### Centre name:
A designated centre for people with disabilities operated by Health Service Executive

### Centre ID:
OSV-0002471

### Centre county:
Westmeath

### Type of centre:
The Health Service Executive

### Registered provider:
Health Service Executive

### Provider Nominee:
Joseph Ruane

### Lead inspector:
Ann-Marie O'Neill

### 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 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**

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<td>17 May 2016 10:20</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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**Summary of findings from this inspection**

Background to inspection
This was an announced registration inspection. At the time of inspection the legal provider entity was the Health Service Executive (HSE). The registration inspection was taken on foot of an application to register by Muríosa Foundation to become the new provider for the centre. The inspector found that the proposed new provider (Muríosa Foundation) had been working in the centre at the request of the existing provider since April 2016 to support a smooth transition for residents. Appropriate agreements and operational arrangements had been put in place to support and supervise this process.
The centre was previously inspected in September 2016. It was found to be non-complaint across a range of outcomes. This inspection assessed compliance with the Regulations and gathered evidence to assess the fitness of the proposed new provider, Muiríosa Foundation, in providing safe and appropriate supports to residents in line with their application. The proposed new provider had applied to register the centre to accommodate five residents.

How we gathered evidence
The inspector met with residents, some family members of residents, staff, the person in charge, proposed new provider nominee and area manager over the course of the inspection. Policies and documents were reviewed as part of the process including a sample of health and social care plans, complaints log, contracts of care and risk assessments. The inspector observed practice and staff interactions with residents. Residents had varying communication abilities and the inspector interacted with residents in line with their communication styles and preferences as set out in their personal communication plans and following guidance from staff.

Description of the service
The statement of purpose for the centre set out that The Muiríosa Foundation aimed to provide citizens with an intellectual disability and their families a service which promotes individuals best interests, choices and that optimally captures the balance of empowerment and necessary safe guards.

The centre was a four bedroom bungalow located outside a town in County Westmeath. The provider had ensured residents had access to a range of local amenities such as shops, churches, restaurants, pubs, barbers, hairdressers. The centre had the use of three cars to facilitate residents accessing local amenities. The centre accommodated five adult residents with varying degrees of intellectual disability and specific support needs in the management of epilepsy, mobility, healthcare and nutritional management and behaviours that challenge.

Overall judgment of our findings
The inspector found improvements had taken place since the proposed new provider had been working alongside the existing provider in April 2016. Of the 18 outcomes assessed 16 were found to be compliant or substantially compliant including communication, admissions and contracts of care, social care needs, healthcare needs and governance and management. Moderate non compliance was found on this inspection for Outcome 1, Rights, dignity and consultation and Outcome 6, Safe and Suitable Premises.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.
Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Residents’ rights, dignity and consultation were well met in this centre. Residents’ opinions, preferences and civil and religious rights were upheld to a good standard. However, one bedroom in the centre did not provide residents with an appropriate standard of privacy. This privacy issue was identified on previous inspections of the centre. While policies and procedures for the management of residents’ finances were comprehensive the inspector found they were not implemented in robustly in the centre.

The centre had a complaints policy and procedure. It met the requirements of the Regulations. In addition the complaints procedure was displayed in a prominent position in an easy read format.

The inspector reviewed the complaints log for the centre. There were no new complaints logged at the time of inspection. The inspector reviewed the documentation for logging complaints and found it suitable to meet the matters as set out in the regulations, for example complaints documentation would ensure the complainant’s satisfaction with how their complaint was managed would be documented.

As outlined in the opening paragraph one bedroom in the centre did not provide residents with appropriate privacy. The designated centre was a bungalow consisting of four bedrooms one of which was a twin room. As identified on previous inspections the premises did not promote the privacy and dignity of residents particularly with regard to the two residents sharing a bedroom.
Although the previous provider had installed curtain to enhance residents’ privacy in the shared bedroom, the inspector was still not satisfied residents’ privacy and dignity was being adequately provided for.

