<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Muiríosa Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004590</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Westmeath</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Muiríosa Foundation</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Josephine Glackin</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Jillian Connolly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the</td>
<td>14</td>
</tr>
<tr>
<td>date of inspection:</td>
<td></td>
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<tr>
<td>Number of vacancies on the</td>
<td>0</td>
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<tr>
<td>date of inspection:</td>
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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: 15 April 2015 10:00  To: 15 April 2015 20:00
16 April 2015 10:00  16 April 2015 17:00

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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<tr>
<td>Outcome 02: Communication</td>
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<tr>
<td>Outcome 03: Family and personal relationships and links with the community</td>
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<tr>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<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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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: General Welfare and Development</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<tr>
<td>Outcome 13: Statement of Purpose</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</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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<td>Outcome 18: Records and documentation</td>
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</table>

Summary of findings from this inspection
This inspection was conducted following an application by the provider, Muiriosa Foundation, to register the designated centre under the Health Act 2007. The centre is located in Meath and Westmeath, as it consists of four community houses. As of the day of inspection, three of the four houses were occupied. It is proposed that once the centre is registered, residents will transition to the fourth community house and their current home will cease operation.

The centre is the home for fourteen residents. The findings of this inspection report were gathered by the inspector speaking with residents and staff, observing practice and reviewing documentation. This was the first inspection of the designated centre.
Two of the community houses had been involved in a monitoring inspection previously, however the organisation had re configured the structure of the centre in July 2014 and the two houses had transferred to this centre.

Residents reported that they were happy with their home and the services provided to them. Staff were knowledgeable of the residents and their needs. In the main, the services provided were safe and effective. Compliance was identified in ten of the eighteen outcomes inspected. Substantial compliance was identified in Outcome 1: Residents’ rights, dignity and consultation and Outcome 18: Records and Documentation. The remaining six outcomes were identified as moderate non-compliance. Improvements were identified as being required in the assessment and monitoring of risk, the clinical governance of the centre, the medication practices and the fees documented in the written agreement between the resident and the provider.

The action plan at the end of this report identifies the failings 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):
No actions were required from the previous inspection.

Findings:
The organisation has a complaints procedure in place which was dated January 2015. Each of the community houses had a complaints' log maintained in the designated centre however there were no complaints recorded as of the day of inspection. The complaints procedure was located in a prominent position in each of the community houses. There was a person nominated to respond to complaints and the system in place incorporated review and a system of appeal.

There was an external advocate in place for residents to contact if required. Residents had access to a range of activities inclusive of a formal day service and accessing activities within their local community supported by residential staff. Residents stated that they were satisfied with the occupational and recreational activities available to them.

The inspector observed staff engaging with residents in a dignified and respectful manner. Residents stated that staff was ‘very good.’ All residents had their own bedroom and therefore were facilitated to undertake personal activities in private. Inspectors also observed that residents were supported to have a key to their own room if requested. Residents and staff further stated that there was good communication with residents regarding the day to day operations of the designated centre such as activities and meal planning. Improvements were required with consultation with residents regarding utility bills. Individuals were named as the account holder for some utility bills. Management stated that this was a requirement of the utility company however there was no evidence that the resident or their representative had agreed to this.

There was a policy in place regarding the personal possessions of residents and there
was a record maintained of the personal belongings of residents.

There was one incident recorded in which a resident expressed dissatisfaction as staff was speaking about them in front of other residents, which does not promote the privacy of residents. The inspector observed that all personal documentation of residents was stored in a secure location.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
The organisation had a policy in place for communication with residents. Of the sample of personal plans of residents reviewed, residents had an assessment by the Appropriate Allied Health Professional regarding their communication needs. Care plans and guidelines were in place to enable staff to support residents appropriately and to understand their communication needs. As stated previously staff were observed to engage appropriately with residents and to understand their needs.

