Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Morenane House
Centre ID:	OSV-0001819
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Joseph's Foundation
Provider Nominee:	David Doyle
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 October 2016 09:15	05 October 2016 19:30
06 October 2016 09:15	06 October 2016 17:00

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

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

Summary of findings from this inspection

Background to the inspection:
This inspection was the second inspection of this centre by the Health Information and Quality Authority (HIQA) and was carried out to inform a decision to remove and vary the centres conditions of registration. The provider wished to increase the number of residents who could live in the centre. The last inspection was undertaken in October 2014 to inform the original decision to register the centre; those inspection findings were satisfactory.

How we gathered our evidence:
Prior to the inspection the inspector reviewed the information submitted by the provider with the application to vary and remove conditions and other relevant

information such as the previous inspection findings and submitted notifications.

The inspector met and spoke with four of the five residents living in the centre. Some of the residents were able to interact well verbally; others engaged and expressed their views non-verbally. Residents also communicated their views in the manner in which they reacted to the inspector, to staff, how they interacted with other residents and their general demeanour.

The inspection was facilitated by the person in charge, the nominated provider, the manager for adult services (who was also the nominated person participating in the management of the centre (PPIM)), and the co-ordinator of residential services. The inspector also met with the frontline staff on duty during the inspection.

Records including health and safety and fire safety records, records of complaints, minutes of meetings, resident and staff related records were reviewed and discussed with staff. The inspector observed staff and resident interactions and the manner in which supports and services were provided.

Description of the service:
The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The inspector found that the service to be provided was as described in that document. Residential services were provided to five residents with medium to high needs and who required support to manage behaviours that challenged. It was planned to provide supports to two additional residents in two apartments adjacent to the main premises.

Overall judgment of our findings:
The overall inspection findings were satisfactory and of the sixteen outcomes reviewed the provider was judged to be compliant in thirteen and in moderate non-compliance with the remaining three.

The provider had failed to ensure that each resident was supported at all times to communicate in accordance with the resident's needs, skills and wishes.

Failings were also identified in the controlled medicines register as it was not maintained in a manner that fully complied with the relevant controlled medicines legislation.

While residents were seen to have good access to the multi-disciplinary team improvement was required to ensure that the review of the support plan was multi-disciplinary.

The provider was also requested to review the working arrangements of the person in charge.

There was evidence that positive relationships between residents and their families were promoted and supported by staff. Residents had access to structured day services where they participated in a broad range of activities and were supported by staff to participate in local events and amenities. Residents said that they enjoyed

these events, that they liked the house and the staff.

The provider had completed works on the apartments to address deficits identified at the time of the last inspection which prevented their use by residents at that time.

There were effective systems for the review on a consistent basis of the quality and safety of the supports and services provided to residents.

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 provider accessed a national advocacy service as necessary. There was also an internal advocacy group facilitated by a social worker. One of the residents from the centre participated in this group which was described by staff as very proactive; residents were reported to seek out senior management as necessary so as to progress issues.

Staff were aware of each resident's religious beliefs and preferences; resident's choices were reflected in the support plan and in the minutes of residents meetings. Residents confirmed that they were supported by staff to attend mass locally in line with their wishes.

Staff said and a resident confirmed that staff and residents discussed and agreed on a weekly basis issues such as the menu, what residents wished to do for the weekend and the coming week; these meetings were recorded. The inspector reviewed some records and saw that they were completed by staff in a manner that reflected each resident's participation and their expressed preferences. Any queries or reassurances required by residents were also seen to be clearly recorded as answered by staff. The records seen indicated that this was a meaningful process of consultation that residents engaged with; it would have been enhanced further by the follow-up and documentation of agreed actions and this was recommended at verbal feedback.

There were policies and procedures in place for the management of complaints. The most recent complaint seen to be logged was in 2015; there was no evidence that this was not correct and accurate. There was evidence that this complaint was listened to

and there was evidence of the action taken to resolve the matter complained of. Complaints and concerns that they may have, were also seen to be discussed with residents on a weekly basis at the meetings referenced above.