Residents were consulted with and participated in decisions about their care and about the running of the centre. There would be regular residents’ meetings which would facilitate residents to make plans and discuss matters important to them. Staff recorded minutes of the meetings, which showed that residents had given feedback on specific items that concerned them such as how to make complaints, their rights, activities and goals. The inspector reviewed a resident meeting that had taken place. There had been a set agenda and items discussed included the inspection and information for residents about the health information and quality authority and what to expect. As residents’ communication profiles and systems became more established residents would have more opportunities to be involved in the resident meetings and the meetings would be tailored to meet residents’ communication systems.

The inspector observed interactions between residents and staff that were respectful and caring and were delivered ensuring that the dignity and privacy of the resident was maintained.

Residents’ had opportunities to participate in activities that were meaningful and purposeful to them. At the time of inspection the person in charge and staff were in the process of carrying out activity sampling with residents to ascertain what they were interested in or liked.

Some residents were beginning to engage in more activities out of the centre in their local community and their choices were respected. For example, a resident with no verbal communication abilities indicated to staff they wished to go for a drive by getting their coat and bringing staff to the door. The inspector observed staff ask the resident if they wished to go for a spin in the car and brought the resident out for a drive there and then. This evidenced that residents’ choices were respected and facilitated as much as possible by staff supporting them.

There were systems in place to safeguard residents’ finances. As per the policy of the organisation all residents are presumed to have capacity to make a decision regarding their personal finances. An individual assessment is carried out with each resident by relevant team members who know the person using the framework, ‘working with a person’s financial decision-making ability’.

Residents living in the centre had been assessed as requiring supports. Their finances were managed through a private patient property account. The management of residents’ monies using this framework required the organisation to follow national standards and guidelines. Each resident had an individual account where their monies were strictly audited. Residents were also issued a statement of their account on a quarterly basis.

There were also localised financial management systems to manage and safeguard residents’ finances. Financial transactions were documented in individual ledgers which detailed money signed in and out balances checked and receipts were maintained for
purchases. However, while the system was robust in practice the inspector found it was disorganised. Where residents had made purchases some receipts were not available to validate their purchase. Therefore, while robust policies and procedures were in place to manage residents’ finances they were not carried out systematically by staff working in the centre. This needed to be addressed to ensure residents’ finances were adequately protected.

Each resident had a documented property list in their personal plan. Laundry facilities were adequate and were appropriately set up for residents to manage their own laundry if they wished.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Resident communication needs were under review and assessment at the time of inspection. There was evidence to indicate the person in charge and staff actively supported residents communication needs and used assistive technology and expertise from relevant allied health professionals where necessary to further support resident's.

There was an organisational policy on communication which met the requirements of Schedule 5 of the Care and Welfare Regulations.

Residents had access to televisions, radios, mobile phones and the internet. Some resident had their own iPad (hand-held computer device). The person in charge informed the inspectors that they would be able to download certain communication and sensory programs on the iPad to cater for residents individual communication repertoires. There were also plans in place to upload photographs of local areas or to represent activities and use these on resident's iPad to introduce a visual timetable to them using assistive technology.

Inspectors reviewed a sample of communication passports for residents. At the time of inspection the person in charge was in the process of developing up-to-date communication passports for residents. Staff were getting to know residents and their communication styles and repertoire and through this process would create communication systems specific to resident's individual needs.
There was evidence that staff had begun to use objects of reference as a way for some residents to communicate their needs or choices. For example, some residents were being encouraged to use a plastic cup to represent to staff they wanted a cup of tea, for example. Previously the resident would bring staff by the hand to various places and items if they wished to express a communication or a need.

Residents had access to speech and language therapist and had been assessed in the past. The person in charge had made referrals for residents to have an up-to-date speech and language assessment due to a change in their needs being identified.

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

**Findings:**
Through the implementation of a discovery process the person in charge and staff had begun to identify residents’ family and personal relationships and had also started to help residents re-establish residents' connections with their families and community.