Residents had access to a telephone including a portable telephone which enabled them to speak to family and friends in the privacy of their own room if required. There was also evidence that residents were involved in local community groups and had access to media through forums such as radio and televisions.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was documented evidence that residents were supported to maintain relationships with family and friends. In the main, residents were temporarily absent from the designated centre on a regular basis as they were visiting family and friends. Residents spoke about visitors being welcome in the designated centre and staff supporting residents to provide refreshments to their guests. There was a policy in place regarding visitors to the designated centre which was dated June 2014. The policy referenced the appropriate actions to be taken as required by Regulation 11. There was evidence that family were informed regarding the well being of their relative and also invited to attend meetings regarding the care of the resident in accordance with residents’ wishes.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
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<tbody>
<tr>
<td><em>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.</em></td>
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**Theme:**
Effective Services

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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**Findings:**
There was a policy in place regarding the procedures in place for admissions, including transfers and discharge and the temporary absent of a resident from the designated centre. However a review was required of the policy as it pertained to residents’ admission or discharge from the Muiriosa Foundation as opposed to the procedures in place for admission and discharge of residents from designated centre to designated centre within the foundation.

Residents had a written agreement in place which considered the care and welfare of residents. Each resident also had a tenancy agreement in place. However the inspector found that a review was required as there was inconsistent information in the documents and therefore they did not correlate. For example, the amount payable for rent and service charge stated in the tenancy agreement was higher than that in the written agreement. The inspector confirmed that residents were being charged the lower amount. However the breakdown of costs actually charged to residents differed from the breakdown as stated in the written agreement. For example residents were paying less of a ‘kitty’ expense and more for utilities than stated in the written agreement. Amendments had also been made to the contract of care post residents signing the initial agreement however evidence did not support that residents were agreeable to the amendments.

The written agreement stated that additional charges could be applied to residents for activities such as complimentary therapy, hairdressing etc.
Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his/her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Of the sample of personal plans reviewed by the inspector, each resident had an assessment in place of their health, personal and social care needs. There was also evidence that tools were utilised to assess the nutritional and manual handling needs of residents. There were plans of care developed for needs identified following this assessment. There was also evidence that residents had regular access to Allied Health Professionals such as occupational therapy and physiotherapy. Improvements were required to the assessment and care plans in place to meet the health care needs of residents; this is evidenced in Outcome 11.

Personal planning meetings were conducted with residents. It was documented in the minutes of these meetings that family members or friends were also present at these meetings. Following on from these meetings actions/goals for residents were developed which focused on both short and long term goals of residents. For example, going shopping weekly or going to concerts were documented and also holidays and joining community groups were included as longer term goals. The actions required to achieve these goals and the persons responsible were also documented. There was evidence that some of the goals had been achieved and the progress that was being made towards achieving others. The personal plans were also in the process of being made accessible to residents through photographs. Residents demonstrated that they were active participants in their personal planning, through showing their personal plans to the inspector and discussing their goals.

As stated previously, as part of this registration inspection, the inspector inspected a new premises for which residents from one of the community houses were proposed to transition to. As of the day of inspection, the process of transitioning had commenced and each resident had an assessment in place which identified the supports they may require for a successful transition. There was evidence that residents had been supported to visit their new home.
**Judgment:**
Compliant

**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):**
No actions were required from the previous inspection.

**Findings:**
This inspection involved four community houses. Three of the community houses were occupied by the fourteen residents and one of the houses was proposed as being the new home for four of the residents. The plan of the organisation is that once the residents had transitioned to their new home, their current house would cease operation. The inspector confirmed that this was required as their current house was not fit for the assessed needs of the residents. This was due to inadequate communal space and resulted in a fire exit being blocked to facilitate the kitchen table.

As stated in Outcome 1, each of the residents had their own bedroom. Inspectors observed that the bedrooms were personalised and reflective of a homely environment. Three of the community houses had a kitchen/dining room and sitting room. The proposed community houses had an open plan sitting/dining/kitchen area. This house was a bungalow, as was one of the other community houses. Two of the community houses had stairs. The appropriate assessments were in place to ensure that stairs were appropriate for the needs of the residents.

The inspector determined that in the proposed residence, three of the bedrooms were only suitable for residents who required no assistive equipment for their mobility needs due to the size. There was suitable number of bathrooms in each of the houses. However one of the houses did not have suitable storage, resulting in residents’ wheelchairs/hoist being stored in the communal bathroom which is not suitable from an infection control perspective. There was also a risk identified by the inspector in respect of this from a fire perspective as stated in Outcome 7.

The houses had appropriate ventilation, heating and lighting as of the day of inspection. There were also suitable procedures in place for the disposal of waste. There were laundry facilities in each of the houses, which residents could access if they choose. However residents stated they were happy for staff to complete same.

