<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by Autism West Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0002065</td>
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<tr>
<td><strong>Centre county:</strong></td>
<td>Galway</td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td><strong>Registered provider:</strong></td>
<td>Autism West Limited</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Tressan Dooley Kelly</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Lorraine Egan</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Florence Farrelly;</td>
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<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
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</table>
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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 15 July 2015 10:00
To: 15 July 2015 16:00

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tbody>
<tr>
<td>Outcome 02: Communication</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 12: Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<tr>
<td>Outcome 18: Records and documentation</td>
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</tbody>
</table>

Summary of findings from this inspection
This was the sixth inspection of the centre, the purpose of the inspection was to follow up on the actions arising from the last inspection and the discuss the new governance and management arrangement with the incumbent and incoming provider nominee. As part of this inspection inspectors met with residents, the provider nominee, the chairperson of the board of management, the person in charge and staff members.

Inspectors were informed the chairperson of the board was being nominated as provider nominee effective from July 16 2015. However, a fully completed notification detailing this change had not been received by the Authority.

Inspectors observed practices and reviewed documentation such as minutes of meetings, medical records and policies and procedures.

Inspectors followed up on actions arising from the inspection in February 2015. Inspectors found that many areas which had been identified as requiring improvement in this inspection had been addressed. However, some of these had not been addressed in line with the timeline provided in the previous action plan response. It was evident many of these had been addressed in the week prior to this
announced inspection.

Improvements were required to

- the provision of training for staff in the sign language used by residents to communicate
- response to the control measures in place to ensure adequate staffing levels are in place should an incident occur
- fire drills to ensure the residents can be evacuated safely in the event of a fire at night
- structures in place to ensure adequate governance.

Notwithstanding the improvements noted by inspectors in terms of residents' quality of life, the Authority is concerned regarding the long term sustainability of the centre. The improved governance in the centre was identified as being provided by a person who was not employed by the service provider. The provider nominee told inspectors they were waiting for another service provider to outline a plan to provide the long term support for residents.

The findings are discussed further in the report and improvements required and the provider's response are detailed in the action plan at the end of the report.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Not all aspects of this outcome were reviewed on this inspection.

Inspectors observed respectful interaction between residents and staff. It was evident residents were respected and consulted in regard to their day. Staff interacted with residents in line with their assessed needs and supported them to choose what they would like to partake in.

Meetings had taken place with residents and their family members in regard to their behaviour support plans and the use of physical restraint. Behaviour support plans had been reviewed to reflect this.

All staff working in the centre had received training in Studio III to ensure they could respond to residents in line with their assessed needs. The person in charge told an inspector that new staff would receive this training prior to commencing in the centre.

Judgment:
Compliant

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

Findings:
Not all aspects of this outcome were reviewed on this inspection.

Inspectors observed staff communicating with and responding to residents in line with their assessed needs.

One staff member had received training in the sign language used by residents to communicate (Lámh) since the previous inspection and seven staff members had received this training in 2014.

Five staff members had not received training in Lámh and some staff members had not received any training in communicating with residents. The provider’s action plan response to the inspection in February 2015 stated that all staff would receive training in Lámh by April 30 2015. The action pertaining to this is included in the action plan under Outcome 17: Workforce.

Judgment:
Compliant

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:
Not all aspects of this outcome were reviewed on this inspection.

Inspectors reviewed the accident and incident log and found that an incident which required two staff to support a resident had taken place. When this incident was taking place the other residents were not being supervised and there was no available support should the residents have required it. Although this had been identified on the incident report appropriate measure to mitigate the risk had not been put in place and control measures had not been identified.
All staff had taken part in a fire drill in the centre. However, fire drills had not taken place at night. A record of a fire drill which took place in the morning identified a resident as having refused to leave their bed. The resident's personal emergency evacuation plan was signed as having been reviewed two months after this fire drill however, it had not been updated to reflect the finding of the fire drill. This had not been identified as a risk or appropriate measure put in place to address the risk.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Not all aspects of this outcome were reviewed on this inspection.

The procedure for supporting residents regarding their money had been improved. The system had been strengthened to ensure residents' finances were protected from the risk of financial abuse.

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Not all aspects of this outcome were reviewed on this inspection.

Information received by the Authority the week prior to the inspection outlined concern regarding medication management practices in the centre. Inspectors followed up on this and found that this was being responded to by the person in charge and the person providing management support. The error appeared to be one of documentation and the person in charge outlined to inspectors the reason for this error and the measures being implemented to prevent re-occurrence. Inspectors were satisfied that this issue had been appropriately managed by the person in charge.

