Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Issued by the Chief Inspector

Name of designated centre:	Community Living Area J
Name of provider:	Muiríosa Foundation
Address of centre:	Laois
Type of inspection:	Announced
Date of inspection:	22 January 2020
Centre ID:	OSV-0002722
Fieldwork ID:	MON-0022494

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Community Living Area J, Fountain View, is a large bungalow situated on the outskirts of a small town in a semi-rural setting. The centre provides residential support for up to four adults with an intellectual disability, both male and female. Residents may also present with physical disabilities and/or behavioural needs. The staff team consists of both social care workers and care workers and there was a minimum of two staff on duty at all times to support the residents. Residents also have access to nurse support if required and multi-disciplinary services including occupational therapy and behavioural support. Local amenities include a range of cafe's and restaurants, local parks, pubs, clubs, a hotel and leisure centre. Each Resident has a named key worker to support them with daily and lifelong planning.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 22 January 2020	09:30hrs to 17:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with all three residents living in the designated centre on the day of inspection. Some residents used verbal methods to communicate and others nonverbal methods. All residents left the centre on the morning of the inspection to attend either their day services or person centred activities. The inspector observed residents getting their breakfast and going about their normal daily routine. This appeared to be a relaxed experience. Residents then returned home in the evening time and the inspector observed the residents sitting down together and watching television before having their dinner. Residents appeared comfortable in each other's company. One resident had a chair they preferred to sit in and this preference was respected by staff and other residents.

Residents had a wide range of personalised social goals and daily activity planners in place. One resident enjoyed going for a swim in the local leisure centre with support from staff on the day of inspection. Another resident went out for lunch with staff and met with a peer. Two residents enjoyed a seaside holiday last year and two residents enjoyed going to see a play in Dublin. Residents regularly went out to the local pub and social club, or to local shops and restaurants. Residents were consulted about their preferences and choice regarding meals and planned activities.

There were no complaints communicated with the inspector regarding the service being provided on the day of inspection. Staff working with the residents appeared knowledgeable regarding residents individualised needs and goals when spoken with. The centre had been personalised to suit the resident's preferences and appeared to be a warm and homely environment. Residents appeared to be enjoying a person centred residential service and overall, the inspector found the residents appeared happy and content living together in their home.

Capacity and capability

The purpose of the inspection was to inform the renewal of registration of the designated centre. Overall, the inspector found that the provider, person in charge and people participating in management were striving to implement a person centred and safe service to the residents living in Community Living Area J. Actions from the previous inspection had been addressed. Documents required to inform the renewal of registration had been submitted to the Office of the Chief Inspector within the required time frame and the centre had a statement of purpose in place that accurately described the service that was provided.

Improvements in the governance systems were noted since the centres most previous inspection. The person in charge (PIC) had the skills, experience and qualifications necessary to manage the designated centre and oversee the care and support that was provided. The person in charge shared a role between two other designated centres. There was a designated member of staff in charge in the absence of the person in charge, who supported the PIC with administration duties. Another member of management was also allocated to support the PIC in the other designated centres and therefore the person in charge had more time delegated to this designated centre. There was a clear management structure in place and appropriate systems for the governance and oversight of the designated centre. Staff spoken with were familiar with the management structure and knew who to speak with, should an issue arise. Systems were in place for regular auditing and review of the service being provided. Six monthly unannounced thematic audits were completed by a person nominated by the provider.These audits reviewed the care and support being provided and also looked at areas including assessments and personal plans, positive behavioural support, safeguarding, residents rights, communicated training, premises and governance and management. The regulations and standards were used as a tool for making judgments during these audits. Any actions identified from audits and reviews were allocated to a responsible person and outcomes of these were also discussed at team meetings with staff.