Each of the houses had external grounds which were safe and accessible for the needs
of residents.

**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):**

**Findings:**
There was an organisation safety statement in place and risk management policy in place. The statement had been adapted to reflect the designated centre. There was a risk register in place within each of the community houses. However improvements were required to ensure that it was reflective of all of the actual risks within the centre. For example, there was a risk assessment in place for the management of medication. The control measure in place was that residents’ medication was supplied by the pharmacy in compliance aids. However this was not the practice for all residents. Therefore the control measure was not accurate. Individual risk assessments were also in place for residents who had specific needs such as a risk of falls. Improvements were required as the assessment did not always correlate with other assessments in their residents’ personal plans such as their manual handling assessment. For instance in one risk assessment the score had been incorrectly calculated which resulted in an inaccurate level of risk being identified. In another instance a resident was assessed in their personal plan as presenting with agitation at times. However this was not documented in their assessment for risk of falls. The residents in question had not experienced a fall since the assessments had been conducted and the inspector confirmed that staff supporting the resident was aware of the risk. However, a review was required to ensure that the assessments were robust and accurate documents.

The inspector reviewed the systems in place for the management of infection and confirmed that there were policies and procedures in place. There were adequate systems in place for the disposal of general and clinical waste. There were adequate facilities in place for appropriate hand hygiene practices. Staff were aware of the appropriate actions to be taken in respect of laundering clothes and there were colour coded system in place for cleaning and food preparation.

Each of the community houses had an emergency management plan in place which stated the actions to be taken in the event of fire, electrical fault, and flooding or gas leak. Inspectors reviewed the records in place and confirmed that all of equipment required in the event of a fire was maintained at an appropriate interval. There were fire doors in place, with self closers in place. However the inspector observed that these were wedged open on numerous occasions as they were not linked to the addressable fire alarm system. This resulted in the compartmentalisation, as documented in the fire
plan to be irrelevant as in the event of a fire there was no protection in place. Fire drills had been completed at regular intervals with residents. However as of the day of inspection, the inspector was not assured that the plan in place for one resident was feasible with the staffing level at night. The provider responded by conducting a fire drill with the advice of the organisation fire officer and the physiotherapist immediately following the inspection. The provider wrote to the Authority stating that they were assured following on from this that the resident was safeguarded. There was also improvement required in the provider ascertaining if control measures implemented post a fire drill were effective. For example, there were instances in which residents chose not to engage in the process. A review had been conducted post each of these instances however the control measures had not been tested to ascertain if they were effective. The inspector confirmed that staff had received the necessary training in regards to the actions to be taken in the event of a fire. Residents also demonstrated to the inspector on inspection, that they were aware of the actions to be taken in the event of a fire.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The organisation had policies and procedures in place for the prevention, detection and response to abuse. The Health Service Executive policy was also present for the Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures which was implemented in December 2014. Staff were aware of the actions to be taken in the event of an allegation or suspicion of abuse. Residents also reported that they felt safe. There had been no allegations or suspicions of abuse in the designated centre.

There were policies and procedures in place regarding supporting residents who exhibit behaviours of concerns and restrictive practices. The designated centre had reported to the Chief Inspector the use of restrictive interventions such as bedrails and lap straps as required by Regulation 31 (3) (a). The inspector confirmed that the interventions were utilised following appropriate assessment and in consultation with the resident. One resident reported that it was their choice to have bedrails in place. There had also been medication as required reported as a chemical restraint on the quarterly report form. The inspector reviewed the documentation supporting the administration of same, and
confirmed that the relevant positive behaviour support plans were in place which had been completed with the appropriate professionals and in consultation with the representatives of the resident. There were regular reviews conducted of the support plan to ascertain the effectiveness of same and efforts had been made to identify the cause of the behaviour and to alleviate the behaviour utilising the least restrictive method. The team were advocating for the removal of medication as an intervention as the conclusion was that the cause could be potentially due to the unsuitability of the environment. Plans had been initiated to address this.

Judgment:
Compliant

**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:**
The inspector confirmed that each community house within the designated centre had an accident/incident log in place. Of the sample reviewed, the inspector confirmed that all of the necessary notifications had been reported to the Chief Inspector as required by Regulation 31.