There were systems in place that promoted the safeguarding of residents personal finances. Financial records were maintained by staff for each resident all of whom required support from staff in the management of their personal monies. The inspector saw records of each financial transaction, the purpose for which monies were used, supporting receipts and generally two staff signatures for each transaction. An internal audit of these systems was completed in May 2016; no anomalies were noted.

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):
No actions were required from the previous inspection.

Findings:
The inspector saw that staff completed explicit assessments of each residents communication ability. These assessments incorporated assessment of comprehension and skills such as literacy skills as well verbal communication ability. Based on the outcome of the assessment a plan of support was put in place.

The assessment and the plan clearly identified each resident's preferred and most effective means of communication. However, the provider had failed to ensure that each resident was supported at all times to communicate in accordance with the resident's needs, skills and wishes.

Staff said and it was clearly recorded in records seen that one resident communicated through Irish Sign Language (ISL), one record seen by the inspector described this as the residents "first language". However, the inspector saw and staff spoken with confirmed all staff working in the centre did not know how to sign; a note book and pen were utilised by staff and the resident in lieu of ISL. The person in charge told the inspector that two staff including herself were proficient in ISL and that two further staff were adequately skilled in ISL. On average there were nine staff on the weekly rota. The person in charge said that there were times when the resident had a preference for the written word.

However, the deficit of staff skilled in ISL was noted to be referenced repeatedly in

records seen by the inspector in addition to the communication plan; these records included risk assessments, behaviour management records and communications to the provider from external parties.

The provider had a policy on communicating with residents which stated that the provider aimed "to communicate with service users using their preferred method of communication". The policy did reference communication methods such as visual supports, assistive technology and Lamh (manual signing) but not ISL.

Resident were seen to have good access to media, personal ipad's and internet access. Staff also used visual schedules and social stories with residents.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
There was evidence that positive relationships between residents and their families were promoted and supported by staff. Residents continued to enjoy regular structured home leave and records seen indicated that these arrangements were flexible and responsive to family and resident circumstances. Staff said and the inspector saw that there were no unreasonable restrictions on visits. Staff were seen to provide residents and their visitors with privacy while also integrating the other residents and the normal routine of the house into the visit.

Residents and their visitors had a choice of three communal areas so privacy was possible as required and requested.

There was evidence that families were invited to and did attend reviews of personal plans. In the intervening period between these formal reviews there was evidence of ongoing and open communication between staff and families in the interest achieving positive outcomes for residents. Staff were seen to complete a log of all such communications.

Staff described the local community as inclusive. Residents confirmed that they were supported by staff to participate in local activities such as the much enjoyed monthly social and other local groups and amenities.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
There were organisational policies and procedures in place for admission to and transfer and discharge from the service.

Each resident and their family had been provided with an explicit contract for the provision of supports and services. The contract included details of the supports and services to be provided, the applicable fee and services that may be availed of but that were not included in the basic fee.

Judgment:
Compliant

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

Findings:
Each resident had a plan of support.

The plan was seen to be based on the outcome of a current comprehensive assessment of the resident's holistic needs. Where a need was identified a plan of support was put in place. The plan was seen to be kept under review and updated to reflect any changes in needs, for example a requirement for additional healthcare support.

Since the last inspection each resident was seen to have been provided with a copy of their support plan in a format that was accessible and meaningful to them.

However, what was not clear was how staff consulted with and ensured the participation of the resident in their plan. The person in charge said that this would be facilitated going forward through key-worker meetings that had recently commenced.

The support plan incorporated the personal plan and each resident's personal goals and objectives. These were reviewed and agreed annually, reviews were recorded, residents and their families participated as did other relevant stakeholders such as the day service staff. However, the records for progressing goals did not always accurately reflect what was requested and agreed at the review, responsible persons were not always identified and it was not clear if all agreed goals had been met and if not why not.