During the course of the inspection, the inspector met with some family members of a resident living in the centre. They told the inspector that they had been disappointed that the standard of care and support their sibling had been found to not adequately meet the standards and regulations when the centre was operated by the previous provider. They now found the centre to be a more relaxed homely environment when they visited. They appreciated the open communication from the provider, person in charge and staff now working in the centre and wished for this to continue.

The provider had increased the transport resources for the centre and staffing numbers to facilitate residents' having increased opportunities to participate in their local community. Some residents were now enjoying daily trips to their local village, for example.

**Judgment:**
Compliant
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<th><strong>Outcome 04: Admissions and Contract for the Provision of Services</strong></th>
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<td><strong>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.</strong></td>
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**Theme:**
Effective Services

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

**Findings:**
Due to the transition of a new provider the current contracts of care were not available to inspectors on the day of inspection. Inspectors reviewed the provisional contract of care between residents and the new service provider and found they met with compliance.

There were also up-to-date policies and procedures in place for admitting residents, including transfers, discharges and the temporary absence of residents.

The provisional contract of care was clearly presented and outlined the supports and services to be provided. At the time of inspection the new provider was still in the process of establishing the set fees for residents. The provider informed the inspectors that once a fixed fee was agreed the provider will then consult with residents and their families and finalise the contracts of care.

Residents and their families were informed and kept up-to-date with the transition process from the old provider to the new one.

**Judgment:**
Compliant

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<th><strong>Outcome 05: Social Care Needs</strong></th>
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<td><strong>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.</strong></td>
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**Theme:**
Effective Services
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
At the time of inspection the person in charge was actively carrying out an assessment of need for all residents. There was evidence to indicate when residents' assessments of need were completed personal plans for residents would be of an appropriate standard to meet their social care needs.

The inspector reviewed a sample of personal plans for residents. An evidence based assessment model provided the framework by which the person in charge had begun to assess residents specific social care needs. From assessments carried out the person in charge had begun to identify residents needs in relation to managing healthcare needs such as epilepsy, behaviours that challenge, mental health and nutrition.

For each need identified there was a documented plan of care to support residents. There was also evidence in residents' personal plans that allied health professionals had been involved in the assessment and recommendation of interventions for residents. For example, behaviours support plans were in the process of being drafted which would guide staff working in the centre in supporting residents.

Personal plans were well laid out, organised and information was easily retrievable. Daily notes and observations were documented and detailed.

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

Findings:
The centre was homely, clean and well maintained however, as identified on previous inspection reports, the facilities, size and layout of the premises could not meet the needs for the number of residents living there.
The designated centre was a bungalow with garden space to the front and rear. The centre had four bedrooms, one of which was a shared bedroom. There was also an external brick built building which was utilised to store assistive equipment such as standing frames for residents and other assistive equipment as necessary.

However, the inspector determined the premises were not adequate to meet the needs of some residents living there. The twin bedroom measured 14.65m² and was occupied by two residents. Both used assistive equipment. There was inadequate space between the beds to enable these residents to undertake personal activities in private. There was inadequate space for safe manoeuvring of wheelchairs and other assistive equipment. This issue had been identified on previous inspections and is referenced in Outcome 1 of this report with regards to lack of privacy arrangements for residents.

There were however, an adequate number of toilets and bathing facilities. An assisted bath was also provided for in the centre. The centre was homely with tasteful furnishings throughout. An accessible garden area was provided to the rear of the centre. The centre also provided two living room spaces residents could use to engage in activities and meet with visitors in private if they wished. Residents’ bedrooms were nicely decorated and personalised to their taste. A large kitchen and dining area was available in the centre with adequate equipment and appliances for the preparation and cooking of meals. Laundry facilities were also available in the centre and could be used by residents if they wished to launder their clothes.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The health and safety of services users, visitors and staff was adequately provided for in the centre. The person in charge had begun to implement appropriate identification and management of risk systems. Fire detection and containment systems in the centre were adequate. Some fire safety checks had not been adequately documented but these were updated on the first day of inspection. Vehicles used by the centre required up-to-date servicing.