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:**
The designated centre had a policy in place in respect of residents’ access to education, training and employment. There was varying levels of access to training and recreational activities for each of the residents based on their assessed needs. In some instances residents had access to a formal day service in which they accessed work experience...
and skill development. In other instances residents were supported by their residential staff. The inspector found that there was an emphasis on community integration within the centre, with residents being active participants within their community such as the choir, library and community social clubs.

**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:**
In the main, the inspector found that the majority of the health care needs of residents were met. There was evidence that residents had regular access to their general practitioner and were facilitated to attend appointments with Allied Health Professionals and in acute settings. As stated in Outcome 5, residents had assessments in place and care plans developed as a result of a need identified, such as epilepsy. Whilst these plans were reviewed annually, the inspector found that improvements were required to ensure that if there was a change in need or if an acute need was identified that the assessments were updated and appropriate care plans were put in place to support this need. For example, on discharge from an acute setting a resident had required intensive intervention post surgery. There was evidence that a nurse had attended the resident daily to attend to their wound management, however there was an absence of care plans in place to direct the care required. For example, staff documented daily that the fluid input and output of the resident was good. However the staff documenting same did not have the appropriate qualifications to be making that judgement and there was no plan of care in place to guide same. Staff were also documenting the temperature of the resident however there was no guidance to inform of the normal parameters of the resident's temperature and the actions to be taken if a concern arose. A risk management plan had been developed however it was generic and did not provide the specific information as required and previously stated.

There was a policy in place for monitoring and documenting the nutritional input of residents which was dated July 2014. Residents were supported to engage in a healthy life style by accessing local community groups for healthy eating. Residents' weight was monitored monthly and an evidence based tool was utilised to ascertain their nutritional status. Residents were further supported to take responsibility for their own health by being facilitated to attend cooking courses. Residents stated that the food was good and that they regularly were provided with their favourite food. There were residents who were documented as requiring modification to their food due to a potential risk of choking however this assessment had not been conducted by the appropriate Allied
Health Professional. The inspector determined that a risk was present to the residents’ dignity in respect of this due to risk adverse interventions in the absence of an actual need. Improvements were also required in the care plans for residents who had a diagnosis of diabetes. Whilst there were risk management plans in place in the event of a resident being hypoglycaemic or hyperglycaemic, there was an absence of prevention measures documented or linkage to other health care needs which may pose a risk based on a diagnosis such as hypertension.

**Judgment:**
Non Compliant - Moderate

**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:**
There was a policy in place regarding the appropriate practices in place for the management of medication. The centre had a policy in place for non-nursing staff to administer medication and the appropriate training had been provided to staff. There were residents who were prescribed medication as required in the event of a seizure and not all staff supporting the residents had received the relevant training in the administration of same or epilepsy management. The risk was reduced as it had been a significant number of years since the residents had experience a seizure. However as the medication had not been discontinued, all staff supporting the residents should have the knowledge to administer the medication.

Inspectors reviewed a sample of prescription and administration records and confirmed that the appropriate information was recorded as required by best practice such as the name, date of birth, general practitioner and allergies of the resident. There was a signature of the prescriber present for all medications and any medications which had been discontinued. Medications were in the main stored in a secure location however the inspector observed in one instance the key to be left in the press. Residents were not present at the time, however a risk remained.

There was guidance in place for staff regarding the administration of medication as required by the general practitioner. There had been a number of medication errors recorded in the designated centre. Whilst the incidents had been reviewed, the actions arising from the review were ineffective as they did not identify that staff had not adhered to the policy of the organisation in response to a medication error. The actions arising from the reviews had not been implemented in practice. For example, it was documented that incidents would be reviewed at the next team meeting. The inspector reviewed the minutes of the meetings, and found the incidents had not been reviewed.
**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:**
As part of the application to register the designated centre, the provider was required to submit the Statement of Purpose for the designated centre to the Chief Inspector. The document submitted was dated 15 April 2015. The inspector reviewed the document and determined that it contained all of the items as required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Evidence identified on this inspection confirmed that the centre is operating in line with the Statement of Purpose.

**Judgment:**
Compliant

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**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:**
The organisation has clear line management structures in place which outline the roles and responsibilities to ensure that the services provided were safe and effective. The provider nominee is the regional manager. There is an area manager who reports to the regional manager. The person in charge is the local manager who reports to the area
The person in charge commenced their role in July 2014. The person in charge is full time and has the qualifications and skill to manage the designated centre. The inspector was informed that plans were in place to ensure that the person in charge shall have an appropriate qualification in health or social care management at an appropriate level within three years of the regulations being operational as required by Regulation 14 (3) (b).

