<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Greenville House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002113</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Cork</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Cork Association For Autism</td>
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<tr>
<td>Provider Nominee:</td>
<td>Cormac Coyle</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Julie Hennessy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>13</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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</table>
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 05 September 2017 10:00  
To: 05 September 2017 15:30

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

<table>
<thead>
<tr>
<th>Outcome 08: Safeguarding and Safety</th>
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<tbody>
<tr>
<td>Outcome 12: Medication Management</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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</tbody>
</table>

**Summary of findings from this inspection**

Background to the inspection:
This was the seventh inspection of this centre by the Health Information and Quality Authority (HIQA). Previous inspections took place on 21 and 22 October 2015, 4 and 9 May 2016, 16 November 2016, 4 January 2017, 4 April 2017 and the 5 June 2017.

On 24 February 2017 the provider was issued with notices to refuse and cancel registration of this centre on foot of on-going concerns regarding the quality and safety of the service identified over successive inspections. The provider submitted a representation to HIQA on 24 March 2017 that proposed how to address the grounds cited in the notices of proposal. Following the most recent inspections against the provider's representation, a decision was made to afford the provider more time to implement their action plan.

Since February 2017, the Board of Cork Association of Autism has continued to receive substantial support from their main funder, the Health Service Executive (HSE), to address the failings cited as grounds in the notices of proposal. This support has taken the form of a secondment of an interim chief executive officer (CEO) and secondment of personnel with experience in key areas such as human resources, positive behaviour support, restrictive practices, quality and risk management and service provision and delivery.

The purpose of this focussed inspection was primarily to follow up on two major non-compliances identified at the previous inspection. Also, as unsolicited information of concern was received since the previous inspection, this was also included as a line of enquiry at this inspection. The provider was informed of this inspection the day
prior to the inspection.

How we gathered our evidence:
As part of the inspection, inspectors met with seven residents, a senior manager on secondment from the HSE who fulfilled the dual role of chief executive officer and representative of the provider, the person in charge on secondment for a six-month period, the social care leader, a number of staff on duty, a consultant providing support to the newly formed restrictive practice committee and the multidisciplinary team. Inspectors also reviewed relevant documentation, including the staff training matrix, residents’ medication charts, audits and residents’ support plans.

Description of the service:
The centre provides residential care specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque environment and there is also a day service and other facilities, such as horticulture and outdoor gym equipment in the grounds. The centre comprises a main house and six cottages and can accommodate 13 residents. The main house can accommodate five residents and each cottage can accommodate either one or two residents.

Overall judgement:
Overall, the cumulative findings from this inspection and two previous inspection demonstrated steady and sustained improvement in relation to the care and support being provided to residents in the centre. This improvement had resulted in a quantifiable reduction in incidents and safeguarding events involving residents with a resultant improvement in quality of life outcomes.

A summary of outcomes inspected is as follows:
Under Outcome 8; the representative of the provider demonstrated that they had responded appropriately to concerns raised in the form of unsolicited information since the previous inspection. The provider representative had ensured that an investigation had been initiated into the nature of the allegations raised and had taken interim steps pending the outcome of that investigation. The lines of enquiry inspected under this outcome at this inspection were found to be in compliance with the regulations.

Under Outcome 12; a new medication management system was being implemented since the last inspection. Some elements of the system had yet to be implemented in full. As a result, full reassurance regarding the robustness of the system was yet to be demonstrated. The failings under this outcome have reduced in risk from the level of major to moderate non-compliance with the regulations pending full implementation of the new medication management system.

Under Outcome 14; a governance review had been commissioned by the HSE and had commenced; this would inform the long-term governance and management plan for this centre. A date for completion of the review had been provided to HIQA. The failings under this outcome have reduced in risk from the level of major to moderate non-compliance with the regulations pending outcome of the HSE review and clarification of the arrangements for the centre going forward.
The inspection findings are detailed in the body of this report and required actions outlined in an action plan at the end of this report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:
Specific lines of enquiry were included on this inspection. This included information of concern received since the previous inspection and an action from the previous inspection that related to oversight of restrictive practices in the centre. Overall at this inspection, structures were in place for the review and oversight of any restrictions in place in the centre. The representative of the provider demonstrated that they had responded appropriately to concerns raised in the form of unsolicited information since the previous inspection.

