as not possible to provide alternative dining space however to make best use of the space available the following actions have been taken:
  - o Two sittings to be continued as per wishes of individuals.
  - o Unused and unnecessary equipment removed from dining room to allow more space
  - o New dining tables and chairs have been purchased.
  - o The practice of administration of medication from the medication trolley in the dining

room during meal time has been discontinued.

o The wash trolley will be removed from the dining room during meal times

**Proposed Timescale:** 14/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The following matters were not provided for:

- Ventilation in area for storage of cleaning chemicals
- A kitchen area with suitable and sufficient cooking facilities
- Toilets of a standard suitable to the needs of residents
- Laundry facilities were in the sluice room

**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:**

Actions taken:

- Ventilation has been installed in storage area for cleaning chemicals. Date completed: 1st August 2014
- The sluice equipment which had been decommissioned prior to inspection has been removed from the laundry room. This room operates as a laundry room only. Date completed: 31st July 2014
- Privacy thumb locks have been added to each toilet door to promote privacy and dignity of each individual. Action completed: 3rd September 2014.
- Signage is in place to show when the bathroom is in use. Action completed: 1st August 2014.
- A formal meeting took place between operations manager, maintenance manager, area director and person in charge to ascertain general maintenance works required. Action completed: 18th September 2014

Actions planned:

- Required works identified will be prioritised in order of urgency. Date for completion: 10th October 2014
- Quotations for works to convert the current toilet area into two separate toilet facilities, each with its own entrance will be requested. Date for completion: 3rd October 2014. Once costs have been received for the conversion of the toilet area, work on same will be prioritised in line with other works required in the designated centre.
- Prioritised works required will be carried out in line with the organisation's available resources. Date for completion: 30th April 2015
- An alternative kitchen area located beside St. Agatha's unit which has suitable and sufficient cooking facilities will be utilised. Date for implementation: 31st October 2014
- In the interim the practice of providing food items not on the day's menu from central kitchen as per individual preferences/requests will continue.
- Notification of identified alternative kitchen area will be submitted to HIQA as

requested by the 14th October 2014.

**Proposed Timescale:** 30/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no evidence of compliance with planning and building regulations available on the day of inspection.

**Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

Actions planned:

- Documented evidence of compliance with planning and building regulations will be submitted to the Health Information and Quality Authority registrations office in line with the phased plan which has been submitted by the organisation. Date for completion: 30th September 2014

**Proposed Timescale:** 30/09/2014

## **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 hazards present in the designated centre were assessed.

**Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

Actions Taken:

- Since the inspection the organisation has developed a document entitled "Risk management policy: Overarching framework" which specifies how all of the elements of the risk management policy fit together. The overarching framework details the role of the Safety Statement, Location Specific Safety Statement, Policy and guidance on the management of risk individual service user and the various risk registers (local, regional and organisational).

The role of the Location-specific Safety Statement in identifying and profiling local hazards is specifically referenced in the policy (page 4).

- A common Risk Assessment and Management Plan applies to assessing and managing all categories of risk. This risk assessment and management plan requires the specification of the agreed risk-control measures and their corresponding risk ratings.

**Proposed Timescale:** 30/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The inspector observed inadequate hand hygiene practices.

**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:**

Actions planned:

- All staff members will be retrained in hand hygiene practices in line with the organisation's document "Hand Hygiene Guidelines" October 2011 Date for completion: 1st October 2014
- The local manager will undertake spot checks to ensure that staff on duty adhere strictly to the organisation's "Hand Hygiene Guidelines". Individual feedback will be given to each staff member in relation to the spot checks. Date for completion: 1st November 2014.
- Proper hand hygiene will form part of the local induction to the unit for all new staff.

**Proposed Timescale:** 01/11/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no evidence that all residents could be evacuated in an appropriate time frame at night.

**Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

Actions taken:

- A full fire evacuation (i.e. evacuating people to the assembly point outside of the building, not just to the nearest compartmentalised zone) was carried out on 18th September 2014. All individuals were safely evacuated within 13 minutes 11 seconds

by registered nurse on duty. This evacuation was supervised by the Fire Officer, Person in Charge and Manual Handling Officer. Action completed: 18th September 2014

Actions planned:

- Full night time evacuations will take place over the course of the next two weeks, under supervision of Fire Officer, Person in Charge and Manual Handling Officer, to ensure that all staff on duty (including night staff) can safely evacuate each individual in the event of an emergency within the required time. Date for completion: 10th October 2014. The learning points emerging from these supervised evacuations will guide appraisal and feedback to staff.
- Following the above, a detailed report on the outcomes of the actions taken, inclusive of the dates evacuations took place, the zones evacuated the number of residents and staff involved will be submitted to HIQA as requested by the 14th October 2014.
- All staff will attend fire training. Date for completion : 1st October 2014
- The Fire Officer and Manual Handling Officer will conjointly review each personal evacuation plan to determine whether each individual can be safely evacuated by one person. Date for completion: 10th October 2014.
- Night time staffing levels will be reviewed in line with revised evacuation plans. Date for completion: 17th October 2014.
- A report outlining the review of personal evacuation plans and staffing levels will be submitted to HIQA as requested by the 21st October 2014.
- The manual handling instructor has completed training with nine staff members in the use of "ResQ Mat". All staff members will complete this training: Date for completion: 3rd October 2014.
- The emergency fire plan will be reviewed by the Fire Officer to ensure that it fully reflects appropriate use of the compartmentalised zones. Date for completion: 10th October 2014.

**Proposed Timescale:** 17/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Two staff were not trained in the prevention and management of fire. Staff did not have sufficient knowledge of the systems in place regarding the prevention and management of fire.

**Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Actions planned:

- All staff will attend fire training. Date for completion : 1st October 2014
- On completion of the update of the emergency fire evacuation plan, information sessions for staff on same will be held to ensure that all staff are knowledgeable in the

updated plan. Date for completion: 28th November 2014

- The manual handling instructor has completed training with nine staff members in the use of "ResQ Mat", all staff members will complete this training: Date for completion: 3rd October 2014.

**Proposed Timescale:** 28/11/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no evidence of fire compliance by a competent person available on the days of inspection.

**Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

Actions planned:

- A designated fire officer met with inspectors on the 24th July 2014, on second day of inspection and confirmed that there are two compartmentalised zones and that an "L1 addressable" fire detection and alarm system is in place.
- Evidence of fire compliance by a competent person (as per regulations) will be lodged with HIQA by 30th September 2014 (as signalled in the registration documentation submitted).

(The competent person has verbally advised that he will be deeming the designated centre to be compliant.)

**Proposed Timescale:** 30/09/2014

**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:**

There was evidence that residents' lives were negatively impacted by the behaviours of others. However there was no evidence that all efforts had been made to address this.

**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:**

## Actions Planned:

- A placement review is currently underway in relation to an individual whose actions negatively impact on others.
- An alternative designated centre has been identified where compatibility between this individual and the people living there would appear to be greater.
- Consultation with the individual's family in relation to the move has commenced. (The advantage of the move to the alternative designated centre is that due to its proximity to the family home family contact will be enhanced.)
- A specific transition plan to ensure success of the move will be undertaken by staff who support the individual. A copy of this transition plan will be made available to HIQA as requested by the 21st October 2014.
- Risk assessments are being carried out in relation those individuals whose lives are being compromised by the behaviours of this particular individual.
- Two team meetings with the senior psychologist have been scheduled to facilitate the identification of appropriate and proportional risk-control measures risk-control measures. Date for completion: 14th October 2014

**Proposed Timescale:** 21/10/2014**Outcome 12. Medication Management****Theme:** Health and Development**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The inspector observed a risk in the administration of medication as medication was set aside once dispensed.

**Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

## Actions Taken:

- Discussion was held on the organisation's updated "Medication Management Policy & Guidelines" August 2014, at a team meeting. One of the focus points of this discussion will be the completion of the "Root Cause Analysis Checklist for Prescribing Errors" which allows an individual to undergo reflective practice in regards of medication errors. Action completed: 24th September 2014
- At this meeting each registered has also been advised to undertake HSEland e-learning programme on Medication Management. Action completed: 24th September 2014
- Each registered nurse has also been sent a letter by the person in charge communicating need to strict adherence to local policy and also to Nursing and Midwifery Board of Ireland publication entitled 'Guidance on Medication Management', a

copy of which has been furnished to each registered nurse. Action completed: 24th September 2014

**Proposed Timescale:** 24/09/2014

### **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 was not reflective of the actual practices of the designated centre.