There was evidence that there were regular staff meetings within the designated centre with a standing agenda, that reviewed practices such as person centred planning and support and restrictive practices. There was also evidence that the provider nominee meets with the person in charge at appropriate intervals. A review of the quality and safety of care provided had been conducted by the regional manager in December 2014. There was evidence that actions identified such as prescriptions sheets being incomplete had been acted upon. Improvements were required however as it stated that residents’ views had not been incorporated as they were not present. Consultation with residents within the review is required by Regulation 23 (1) (e).

Whilst the systems in place promote a robust management system and review of the quality of care provided, evidence within this report demonstrates that a review was required in respect of the clinical governance of the centre considering the findings in Outcome 11 and 12.

**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:**
The person in charge had not been absent from the centre for more than 28 days since they commenced their post in July 2014. The provider demonstrated their awareness of the requirement to notify the Chief Inspector as required by Regulation 32 if this were to occur. As part of the application to register the provider had nominated two managers within the service to deputise in the event of the person in charge being absent.

There was also a system in place to ensure that there was always an appropriate member of management available to support staff in the event of the person in charge being absent for less than 28 days.

**Judgment:**
**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 cumulative evidence on this inspection demonstrated that the designated centre was effectively resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. The inspector determined that there was sufficient staff to meet the needs of the residents, which staff and residents also confirmed. There was also sufficient transport available to facilitate residents to meet their personal goals.

**Judgment:**  
Compliant

**Outcome 17: Workforce**  
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**  
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**  
No actions were required from the previous inspection.

**Findings:**  
The inspector reviewed the roster for the designated centre and confirmed that a planned and actual staff roster is maintained in the designated centre. Evidence supported that the number and skill mix of staff were appropriate to meet the needs of residents. The inspector observed staff to be knowledgeable of the needs of residents and to engage appropriately with residents. However as stated in Outcome 11 and 14, a review was required to ensure that when nursing care is required in is provided as stated in Regulation 15 (2) as documentation did not support same. Staff had the appropriate mandatory training and practice supported that they received additional training such as medication management in order to meet the Statement of Purpose. However as stated in Outcome 12, not all staff had received training in the
administration of medication in response to a seizure or epilepsy, however were supporting residents who were prescribed same.

Staff stated that they felt supported and had access to management when required. Residents stated that they felt there were sufficient number of staff available to meet their needs.

**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 information has required by Schedule 2 to be maintained in respect of staff are maintained in the head office of the organisation. Therefore the inspector completed an additional fieldwork day and confirmed that the information as required was maintained in respect of staff. The inspector further confirmed that a directory of residents was maintained in the designated centre and contained the relevant information inclusive of the name, address, date of birth and date of admission to the designated centre. A record was further maintained of all dates in which residents were temporarily absent from the designated centre. All of the records as required by Schedule 3 and 4 of the regulations were maintained in the centre.

The inspector confirmed that the policies and procedures as required by Schedule 5 were maintained in the designated centre. As stated in Outcome 4 a review was required of the policy for the admissions, transfers and discharge of residents from the designated centre to ensure that it was reflective of the procedures for the designated centre. Also the policy in respect of medication management had not been adhered to as regards to the actions to be taken in the event of a medication error.

**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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Muiríosa Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004590</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>15 April 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>08 July 2015</td>
</tr>
</tbody>
</table>

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:**

Individuals were named as the account holder for some utility bills. Management stated that this was a requirement of the utility company however there was no evidence that the resident or their representative had agreed to this.

**Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
The two family members were contacted and consent obtained for their family member to be named on the utility bill pertinent to the household package i.e. Phone and electricity.
The consent was documented and filed within the persons personal documentation.

**Proposed Timescale:** 19/05/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was one incident recorded in which a resident expressed dissatisfaction as staff was speaking about them in front of other residents, which does not promote the privacy of residents.

**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:**
- Incident was addressed in Supervision Meeting with staff member. Completed: 16/04/2015.
- Staff within the house have received refresher training in “Protocol for Communicating with Residents”, August 2014. Completed: 29/04/2015.