There was clear evidence that residents had as appropriate to their needs good access to and support from the multi-disciplinary team. However, the inspector did not see evidence of and it was agreed at verbal feedback that the review of the support plan was not multi-disciplinary.

Transition plans for proposed residents were in place so as to ensure that arrangements were in place in the designated centre to meet their assessed needs.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:

The inspector reviewed the existing premises and the premises to be used to provide accommodation to the additional two residents. The buildings were separate to each other but located on the same site. The inspector was satisfied that both premises met regulatory requirements and were suited to their stated purpose and function.

The centre was located on a spacious well maintained site in a rural location. Transport was available and residents had access to a choice of urban centres and the amenities that they each offered.

The original premises was a domestic style two storey building that was well maintained, homely and welcoming.

Bedrooms for four residents were provided on the ground floor; one bedroom was on the first floor. The location of the bedrooms was seen to be suited to the needs of the residents and each room offered sufficient space including provision for personal storage. Bedrooms were seen to be decorated and fitted to reflect each resident's interests and personal choices.

Adequate bathroom facilities were provided. One bedroom had en-suite shower, toilet and wash-hand basin facilities; a bathroom with floor-level bath, shower, toilet and wash-hand basin was conveniently located to the other bedrooms. There was a separate toilet available off the utility room. There was a further bathroom with shower, toilet and wash-hand basin on the first floor.

The kitchen was centrally located, adequately equipped, incorporated sufficient dining space and a spacious communal area.

There was a separate pleasant communal room and a further conservatory type communal space available to residents.

The utility area accommodated the facilities for personal laundry.

The additional accommodation was provided in a separate building that had been refurbished to accommodate two apartments. Each apartment had its own separate entrance and comprised of a communal room and a fully fitted kitchen downstairs and a bedroom and bathroom upstairs. One apartment had two bedrooms but only one of these bedrooms was to be registered for resident use. At the time of the last inspection the accommodation at first floor was deemed unsuitable for resident use by HIQA due to restricted ceiling height. The provider had completed works to address this.

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:
The inspector saw an up-to-date safety statement and a risk management policy; the latter informed the identification of hazards, the assessment and management of risk and the management of any accidents, incidents and adverse events.

There was a suite of generic risk assessments and an up-to-date centre specific risk register. The register included a comprehensive range of environmental and work related risk assessments, resident specific risk assessments and the risks as specifically required by Regulation 26 (1) (c). Identified controls were seen to be reflected in the support plan. There was evidence of risk control measures in practice such as the highlighting of steps, window restrictors and the secure storage of chemicals.

The inspector saw that both buildings were serviced by an automated fire detection system, emergency lighting and prominently located fire fighting equipment. The fire register was well maintained and certificates were in place for the inspection and testing of these fire safety measures at the prescribed intervals and most recently in October 2016, January 2016 and November 2015 respectively. Staff also undertook and consistently recorded daily, weekly and monthly inspection of these fire safety measures.

Fire action notices and a diagrammatic evacuation plan were prominently displayed. Easy read fire action notices were displayed in each resident's bedroom.

Escape routes were seen to be clearly indicated and unobstructed. Final fastenings were easily released thumb turn devices.

Up-to-date personal emergency evacuation plans (PEEPS) were in place for each resident. There was documentary evidence that residents participated in regular simulated fire drills; adequate evacuation times were recorded. Any difficulties encountered during the drill were reflected in the PEEP. The inspector saw that fire safety measures had been adapted to meet the needs of, and alert in the event of fire, residents with a sensory disability.

There was an emergency plan that provided guidance to staff on the actions to be taken in response to situations such as fire and evacuation or loss of power.

Judgment:
Compliant

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:
There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons, risk assessments, staff training, regular staff supervision and evidence of ongoing communication between staff and family members.

The person in charge said and the inspector saw records confirming that the person in charge did monitor resident safety and well-being and sought advice from relevant safeguarding personnel on any matters of concern. Records seen supported communication between for example, the person in charge, psychology, social work and the provider. Plans and interventions for promoting and protecting resident safety where they perhaps lacked safety awareness were in place.