An inspector followed up on the actions arising from the inspection in February 2015. Appropriate practices relating to the management of medication were in place. The policy on the management of medication had been updated to include the practice of transcribing. Original medication prescriptions were in place and residents' medications had been reviewed in recent months.

Incidents relating to medication were viewed by an inspector. Incidents outlined the response which included liaising with medical professionals where necessary and seeking and following professional guidance.

A medication audit had been carried out by a person external to the centre the week prior to the inspection. Areas identified as requiring improvement had been or were in the process of being addressed.

Judgment:
Compliant

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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
At previous inspections in December 2014 and February 2015 inspectors identified inadequate management systems which were placing residents at risk. The provider
responded to the immediate action plan issued in December 2014 by stating that a person to provide management support would be in place on January 1 2015. At the inspection in February 2015 inspectors found that this person was not in place.

Following the inspection in February 2015 the inspector contacted the provider to ensure the management support was being provided as outlined in the action plan response. The inspector was told that the chairperson of the board and the provider had met with this person and that management support was being provided. The date outlined in the action plan response of the inspection in February 2015 was April 30 2015.

As part of this inspection inspectors followed up on the management support being provided. Inspectors were told that management support had not been provided as outlined in the previous action plan response. The chairperson of the board and the provider outlined reasons for not ensuring this was in place as one of a reluctance to compromise the centre's links with another service provider.

Inspectors were told that a person to provide management support to the person in charge had been appointed by the external service provider in the week prior to this inspection. Inspectors met with this person and found they were knowledgeable of the Regulations. They outlined their role in assisting the person in charge to fulfil her regulatory responsibilities and to provide support and guidance for the person in charge. It was evident that issues had been identified and responded to in the week since this person was appointed. The person in charge outlined the way she had been supported by this person to identify the areas which required improvement and to implement measures to ensure compliance with the Regulations.

The addition of the external person to provide management support was not clear in regard to the lines of authority and accountability in the centre. There was no outline of this person's role, allocated number of hours or minutes of meetings with the provider in regard to the role and responsibilities of this person. The provider told inspectors she had a number of teleconferences with this person in which the person had outlined the support they would provide.

The Authority is concerned that the management support is dependent on a person external to the centre who is not employed by the provider. There was no acknowledgement or assessment of the risk associated with this. The action relating to this is included in the action plan under Regulation 26 (2) under Outcome 7: Health and Safety and Risk Management.

The chairperson of the board and the provider nominee outlined the plan for the chairperson of the board to take over the role of provider nominee on July 16 2015. However, although a partially completed notification form had been received by the Authority the notification form did not outline the detail of the newly appointed provider nominee.

**Judgment:**
Non Compliant - Moderate
**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):**  
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**  
The long term sustainability of the centre remains unclear. The provider told inspectors the centre was a ‘holding operation’ until such time as another service provider would take over the care and support of the residents. She said the service was ‘unsustainable’ in its current format.

The provider told inspectors that they were awaiting another service provider to make a decision regarding providing a service for the residents. The provider did not outline a proposed plan or timeline regarding this nor did she show inspectors evidence of a formal undertaking by another service provider in regard to providing a service for the residents. She told inspectors they were waiting for a ‘planned timeline’ from the other service provider.

Inspectors were concerned that the centre was dependent on the decision of another service provider. There was no alternative plan if the identified service provider decided not to provide a service for the residents.

**Judgment:**  
Non Compliant - Major

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**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):**  
The action(s) required from the previous inspection were satisfactorily implemented.
**Findings:**
Not all aspects of this outcome were reviewed on this inspection.

Staff training records were maintained in the centre and all staff had received training in fire prevention, manual handling, the prevention, detection and response to suspected or confirmed allegations of abuse and the management of behaviour that is challenging.

A staff training needs analysis had been carried out in the week prior to the inspection and staff training needs had been identified.

Some staff had not received training in the sign language used by residents to communicate. This is discussed further under Outcome 2: Communication.

**Judgment:**
Substantially Compliant

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

**Findings:**
Not all aspects of this outcome were reviewed on this inspection.

On the previous inspection eight policies were not in place. On this inspection six of these policies were in place and the remaining two had been identified as required. There was no health and safety policy and the policy on education, training and development was in draft format and not in use in the centre.