**Proposed Timescale:** 29/04/2015

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The information contained within the written agreement of the breakdown of fees to be charged differed from the breakdown of the fees actually paid by residents.

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

**Please state the actions you have taken or are planning to take:**
- The Contract of Care has been amended and details all fees individuals are liable for
within the designated centre.  
Completed: 16/04/2015

• The addendums were signed by next of kin and are held within the persons personal documentation.  
Proposed completion date: 17/07/2015

• Amended Contract of Care was submitted to HIQA.  
Completed: 08/05/2015.  

**Proposed Timescale:** 17/07/2015

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### 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:**

Evidence did not support that the systems in place for the assessment and management of risk was effective due to inconsistencies identified in assessments and the inaccurate control measures documented.

**Action Required:**

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:**

- The Risk Assessments and Management plans were reviewed for all categories of risk by the person in charge. Completed: 09/06/2015
- Manual Handling and Falls Risk assessments were reviewed and amended by the person in charge and manual handling instructor. Completed: 26/06/2015.

Night time Fire Evacuation.

- Increased control measure using a Res Q mat for one individual was identified as the most successful equipment for evacuation. This was tested and it was established that the added control was effective. Night time Fire evacuation drill was held on 16/05/2015 and 27/06/2015. Successful evacuation for all individuals residing within the house was within 5 minutes.
- The individual that choose not to engage with fire evacuation has successfully been evacuated and control measures were tested. Evacuation time. 1 Minute. Completed: 04/05/2015.

Medication Administration Error Risk Assessment.

- Medication Administration Error risk assessment controls have been amended to include medications that are not in a blister pack by the person in charge. Completed on 26/06/2015.

**Proposed Timescale:** 26/06/2015
<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>A fire exit was blocked.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td><strong>Rental Property</strong></td>
</tr>
<tr>
<td>• One fire exit remains blocked due to location of dining room table. However, there are 3 alternative exits available. The blocked fire exit has been risk assessed and the rating is scored as low.</td>
</tr>
<tr>
<td>• Additionally this rental property will no longer be in use once registration process for an alternative house is complete.</td>
</tr>
<tr>
<td><strong>Other property</strong></td>
</tr>
<tr>
<td>• All corridors and escape routes are free of obstruction and wheelchairs are stored as detailed in Individual Evacuation Fire Plan. Completed: 17/05/2015</td>
</tr>
<tr>
<td>• Daily checks of Fire Exits are undertaken and recorded to ensure fire exits remain unblocked.</td>
</tr>
<tr>
<td>• Proper storage of equipment discussed at Staff Team Meeting on 29/04/2015.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 17/05/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>There was no evidence that control measures identified post a fire drill had been tested to ensure that they were effective.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>• Discussion took place with the individual, staff and person in charge explaining the importance and requirement of fire evacuations. Completed: 29/04/2015</td>
</tr>
<tr>
<td>• The individual that choose not to engage with fire evacuation has successfully been evacuated and control measures were tested. Evacuation time 1 Minute. Completed: 04/05/2015</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 04/05/2015</td>
</tr>
</tbody>
</table>

| Theme: Effective Services |
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector observed fire doors to be wedged open which removed the purpose of them.

Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
• Post inspection staff were informed of the importance of fire doors not being wedged open. Completed: 16/04/2015
• Person In Charge discussed the Fire Regulations and the closure of doors in fire prevention at the staff team meeting on 29/04/2015.

Planned Actions:
• New door closures linked to central fire alarm system to be installed to enable easy access for staff. Proposed completion date: 31/07/2015

Proposed Timescale: 31/07/2015

Outcome 11. Healthcare Needs
Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to inadequacies identified in the personal plan of residents it was not clear if the appropriate health care was provided to residents.

Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

Please state the actions you have taken or are planning to take:
• The person in charge and area director have reviewed all of the healthcare plans to ensure that the existing care plans are fit for purpose and support each person’s individual healthcare needs appropriately. Completed: 21/05/2015

Planned actions:
• Person In charge and area director will ensure that appropriate health care plans are in place for the acute health conditions of individuals as the need arises.
• The area director will link with the nurse practice development co-ordinator if specific healthcare plans are needed. This will assist the person in charge to ensure appropriate healthcare plans are in place.

Proposed Timescale: 21/05/2015
Theme: Health and Development
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were documented as requiring their food modified however this was not following the recommendations of an Allied Health Professional.