Since the previous inspection, unsolicited information had been received relevant to this centre. The provider representative had acted in a responsive manner and ensured that an investigation had been initiated into the nature of the allegations raised and had taken interim steps pending the outcome of that investigation. Communication with key stakeholders was evidenced. This process was supported by ongoing consultation forums with residents' representatives, advocates, the confidential recipient appointed by the health service executive (HSE) and the national safeguarding team. Evidence of learning from previous incidents involving residents was demonstrated. The investigation commissioned by the representative of the provider was near completion and the representative of the provider had committed to implementing any recommendations that may arise from that review.

At the previous inspection, the restrictive practice committee required further review and development to ensure its effectiveness. Since the previous inspection, the restrictive practice committee had been developed to include members of the multidisciplinary team. A person with significant experience and knowledge of restrictive practice and human rights had been identified as chair of the committee. Restrictive practice training
had been provided to the committee members with a wider training plan developed for all staff. The committee was due to meet shortly and complete a full review of any restrictive practice in the centre. Work to inform this committee meeting had already taken place, with a log of current restrictions developed.

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

**Findings:**
This outcome was found to be at the level of major non-compliance at the previous inspection. A new medication management system was being implemented since that inspection. Some elements of the system had yet to be implemented in full. As a result, full reassurance regarding the robustness of the system was yet to be demonstrated.

At the previous inspection, adequate reassurances were not provided with respect to practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. Since the previous inspection, a new medication management system was being implemented. A policy had been developed and approved by the Board and staff had received training in relation to the new system. However, some elements to support the new system which were described at the previous inspection had yet to be implemented. For example, at the previous inspection it was outlined that training on specific aspects of the system would be completed by an appropriately qualified healthcare professional. While a suitable trainer had been identified, training dates were yet to be agreed.

At the previous inspection, it was outlined that the auditing system going forward would involve monthly internal audits and quarterly audits by a community pharmacist. At this inspection, weekly and monthly internal audits were being completed by team leaders and the person in charge. An appointment had been arranged with a community pharmacist to discuss what support the person in charge might put in place to facilitate the pharmacist in meeting their obligations to residents and their input going forward. A template was available to complete an audit that considered all aspects of the medication management cycle but such an audit had yet to take place.

An inspector viewed the new system that was being piloted in one part of the centre. Staff clearly articulated how the new system worked. Staff signature sheets were in an
older file, but this was addressed on the day of the inspection. However, a transcribing system was in place and it had not been recorded who had transcribed the medicines. There were arrangements in place for the reporting, recording and review of any medication errors.

Other failings that had been identified at the previous inspection had been satisfactorily progressed. At this inspection there were appropriate and suitable practices in place relating to the storing of medicines that required refrigeration. Also, any supplements being administered by staff had been prescribed and were approved by relevant licencing bodies (medical or pharmaceutical).

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
This outcome was found to be at the level of major non-compliance at the previous inspection as a plan was not in place that detailed the long-term governance and management arrangements for this centre. Since the previous inspection, a review commissioned by the Health Service Executive (HSE) had commenced. While the current governance and management arrangements in the centre were effective, this outcome will however remain non-compliant pending the outcome of the HSE governance review and nomination of a permanent person in charge.

Notices of proposal to refuse and cancel the registration of this centre were issued on 24 February 2017. As also outlined following the previous inspection, the Board of Cork Association of Autism had received and was continuing to receive substantial support from their main funder, the Health Service Executive (HSE), to address the failings cited as grounds in those notices. This support took the form of a secondment of an interim chief executive officer (CEO) and secondment of personnel with experience in key areas such as human resources, positive behaviour support, restrictive practices, quality and risk management and service provision and delivery.
At the previous inspection a plan was not in place that detailed the governance and management arrangements for this centre in the medium- to long-term. Since the previous inspection, a governance review had been commissioned by the HSE and had commenced. A date for completion of the review had been provided to HIQA. Interim arrangements (up to the end of 2017) have been confirmed with no change to the current interim governance and management of the centre.