There were appropriate fire safety arrangements in the centre. Residents that smoked were supported to do so in a safe way. A designated smoking area was assigned to the rear of the premises with appropriate cigarette disposal systems in place. Residents that
smoked were supported to do so in line with fire safety procedures.

Fire safety extinguishers in the centre had been serviced in March 2016. The fire alarm had been serviced April 2016. Fire exits throughout had thumb lock systems fitted which allowed for ease of opening the exit in the event of an emergency evacuation. Emergency lighting was present in the centre also. Displayed fire evacuation procedures were detailed and specific to the centre. Doors in the centre were fitted with smoke seals and closing devices fitted to the fire alarm which would release on the alarm sounding resulting in the doors closing and containing smoke and fire, protecting residents and staff.

Each resident had a documented personal evacuation plan which outlined their individual support requirements in the event of an evacuation. Two fire drills had been implemented by the new person in charge and staff team in April and May 2016. Residents had not reacted on hearing the fire alarm sound. The person in charge informed the inspector that residents would become more used to the procedure as practice drills were ongoing.

Each resident had a prescribed personal evacuation plan in place which outlined what equipment was necessary for their safe evacuation. They also detailed if the resident would require verbal or physical prompts from staff in order to evacuate safely from the centre.

Infection control measures were sufficient given the purpose and function of the centre. A cleaning rota was in place and the inspector observed a good standard of cleanliness throughout the premises. Paper hand towels were used in the centre. Alcohol hand gels were also located at the entrance/exit doors. Colour coded mops and buckets were in use in and designated to clean specific areas to prevent cross infection. All staff had undergone training in universal precautions for the management of transmittable diseases. Where necessary infection control support plans and procedures were in place.

Potential risks and hazards in the centre were documented in a ‘risk register’. This identified and documented potential risks. Each risk was graded using a risk potential/severity matrix. Risk reduction strategies were documented against each risk. Personal risk assessments had been completed for each resident based on their specific identified needs, for example risks associated with epilepsy.

Organisational policies and procedures contained the matters as set out in the regulations relating to self harm, aggression and violence, accidental injury and unexpected absence of a resident. An emergency management policy with procedures was in place also to direct staff in the event of such an event, for example, power outage, flooding. Emergency accommodation was identified within the emergency management policy with contact numbers documented.

All staff had received up to date manual handling training.

Vehicles assigned to the centre were appropriately taxed and ensured however, one vehicle had been identified as requiring a service however, this had not yet happened. This was required to ensure all vehicles used by residents were maintained in a
Judgment: Substantially 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was a policy and procedures for responding to allegations of abuse and staff spoken with were knowledgeable of the types of abuse and of what to do if they witnessed abuse or received an allegation of abuse. There was also evidence that a restraint free environment was promoted. Intimate care plans for residents were not detailed enough to provide adequate guidance and support to staff.

Staff working in the centre had received training in the prevention, detection and response to abuse. Refresher training was also available to staff to ensure their skills and knowledge was maintained and up to date. All staff had also received training in management of actual or potential aggression to provide them with knowledge and skills in responding to behaviours that challenge.

Systems were in place for the management of behaviours that challenge. Staff had received appropriate training. Behaviour support plans were being updated and at the time of inspection residents that required supports in this area were receiving comprehensive evidence based assessments from which interventions and supports would be recommended.

There was a policy and procedures in place for the provision of intimate care. Each resident had an individual intimate care plan. While plans were in place they required more detail in order to meet the regulations such as the type of supports residents required to ensure their independence was promoted as much as possible so that the resident's dignity would be respected.
There was evidence to indicate a restraint free environment was promoted, for example low-low beds and crash mats were in used by residents instead of bed rails. Chemical restraint had been discontinued as a form of behaviour management for residents further evidencing the promotion of a restraint free environment for residents.

**Judgment:**
Substantially 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:**
A record of all incidents occurring in the designated centre was maintained and where required notified to the Health Information and Quality Authority.