**Action Required:**
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**
- The individual was assessed by the appropriate Allied Health Professional (Speech & language therapist/Dietician) and recommendations were put in place by the key worker and person in charge.

**Proposed Timescale:** 14/05/2015

### 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 the medication cupboard to be unlocked.

**Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
- Supervision of staff member occurred regarding the importance of medication being securely locked. Completed: 16/04/2015
- The secure storage of medication was discussed at the Staff Team meeting with the Person In Charge on 29/04/2015

**Proposed Timescale:** 29/04/2015

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The outcomes arising from reviews of medication errors were inadequate and therefore did not reduce the risk of a recurrence.

**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:

- The Area Director at the monthly meetings with the Person In Charge has instructed that all medication errors must properly documented and policy adhered to. Completed: 06/05/2015.

Planned actions:
- Person in charge to engage individual supervision on each occurrence of medication error with the relevant staff member.
- The area director has prioritised medication errors on the agenda for her meetings with the persons in charge reporting to her for the next 3 months.
- The safe administration of medication will be a standing item on Staff Team meetings with their person in charge for the next 3 months after which the need to have it on the agenda will be reviewed by the area director

Proposed Timescale: 31/07/2015

**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 review completed was not reflective of consultation with residents and/or their representatives.

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

Please state the actions you have taken or are planning to take:
- An audit was undertaken and the individuals residing in the designated centre did not return completed questionnaires, however, some families that had completed the family-specific questionnaires returned same and their findings were incorporated into the audit.

Planned actions:
- For the second twelve month audit, the person in charge will be nominated to ensure that the resident’s questionnaires are returned to the regional director.

Proposed Timescale: 31/10/2015

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review was required of the clinical governance of the designated centre.

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

**Please state the actions you have taken or are planning to take:**
- The person in charge and area director have reviewed all of the healthcare plans to ensure that the existing care plans are fit for purpose and support each person’s individual healthcare needs appropriately. Completed: 21/05/2015

Planned actions:
- Person In charge and area director will ensure that appropriate health care plans are in place for the acute health conditions of individuals the need arises.
- The area director will link with the nurse practice development co-ordinator if specific healthcare plans are needed. This will assist the person in charge to ensure appropriate healthcare plans are in place.

**Proposed Timescale:** 21/05/2015

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Documentation did not support that when nursing care was required it was adequately provided.

**Action Required:**
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

**Please state the actions you have taken or are planning to take:**
- An immediate care plan was put in place to support the persons acute healthcare needs by the person in charge and area director. Completed: 21/05/2015
- The person in charge and area director have reviewed all of the healthcare plans to ensure that the existing care plans are fit for purpose and support each person’s individual healthcare needs appropriately. Completed: 21/05/2015

Planned actions:
- Person In charge and area director will ensure that appropriate health care plans are in place for acute health conditions as the need arises.
- The area director will link with the nurse practice co-ordinator if specific healthcare plans are needed. This will assist the person in charge to ensure appropriate healthcare plans are in place.

**Proposed Timescale:** 21/05/2015

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**Outcome 18: Records and documentation**

**Theme:** Use of Information
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review was required of the policy in place to guide the practice on the admissions, discharge and transfer of residents. The policy on medication management had also not been implemented in practice.

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

Please state the actions you have taken or are planning to take:
The Standard Operating Procedure in relation to the Access, Discharge and Transfer of individuals to a new designated centre has been developed. Implemented: 11/06/2015

- An addendum to the Communicating with Residents Policy was developed on outlining more specific procedures in the development of Communication Protocols for each individual. Completed: 25/02/2015

- The Area Director at the monthly meetings with the Person In Charge has instructed that all medication errors must be properly documented and policy adhered to. Completed: 06/05/2015.

Planned actions:
- Person in charge to engage individual supervision on each occurrence of medication error with the relevant staff member with a view to ensuring proper adherence to the organisations policy “Medication Management Policy Issue 3 August 2014”
- The area director has prioritised medication errors on the agenda for her meetings with the persons in charge reporting to her for the next 3 months.
- The safe administration of medication will be a standing item on Staff Team meetings with their person in charge for the next 3 months after which the need to have it on the agenda will be reviewed by the area director.

Proposed Timescale: 31/07/2015