At the previous inspection, a person in charge had been seconded for a three-month period. This secondment was near completion and an alternative suitable arrangement was in place in the form of another secondment for a further six-month period. The incoming person in charge met the requirements of the regulations in terms of experience, skills and qualifications. This newly appointed person in charge had been working in the centre for the previous three months in a quality and governance role, which provided reassurance in terms of continuity of the quality and safety of care and support being provided in the centre.

Other key support structures had also been introduced, in the form of a new multidisciplinary team and restrictive practices committee. In addition, the outgoing person in charge would continue to support the workings of the new multidisciplinary team and restrictive practices committee on a sessional basis. Recruitment for a permanent person in charge had taken place with progress being made in this regard.

The management team were progressing work to be completed in a number of areas, including incident recording, the roll-out of a new complaints policy and form, development of personal plans, care plans, risks assessments and support plans for all residents (as required). Improvement was evident in the areas of communication, the completion of priority assessments of need and behaviour support plans, revision of the corporate and local risk registers and policies to underpin the care and support to be provided. A system of staff supervision had been introduced, lines of responsibility had been clarified and a new team leader structure had been developed to strengthen the support being provided to both frontline staff and the person in charge. Monthly reviews of the service were being completed from a quality perspective. The representative of the provider had also completed an unannounced visit to the centre. Concerted efforts had being made to improve communication with families, advocates and the HSE safeguarding team.

Inspectors held discussions with staff and managers, observed practices and reviewed a sample of residents' files in order to assess overall progress against previously submitted actions plans to HIQA and the provider's own internal audits and reviews. Some works could not yet be completed in full (for example, where reports from assessments were pending) and other areas required further development (for example, care plans). Overall at this inspection, significant progress was demonstrated against actions plans. As a result, at this inspection and two previous inspection, incremental and sustained improvement has been evidenced under the current governance and management arrangements.

Judgment:
Non Compliant - Moderate

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Cork Association For Autism</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002113</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>05 September 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>05 October 2017</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 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 arrangements that would support the pharmacist to meet his or her obligations to residents and the nature of their input going forward was not yet clear.

1. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

**Please state the actions you have taken or are planning to take:**
The Person In Charge has met with the Community Pharmacist, with further agreed follow up meetings. The Community Pharmacy has agreed to provide training, advice to staff, support to residents, and to conduct three monthly auditing of the medication system within the Centre.

**Proposed Timescale:** 30/09/2017

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, elements of the new medication management system had yet to be implemented in full or evidenced to be robust, in particular as they related to:
- staff training required by an appropriate healthcare professional
- oversight and auditing of all elements of the system by an appropriate healthcare professional
- transcribing practices.

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

**Please state the actions you have taken or are planning to take:**
The new Medication Policy and Procedure has been fully rolled out, the procedure clearly identifies the process for the ordering, receipt, prescribing, storing, disposal, and the administration of medicines. The Medication Policy and Procedure also clearly identifies the process for the reporting, recording, and reviewing of any medication errors that may occur.

Staff training was completed in September 2017, with a further training session identified in October 2017.

A weekly medication auditing process has commenced across the Centre and the Community Pharmacist will conduct quarterly medication audits.

**Proposed Timescale:** 30/09/2017

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance and management arrangements for this centre in the medium- to long-term were yet to be determined, pending the outcome of a review by the Health Service Executive (HSE).

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

**Please state the actions you have taken or are planning to take:**
An interim management structure is in place, with clearly defined lines of authority and accountability.

A permanent Person In Charge has been appointed and will take up post before the 30 November 2017.

An Independent Review has been commissioned by the HSE, this review will be completed by the 30 October 2017. The outcome of the review will provide recommendations that will determine the long-term governance and management arrangements of the Centre.

**Proposed Timescale:** 30/11/2017