There were appropriate staffing numbers and skill mixes in place to meet the assessed needs of the residents. The staff team consisted of both social care workers and care workers and there was a minimum of two staff on duty at all times to support the residents. There was a staff rota in place that was maintained by the person in charge. This was available on an online system. Additional staffing was implemented during times when extra support was needed for residents to attend different activities, for example swimming. The centre used an internal relief system to cover periods of staff illness or annual leave. Staff spoken with were familiar with the needs and preferences of the residents. Supervision of staff was completed by line managers four monthly and staff performance and issues were discussed during these sessions. The inspector observed a schedule in place that the person in charge had completed for upcoming supervisions to take place. The inspector did not have the opportunity to review staff Schedule 2 documents as these were located off site from the designated centre.

All staff had received up-to-date mandatory training and additional training to meet the assessed needs of the residents. This included training in areas including safeguarding, fire safety, manual handling, medication administration, children's first and the service online personal planning system. One resident, who was recently admitted to the designated centre, sometimes used a specific nonverbal method to communicate. Training to familiarise staff with this method was scheduled for staff to complete in the coming weeks. The person in charge and human resources team were completing a regular training needs analysis and were highlighting training deficits or refresher training needs and scheduling additional training when needed.

There was an appropriate system in place for the management of complaints. There were no complaints communicated with the inspector on the day of inspection regarding the service being provided. The complaints process was prominently displayed in the designated centre along with details of advocacy services. Any complaints or concerns from residents or their representatives were appropriately recorded and treated in a serious and timely manner. Residents and their representatives were regularly consulted regarding their feedback on the care and support that was provided.

Regulation 14: Persons in charge

The person in charge had the skills, experience and qualifications necessary to manage the designated centre and oversee the care and support that was provided.

Judgment: Compliant

Regulation 15: Staffing

There were appropriate staffing numbers and skill mix in place to meet the assessed needs of the residents. The staff team consisted of both social care workers and care workers and there was a minimum of two staff on duty at all times to support the residents.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had received up-to-date mandatory training and refresher training in line with the assessed needs of the residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and appropriate systems for governance and oversight of the designated centre and the care and support provided.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place that accurately described the service being provided and contained all items set out in Schedule 1

Judgment: Compliant

Regulation 34: Complaints procedure

There was an appropriate system in place for the management of complaints and there was a designated person to manage any complaints received. There were no complaints communicated with the inspector on the day of inspection.

Judgment: Compliant

Quality and safety

The registered provider and person in charge had ensured the designated centre was suitable for the purposes of meeting the needs of each residents in line with their comprehensive assessments. In general, the residents were benefiting from a safe and effective service. Systems were in place to promote personalised support and care. Residents were enjoying their daily lives and were working towards achieving their own social goals.

This centre is a large bungalow situated on the outskirts of a small town in a semi-rural setting. The premises was maintained in a good state of repair internally and externally and was designed and laid out to meet the assessed needs of the residents. The inspector noted paintwork had been completed since the centres most previous inspection. All residents had their own bedrooms and these were decorated in line with the residents own preferences. The centre also had two communal living areas, a kitchen and a dining area. These were a suitable size to meet the needs of the three residents living there. The registered provider had

provided all items set out in Schedule 6, including appropriate storage, bathroom facilities and laundry facilities.

All residents had a comprehensive assessment and personal plan in place that guided the care and support that was provided. These were subject to regular reviews and these reflected resident's most current needs. A key working system was in place and key workers were responsible for maintaining resident's documentation, updating social goals and supporting residents to achieve their social goals. Resident had a number of personalised social goals in place. One resident had goals in place to go on holidays, set up a new savings account and explore a new hobby. Smaller steps were in place to support residents to achieve these goals. Plans in place guided staff to support residents with their activities of daily living and detailed levels of support required. Residents had annual person centres planning meetings and these were used as a forum to discuss and review their goals and aspirations for the coming year.