In general there was evidence that the provider exercised its responsibility to investigate any alleged, suspected or reported abuse.

The inspector observed staff and resident interactions and noted that residents were comfortable with staff. The inspector saw that residents sought out staff and that staff spoke and wrote respectfully to and of residents. Residents knew staff by name and said that they "liked this house" and "liked the staff".

Training records seen indicated that all staff had attending education and training on safeguarding; the training module was based on nationally agreed policy and procedure and was facilitated by the designated person. The contact details for the designated person were displayed in the centre but the designated person was also reported to be accessible to and known to the residents in the day service. The designated person had completed a safeguarding audit in the centre in August 2016; the audit included an evaluation of staff knowledge of safeguarding policy and procedure.

The inspector saw that risk assessments and behaviour management support plans were in place for supporting residents; the plans seen had been recently reviewed by the person in charge and the psychologist. Residents had ongoing access as required to support from psychology and psychiatry.

From speaking with staff and from records seen there was evidence of awareness of what constituted or may constitute a restrictive practice. There was one approved

physical restrictive practice that was included in the behaviour support plan to be used only as a last resort. Training records indicated that staff had completed the required training in the management of actual and potential aggression (MAPA) and refresher training for some staff was scheduled.

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:
Hard copy records of accidents, incidents and adverse events were maintained. It was evident from the records seen and from speaking with staff that accidents and incidents were monitored and analysed centrally so as to identify any patterns or trends and the reasons for them. The nominated provider said that feedback was provided to each centre.

The person in charge was clear on the type of and her responsibility to submit notifications to HIQA.

Based on the sample of records reviewed the inspector was satisfied that notifications submitted to HIQA reflected the log of incidents maintained in the centre.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
The person in charge said that while residents would know and say that they were feeling unwell, they all needed staff support to maintain their health and well-being.

The person in charge confirmed that residents had access to their preferred General Practitioner (GP) and there was documentary evidence that staff facilitated medical review as often as was necessary. As residents spent their day in the day service, staff in the day service also supported residents in relation to their healthcare requirements. Formal records of communication between staff in the day service and in the designated centre were seen by the inspector.

As appropriate to their needs residents had access to other health care services including chiropody, optical screening, psychiatry and psychology. Nursing input was available in the day service. Residents as necessary were seen to be referred to other specific services for investigation and recommended interventions were seen to be in place. Records of referrals and reviews were maintained and recommendations/interventions were incorporated into the support plan. Some of these healthcare support plans would have benefitted from further detail, for example possible side effects or the signs and symptoms of low and/or elevated blood sugars; this was discussed by way of recommendation at verbal feedback.

The inspector observed and records seen reflected staff respect for residents' choices while supporting and encouraging residents to make good and informed healthy living choices in relation to diet and nutrition.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
While there was evidence of good medicines management practice failings were identified in the procedures for the management of medicines that required stricter controls.

The inspector saw policies and procedures signed as reviewed in September 2016 governing the management of medicines.

Medicines were supplied in a compliance aid by a community pharmacy on an individual resident basis. Medicines were seen to be securely stored.

There was a refrigerator specifically for the storage of medicines; staff monitored its temperature daily.

Each resident was seen to have a signed and dated prescription and a corresponding administration record. Prescription records were current and legible, the maximum daily dosage of medicines prescribed on a p.r.n basis (as required) was stated; discontinued medicines were signed and dated as such.

The medicines administration record completed by staff was seen to reflect the instructions of the prescription.

Residents were not participating in the management of their medicines; there were clinical records in place supporting this decision.

Systems were in place for reporting and managing medicines related incidents. The person in charge said that these were monitored to establish any patterns and any remedial actions required to promote safe medicines management. Other systems to support the safety of medicines management practice included the checking of medicines delivered and the return of unused and unwanted medicines to the pharmacy; there were itemised, signed and verified records of the latter.