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

**Findings:**
The person in charge had implemented systems whereby the general welfare and development needs of residents would be promoted to a good standard.

A proactive approach was taken to ensuring residents had opportunities for new experiences such as going for walks; dining in restaurants, meeting their family, going to the beauty salon, shopping and learning domestic and life skills. Some residents were
now participating in activities outside of the centre on a more regular basis than they had before and appeared to enjoy this.

The person in charge and residents key-workers had begun a discovery process to establish each resident's employment/activity needs. Some residents attended day services or outreach services which were tailored to suit their requirements.

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

**Findings:**
Of a sample of health care issues reviewed, inspectors found residents were supported to achieve their best possible health.

Health care plans were being updated and there was evidence to indicate residents were receiving a wide range of healthcare assessments by allied health professionals. This would ensure residents healthcare plans were based on evidence based recommendations.

Residents were receiving timely access to appropriate health care services and treatments. Records showed that routine visits were organised as and when required to the general practitioner (GP), dentist and chiropodist. Some residents could experience seizures due to epilepsy. Support plans to guide staff in how to manage seizures were detailed and informed staff when to administer emergency rescue medication and if a second dose of medication might be required.

The inspector observed some residents using mobility aids during the course of the inspection with the support of staff. Increased staffing resources ensured residents' physiotherapy interventions were being implemented such as the use of a standing frame for some residents or walking with a mobility aid three to four times a day.

Some residents at risk of developing a pressure ulcer were assessed using an evidence based pressure ulcer risk assessment tool. Residents identified at high risk used electronic pressure relieving mattresses and were assisted to move during the day and change their position to prevent the development of pressure ulcers.
The inspector also noted residents' nutritional risk was monitored. Residents' weights were checked and their body mass index (BMI) calculated each time they were weighed. From this information a malnutrition risk assessment tool was implemented to ascertain the level of nutritional risk for the resident.

Some residents were prescribed modified consistency diets by their speech and language therapist as they were deemed to be at risk of choking. Residents meals were appetising and nicely presented and in line with the prescribed consistency. There was appropriate equipment in the centre to ensure meals could be made as prescribed, for example hand blenders and mixing utensils for thickening drinks. Residents were afforded

**Judgment:**
Compliant

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

**Theme:**
Health and Development

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

**Findings:**
Overall, it was found that each resident was protected by the centre's policies and procedures for medication management.

All prescribing and administration practices were in line with best practice guidelines and legislation. Systems were place for reviewing and monitoring safe medication practices.

Most medication was supplied in a monitored dosage system in a blister pack system for residents. Each resident had a designated section allocated to them in lockable cupboard which ensured medications were safely secured in the centre.

Staff involved in the administration of medications had attended safe administration of medication training. Staff who spoke to the inspector was knowledgeable about residents' medications and demonstrated an understanding of appropriate medication management.

The prescription sheets reviewed were clear and distinguished between PRN (as required), short-term and regular medication. Where residents required their medications to be crushed this had been documented on the administration charts by their prescribing doctor. There were no controlled drugs in use at the time of this inspection.
The action from the previous inspection regarding inadequate systems for crushing medication had been addressed satisfactorily. The centre was supplied with a device which eliminated the risks identified with the use of a communal tablet crusher as found on the previous inspection.

A localised procedure was in place for the management of out-of-date or returned medication. The inspector noted that discontinued medications had been returned to the pharmacy in line with the

**Judgment:**
Compliant

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

**Findings:**
The statement of purpose met the requirements of Schedule 1 of the regulations in the most part.

It described the service provided in the centre and would be kept under review by the person in charge. It was available to residents and their representatives.

However, the whole time equivalent hours for the person in charge were not specified on the statement of purpose.

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

**Findings:**
The inspector was assured that the quality of care and experience of the residents living in the centre was monitored on an ongoing basis. Effective management systems would be in place to support and promote the delivery of a quality safe service to residents should the application from the proposed new provider be granted.