As part of the quality improvement plan which had been compiled by a person providing management support in conjunction with the person in charge the requirement for a review of some policies to be further revised to ensure they were centre specific was identified. An inspector was informed that policies would be revised to ensure they are centre specific and guide practice in the centre.
Behaviour support plans had been reviewed and updated to ensure they were meeting the current needs of residents. The plans were signed by staff to indicate they had read and agreed to adhere to the plans.

**Judgment:**
Substantially Compliant

**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:**

Lorraine Egan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<td>Date of Inspection:</td>
<td>15 July 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>10 August 2015</td>
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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 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:
Some risks in the centre had not been identified and/or responded to. The management support is dependent on a person external to the centre who is not employed by the provider. There was no acknowledgement or assessment of the risk associated with this

Action Required:

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
As outlined under Outcome 14 below, a memorandum of understanding between both organisations is being drawn up which will outline management responsibility and accountability as well as detail on the role and function of the person participating in management, their accountability and responsibility to the existing service provider while undertaking this role as well as detail on responsibility should the PPIM be absent for any reason. A system will be put in place for the assessment of any associated risk and for responding to emergencies that may arise and this will be included in the memorandum if deemed appropriate. This memorandum will be finalised on 11th September 2015 and reviewed every three months.

'With regard to incident which required two staff to support a resident which had taken place, and supervision and support of other residents in such circumstances, the following is the action taken - Appropriate measures to mitigate the risk have now been put in place, this includes review and updating of behaviour management strategies, which now includes details of action to take in response to a crisis situation arising in order to ensure the safety and wellbeing of all residents; this will be reiterated at the next staff meeting.'

**Proposed Timescale:** 11/09/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills had not taken place at night to ensure the centre could be evacuated in the event of a fire at night.

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that a night time fire drill will take place, when all five residents are present. All five Personal Emergency Evacuation plans will be updated following this, and will include any changes or special requirements (such as multi-slide mats, or assistive aids) to ensure the safe evacuation of the centre in the event of a fire.

**Proposed Timescale:** 21/08/2015
### Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The addition of an external person to provide management support was not clear in regard to the lines of authority and accountability in the centre.

**Action Required:**
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
A memorandum of understanding is being drafted which will outline a defined management structure. Lines of authority and accountability will be clarified as well as specifying the role of the PPIM as provided for by the external organisation. This memorandum will be finalised on 11th September 2015 and reviewed every three months.

**Proposed Timescale:** 11/09/2015

### Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The long term sustainability of the centre is uncertain.

**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:**
Following the opening of this residential service in 1998, the HSE (then the Western Health Board) referred five young adults with ASD from a local organisation who were admitted for residential care and support. The HSE undertook to fund their care and have met this responsibility satisfactorily on a regular annual basis since then. This undertaking remains in place and will continue. The HSE have asked a local service provider to undertake a due diligence process which is ongoing, to explore the possibility of assuming responsibility for the care of the five residents. This due diligence process is near completion and will be completed on furnishing financial accounts to this service provider for their review.

If this transfer occurs, it will be with the agreement of HSE who will continue to be
responsible for the funding with regards to these residents’ care. If the transfer does not go ahead, the existing provider will continue to provide the service at Cloonmore for the five residents and will liaise positively with the HSE in this regard.

This will be reviewed together with the memorandum of understanding on the 11th of September 2015 and will be reviewed again on the 11th December 2015.

**Proposed Timescale**: 11/12/2015

**Outcome 17: Workforce**

**Theme**: Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect**:  
Some staff had not received training in the sign language used by residents to communicate.

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

Please state the actions you have taken or are planning to take:  
Out of the five remaining staff to be trained in LAMH three places have been secured for 11th September 2015, and the two remaining staff have been placed on a waiting list, with a further date likely to be before end of 2015. While recognising the importance of ensuring all staff are trained in LAMH, a Total Communication approach is what is required in the service. With this in mind two places have been secured on a 2 day course in Picture Exchange Communication System (PECS) on October 5th 2015. In addition to this the PIC will endeavour to secure a further two places on a TEACCH course as soon as a date becomes available.

**Proposed Timescale**: 05/10/2015

**Outcome 18: Records and documentation**

**Theme**: Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect**:  
The centre did not have all the policies required by the Regulations.

**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:**
All outstanding policies and procedures set out in Schedule 5 are being drafted and will be in place in the centre by Friday 11th September 2015.

**Proposed Timescale:** 11/09/2015  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some policies required review as they were not centre specific.

**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:**
The PIC and the PPIM will review and amend all policies and procedures set out in Schedule 5 ensuring that they are centre specific.

**Proposed Timescale:** 11/09/2015