**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:**

Actions planned:

- The Statement of Purpose and Function document is currently being reviewed and revised by the Person In Charge.
- An updated statement of purpose and function document will be forwarded to the registrations office of the Health Information and Quality Authority.

**Proposed Timescale:** 28/10/2014

### **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 was no annual review of the safety and quality of care available on inspection.

**Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

- The Regional Director will undertake the annual review of the quality and safety of care and support in the designated centre.

**Proposed Timescale:** 31/10/2014

### **Outcome 16: Use of Resources**

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staffing levels were insufficient based on the documented needs of residents.

**Action Required:**

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

Actions planned:

- All individualised support plans, service user risk management plans, local risk register, and emergency plans will be reviewed by the Person in Charge.
- Staffing levels will be risk assessed against this analysis by the Area Director and Person in Charge.

**Proposed Timescale:** 03/11/2014

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There was no evidence of staff supervision.

**Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

Actions planned:

- Individual supervision meetings will take place monthly with each staff member. Supervision meetings and actions agreed at same will be documented. Date for completion: 28th November 2014
- The organisation's performance management process has been reviewed and updated. The document "performance conversations template" which was issued on the 30th June 2014 is now used to guide and document performance conversations with staff members. Date action completed: 30th June 2014
- Using the updated performance management process the person in charge will conduct performance management conversations with the relevant staff. Date for completion: 28th November 2014

- Performance management conversations will take place on at least a six monthly basis with all staff members in line with the organisations performance management process.

**Proposed Timescale:** 28/11/2014

### **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 as listed in Schedule 5 were prepared.

**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:**

Actions taken:

- All of the organisation's schedule 5 policies have been reviewed and updated as required.
- Copies of all updated policies are available in the designated centre.
- New policies and updates form part of the local staff team meeting agenda.

**Proposed Timescale:** 02/09/2014

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all policies had been reviewed in a three year period.

**Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

Actions taken:

- All of the organisation's schedule 5 policies have been reviewed and updated as required.
- All policies are reviewed within the three year time frame.

**Proposed Timescale:** 02/09/2014

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The residents guide was inadequate and did not provided for the matters stated in Regulation 20 (2).

**Action Required:**

Under Regulation 20 (1) you are required to: Prepare a guide in respect of the designated centre and provide a copy to each resident.

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

Actions planned:

- The resident's guide will be reviewed and updated by the Person in Charge, in order to ensure that it provides for the matters stated in Regulation 20 (2).
- A copy of the updated guide will be provided to each individual and their family members where relevant.

**Proposed Timescale:** 31/10/2014

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The records maintained in respect of residents were inadequate.

**Action Required:**

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

Actions taken:

- A signature bank has been added to the medication kardex folder for ease of reference. Date completed: 22nd September 2014
- A referral has been sent to the speech and language therapist to assess each individual's communication needs and to identify if any individual requires assistive technology. Action completed: 18th September 2014

Actions planned:

- The review of individual's needs in relation to assistive technology will be completed by the speech and language therapist. Date for completion: 28th November 2014.
- If assistive technology is seen to be required by an individual the speech and language therapist will provide a report on the requirement to the local manager.
- If assistive technology is to be purchased the individual will be supported on same.
- The senior psychologist will undertake a review of all individual restrictive practices in place to ensure that all relevant information is incorporated. Date for completion: 31st

November 2014.

- Restrictive practices are to be audited monthly and done so in consultation with each individual and their representative.
- All drug kardex's to be reviewed by the local manager to ensure all necessary information required is documented. Date for completion: 3rd October 2014
- All PRN protocols are to be reviewed by the local manager detailing specific circumstances for administering PRN medication. Date for completion: 3rd October 2014
- The residents guide will be reviewed and updated by the Person in Charge, in order to ensure that it provides for the matters stated in Regulation 20 (2).
- A copy of the updated guide will be provided to each individual and their family members where relevant. Date for completion: 31st October 2014

**Proposed Timescale:** 30/11/2014