However, while a controlled medicines register was in place it was not maintained in a manner that fully complied with the relevant controlled medicines legislation. The standard of documentation by staff did not ensure a record that supported a robust chain of custody of the medicine at all times. Deficits identified included an absence of required signatures on supply, on receipt and on administration, and difficulty in tracking the movement of the medicine given that two locations shared the one register. Staff confirmed that they did not complete (at the required frequency) and did not maintain records of reconciliation of the physical stock balance with the register. The relevant section of the medicines management policy did not adequately address, in a centre specific manner, the management and record keeping of controlled medicines.

Judgment:
Non Compliant - Moderate

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:
The statement of purpose was kept under review by the provider. The statement of purpose contained all of the information required by Regulation 3 and Schedule 1. The statement of purpose was an accurate reflection of the centre and the supports and services provided to residents.

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):
No actions were required from the previous inspection.

Findings:
The overall governance arrangements were good and did monitor and promote the quality and safety of the supports and services provided to residents, the provider was however requested to review the working arrangements of and the deputising arrangements for the person in charge.

There was a clear management structure. Front-line staff reported to the person in charge who reported to the co-ordinator of residential services, who in turn reported to the manager of the adult services who reported to the nominated provider. All were clear on their respective roles and responsibilities and informed as to the governance of the centre and the needs of the residents.

The person in charge had established service with the provider and had undertaken the role of person in charge since August 2015. However, the duration of the deputising arrangement was discussed with the nominated provider in the context of recent guidance issued by HIQA. The person in charge held suitable core qualifications in social care and participated on an ongoing basis in the providers training programme. On speaking with her, the person in charge had sound knowledge of the residents and their supports and of her regulatory responsibilities as person in charge. The person in charge

confirmed that she had ready access to management and met with her line manager daily. Formal meetings were also convened approximately every six weeks. The senior management team held monthly governance meetings.

The person in charge did work fulltime but this was in her substantive role as social care leader and a member of the front-line team; the person in charge worked exclusively on sleepover shifts. This meant that she was on duty in the house from 16:00hrs to 23:00hrs, then on sleepover until 07:00hrs and back on duty from 07:00hrs to 09:00hrs. This effectively meant that the person in charge was not on duty by day when events such as meetings, multi-disciplinary reviews and reviews of the person centred plans took place. The person in charge confirmed that she did go to such events on her time off when at all possible and was heard by the inspector to make such arrangements. Ten hours of protected time for person in charge administration duties had recently been agreed but the inspector was advised that it was not always possible to integrate these hours into the basic working week due to the logistic difficulties of replacing the person in charge on the frontline team.

While the overall inspection findings were good the inspector was of the view that this was due to the overall governance structures and the commitment and capacity of the person in charge. The nominated provider was requested to review the person in charge working arrangements and to formalize the deputising arrangements. the nominated provider committed to this review.

There were effective systems for the review of the quality and safety of the supports and services provided to residents; these included the unannounced visits and the annual reviews as required by Regulation 23 (1) and (2). Reports were available and the inspector saw that responsible persons and the nominated provider undertook these reviews on a very frequent basis. For example the inspector saw reports of audits/reviews completed by health and safety personnel, the finance department, the safeguarding officer and the nurse-coordinators. There was evidence of the follow-up to completion of any required actions. The report of the annual review was available in the house to residents and their families. Families were consulted with to establish their level of satisfaction with the centre; overall, the responses seen were positive.

Judgment:
Compliant

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 provider had notified the Chief Inspector as required of the absence of the person in charge and had put arrangements in place for the management of the centre during such absence.

Judgment:
Compliant

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

Theme:
Use of Resources

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

Findings:
Based on these inspection findings there was evidence that the centre was resourced to ensure the effective delivery of supports and services to residents.

The centre was well maintained; required works had been completed to ensure that the premises could meet residents' needs safely and comfortably. Staffing arrangements were adequate and a nine-seat vehicle had recently been acquired.