The proposed new person in charge outlined some of the auditing system he had introduced in the centre. He had commenced auditing health and safety, fire safety, medication management, vehicle maintenance and management of residents’ finances.

Arrangements were in place for a person nominated on behalf of the provider to carry out an unannounced visit on a six monthly basis to review the safety and quality of care and support provided in the centre. The inspector reviewed the templates the proposed new provider intended to implement during their unannounced visits and for the annual review of the centre. The inspector were satisfied that if implemented in conjunction with the person in charge’s auditing system the quality of care and experience of residents living in the centre would be effectively monitored.

There was a clearly defined management structure that identified the lines of authority and accountability in the centre. The exiting provider had put systems in place to allow the proposed new provider to work in the centre while they were awaiting a decision on their application. The centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service.

The proposed new person in charge was supported by the area director who had responsibility for oversight of a number of designated centres in the areas. The area director was identified as a person participating in management who would assume responsibility of the centre in the absence of the person in charge and direct care practices and supervise staff to ensure organisational policies and practices were implemented. There were also management systems in place whereby persons in charge from nearby designated centres were on-call at weekends. A rotating roster of on-call would be established.

The regional director also acted as the proposed new provider nominee, and reported directly to the Chief Executive Officer. At a regional level, the management structure consists of area managers, each with the responsibility for a number of designated centres. The proposed new provider nominee demonstrated good knowledge of the regulations and their regulatory responsibilities. She also demonstrated knowledge and understanding of the personalities and needs of residents living in the centre and the areas that required improvement in order to bring about positive meaningful outcomes for residents.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Senior management were familiar with the requirement to notify the Chief Inspector of the absence of the person in charge.

There were systems in place whereby a person in charge from a designated centre in the local area was rostered on-call at weekends when the person in charge of the centre was absent or on leave.

The area director was directed and supervised services in the absence of the person in charge.

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

Findings:
There were sufficient resources provided to ensure the effective delivery of care and support in accordance with the statement of purpose. Inspectors observed activities and routines were not adversely affected or determined by the availability of resources. Two transport vehicles were available for the centre to bring residents to their day services.
and to social outings, for example.

Staffing levels were found to adequately support residents to achieve their individual personal plans and to meet their assessed support needs. Flexibility was also demonstrated within the roster to meet specific needs of residents.

It had been identified on the previous inspection there were inadequate nursing resources to meet the needs of residents in the centre. On this inspection the inspector noted a nurse had been allocated as a member of staff to the centre. The inspector spoke with them during the course of the inspection and they outlined their role in relation to residents healthcare needs and the development of support plans in line with evidence based nursing practice.

**Judgment:**
Compliant

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

**Theme:**
Responsive Workforce

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

**Findings:**
Management systems for the centre indicated that staff would be supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice should the application from the proposed new provider be granted.

The inspector reviewed a sample of staff files and saw that they met the requirements of the Regulations.

A sample roster was reviewed for the centre. This indicated there would be four staff allocated to support residents during the day with two waking staff in the centre at night time. The proposed new provider nominee informed the inspector that the staffing ratio would be adjusted based on the needs of the resident at any given time. The planned staffing arrangements were in line with the statement of purpose.

An induction and appraisal system was in place. In addition, supervisory meetings were to be held with each staff member regular basis. The person in charge outlined the purpose of these meetings which included the provision of support, identifying training
needs and the opportunity to voice any issues or concerns.

A training plan was in place for staff working in the organisation. Records of staff training were maintained. There was evidence that staff had attended a range of training in areas such as the management of behaviour that challenge, safe administration of medication, manual handling and fire safety training.

The proposed provider and proposed person in charge were aware of residents’ needs with regards to behaviours that challenge. Staff had undergone specific training to ensure they had the necessary skills to implement behaviour support interventions and de-escalation techniques to support residents.

From a sample of staff files reviewed they were found to meet the matters as set out in Schedule 2 of the regulations which indicated safe and appropriate recruitment practices had been implemented.