The nominated provider confirmed that there were sufficient resources to meet each residents needs.

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 was satisfied that staffing numbers and arrangements were suited to the number and assessed needs of the residents.
Each resident attended off-site day services Monday to Friday. There was two staff on duty at all times when residents were present in the house. An additional 20 hours of staffing was allocated at the weekend to facilitate resident's social activities. Night time staffing consisted of one staff on sleepover duty and one waking staff. The provider nominee confirmed that staffing levels did not fluctuate with decreased occupancy, for example if a resident(s) was at home. The inspector saw while the occupancy of the house was reduced for some of this inspection, the agreed staffing levels were maintained.

There was a staffing plan for the proposed increase in occupancy. Residents for admission had been identified and, based on their assessed needs each resident was to have 1:1 staff support including a waking night staff in each apartment. These staff were in place and were supporting the resident's in their current location.

Staff files were available for the purpose of inspection. The sample reviewed was well presented and contained all of the documents required by Schedule 2.

Agency staff were used at times. The inspector saw that a service level agreement was in place between the provider and the agency.
The person in charge said that the rota was planned, there was limited reliance on relief and agency staff but if needed staff that were familiar with the centre and the residents were requested.

The provider did utilise the support of volunteers. There was a dedicated volunteer co-ordinator, vetting, training and assessment of skills and interest so that there was compatibility between residents and volunteers.

Staff training records were maintained and included regular, relief and agency staff. The person in charge was aware of any refresher training required by staff and the plan to deliver this training. Training records indicated that all staff mandatory training requirements in safeguarding, fire safety, manual handling and behaviours that challenged were met and/or refresher training was scheduled. Additional training provided to staff included first aid, infection prevention and control and supporting residents with impaired swallow.
Staff files contained evidence of core relevant qualifications in social care, disability studies and care skills.

The person in charge confirmed that there was a formal process of staff supervision.

The regulations and standards were seen to be available to staff.

Judgment:
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:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Joseph's Foundation
Centre ID:	OSV-0001819
Date of Inspection:	05 October 2016
Date of response:	29 November 2016

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 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that each resident was supported at all times to communicate in accordance with the resident's needs, skills and wishes.

1. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all

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

times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
Under Regulation 10 (1) the Registered Provider will ensure that each resident is assisted and supported to communicate at all times in accordance with their needs and wishes. The Registered
Provider will provide training in Irish Sign Language to all members of staff of Morenane House. This training will be provided over a ten week period beginning in November 2016.
The Registered Provider has also sourced on-line training in Irish Sign Language which will be also offered to staff. The Person in Charge is committed to supporting staff in the day to day use of ISL to help residents communicate in accordance with their needs and wishes.

Proposed Timescale: 30th November 2016 – 17th February 2017 (10 week training)

Proposed Timescale: 17/02/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of the support plan was not multi-disciplinary.

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

Please state the actions you have taken or are planning to take:
Under Regulation 05 (6) (a) the Person in Charge will ensure that personal plan reviews are multidisciplinary. Review meetings have now been scheduled and agreed for all residents.

Proposed Timescale: 30th January 2017

Proposed Timescale: 30/01/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records for progressing goals did not always accurately reflect what was requested and agreed at the review, responsible persons were not always identified and it was not

clear if all agreed goals had been met and if not why not.

3. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
Under Regulation 05 (7) the Person in Charge will ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales. All personal plan review meetings have now been scheduled and agreed for all residents.

Proposed Timescale: 30/01/2017

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 controlled medicines register was not maintained in a manner that fully complied with the relevant controlled medicines legislation. The standard of documentation by staff did not ensure a record that supported a robust chain of custody of the medicine at all times.

4. Action Required:
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

Please state the actions you have taken or are planning to take:
Under Regulation 29 (4) (d) the Person in Charge will put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended. All protocols / practices relating to the management of controlled medications have now been reviewed and amended to comply with legislation relating to controlled medications.

Proposed Timescale: 14/10/2016