No volunteers worked in the centre at the time of inspection.

_Judgment:_
Compliant

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

_Findings:_
There are policies and procedures in place which reflect the centre's practice. Policies and procedures are reviewed and updated to reflect best practice at intervals not exceeding three years.

The centre is adequately insured against accidents or injury to residents, staff and visitors. The centre is also insured to cover residents personal property which is outlined in the residents proposed contract of care.
A directory of residents was available which also met the requirements of the Regulations.

There were systems in place to maintain complete and accurate records in the centre.

**Judgment:**
Compliant

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**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:**

Ann-Marie O'Neill  
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002471</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>16 May 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26 July 2016</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:
Residents' privacy and dignity was not adequately being provided for. Two residents shared a bedroom which did not provide them with adequate privacy.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

**Actions Planned:**
- The Muiríosa Foundation is currently seeking suitable alternative living arrangements for one individual.
- Transition planning is currently underway in relation to supporting the individual to move from their current home.
- Once a suitable living arrangement has been secured, the individual will be supported to transition to the new living arrangement in line with the transition plan in place.
- Once the transition process has been successfully completed each individual in the designated centre will have their own bedroom.

**Proposed Timescale:** 30/11/2016

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While robust policies and procedures were in place to manage residents' finances they were not carried out systematically by staff working in the centre. This needed to be addressed to ensure residents’ finances were adequately protected.

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

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

**Actions Taken:**
- All members of the staff team have received induction training on the organisational policy document ‘Guidance on Protection of Service Users’ Personal Possessions, Property & Finances’.
- The policy document was discussed at the local team meeting and re-issued to all members of the staff team on 21st June 2016.
- Each member of staff has indicated that they have read and understand the policy document on a policy sign off sheet.
- The Person in Charge and the Area Director will continue to carry out monthly audits on the management of individual’s finances.
- Any discrepancies identified will be addressed through supervision with the relevant staff member.

**Proposed Timescale:** 21/06/2016
Outcome 06: Safe and suitable premises

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A twin bedroom in the centre did not adequately meet the needs of the two residents residing in it.

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

Please state the actions you have taken or are planning to take:
Actions Planned:
- The Muiríosa Foundation is currently seeking suitable alternative living arrangements for one individual.
- Transition planning is currently underway in relation to supporting the individual to move from their current home.
- Once a suitable living arrangement has been secured, the individual will be supported to transition to the new living arrangement in line with the transition plan in place.
- Once the transition process has been successfully completed each individual in the designated centre will have their own bedroom.

**Proposed Timescale:** 30/11/2016

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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:**
One vehicle had been identified as requiring a service however, this had not yet happened. This was required to ensure all vehicles used by residents were maintained in a roadworthy condition.

**4. Action Required:**
Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

Please state the actions you have taken or are planning to take:
Action Taken:
- The required service on the vehicle in question was completed on 6th June 2016

**Proposed Timescale:** 06/06/2016
<table>
<thead>
<tr>
<th><strong>Outcome 08: Safeguarding and Safety</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
</tr>
</tbody>
</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While plans were in place they required more detail, such as the type of supports residents required to ensure their independence was promoted as much as possible so that the resident's dignity would be respected.

**5. Action Required:**
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

**Please state the actions you have taken or are planning to take:**
**Actions Planned**
- Key workers and the Person in Charge are currently undertaking a review of each individual's intimate care plan.
- Once the review of care plans has been completed, a senior manager will further review the updated care plans.

**Proposed Timescale:** 31/08/2016

<table>
<thead>
<tr>
<th><strong>Outcome 13: Statement of Purpose</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
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</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The whole time equivalent hours for the person in charge were not specified on the statement of purpose.

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

**Please state the actions you have taken or are planning to take:**
The statement of purpose has been updated and subsequently submitted.
**Actions Taken:**
- The statement of purpose and function document has been revised to incorporate the whole time equivalent hours for the person in charge.

**Proposed Timescale:** 19/07/2016