Residents were supported to communicate in line with their own individual needs. Specific communication care plans and diaries were in place for residents with communication needs. The inspector noted a pictorial notice board in place which was used to display staff that were on duty. Regular monthly meetings were held with residents and these were called "house conversations". Topics discussed at these meetings included menu ideas, Christmas plans, day trips planned, individual goals and the upcoming HIQA inspection. One residents tablet device was utilised to record the service policy on care planning and safeguarding and this was then used as an educational tool during key working sessions. An appropriate tool was also used with residents who could not communicate verbally to assess a resident's level of distress or discomfort. One resident, who was recently admitted to the centre, sometimes used a nonverbal method to communicate. Staff were familiar with the residents' nonverbal prompts and training in this nonverbal method of communicated was scheduled for staff to complete.

Appropriate systems were in place for the identification, assessment and mitigation of potential and actual risks in the designated centre. Management had identified potential risks in the centre and individualised risk assessments were completed for residents. This included assessing the risk of falls, choking, burns and risks posed secondary to challenging behaviours. Plans and measures were in place for emergency situations including flooding, water failures, gas leaks, transport breakdown and electrical failures. Six monthly risk review meetings were held with the person in charge and the area director and these were used to review and discuss control measures in place to reduce or eliminate risks.
Identified restrictive practices in place were risk assessed and regularly reviewed.

In general, systems were in place to prevent fire and protect against fire. The registered provider had ensured the provision of adequate firefighting equipment in the designated centre and this was subject to regular servicing with a fire specialist. Appropriate containment measures were in place and staff completed daily checks on the fire detection system. Staff had received suitable training in fire safety and regular fire evacuation drills were completed in an efficient manner. Residents and staff spoken with had a good knowledge of fire evacuation procedures and knew

where the fire assembly point was located. Residents had individualised emergency evacuation plans in place and these detailed the residents awareness of fire safety, their mobility levels, the levels of assistance required to evacuate the centre and equipment potentially needed to support the residents to evacuate. However, the inspector noted that there was no emergency lighting in the back hallway of the designated centre. This was the main exit route for one staff member and one resident in the event of a fire at night time and posed a potential risk.

Safe procedures were in place for the prescription, storage, ordering and administration of medication. All staff had received appropriate training and were competent to administer medication safely. Keys for the medication press were stored securely and there was a separate storage facility in place for the storage of out-of-date or unused medicines. A number of residents prescriptions were reviewed along with resident's medication and it was found that prescriptions were accurately reflecting medicines being administered. All prescriptions were signed by a general practitioner (GP) and were subject to regular review. The person in charge completed regular medication audits and staff regular did stock checks on the resident's medication. Assessments had been completed with all residents to assess their ability to self-administer medication. Clear care plans and protocols were in place for the administration of medication administered as needed (PRN).

Residents were supported to manage their behaviours and had appropriate access to multi-disciplinary healthcare professionals. Positive behavioural support plans were in place where required and staff were familiar with these. In general, the use of restrictive practices was minimal. However, the use of one environmental restrictive practices were not in line with the service policy at times. Their use was not appropriately recorded and was not subject to regular review with the service positive behavioural support team. Evidence of consideration of the least restrictive measure was not observed by the inspector. Furthermore, the use of a sensor alarm to monitor one residents movements at night time, had not been recognised as restrictive and had not been notified to the Office of the Chief Inspector as required. Following discussion with the person in charge, it was clear that this restriction was in place to support the resident with personal care during the night.

Residents were appropriately safeguarded in the designated centre. All staff had received up to date training in the safeguarding and protection of vulnerable adults. There was a designated officer in place who responded to any safeguarding concerns in a serious and timely manner. Staff spoken with were familiar with safeguarding measures and national policy. All staff had up-to-date Garda vetting in place and residents had intimate care plans in place that guided staff to safely support residents with personal care. There were no safeguarding concerns identified on the day of inspection.

Regulation 10: Communication

Residents were being supported to communicate in line with their individual needs and disabilities. Staff were familiar with these individual needs.

Judgment: Compliant

Regulation 17: Premises

The premises was maintained in a good state of repair internally and externally and was designed and laid out to meet the assessed needs of the residents. The registered provider had ensured the provision of all items set out in Schedule 6.

Judgment: Compliant

Regulation 26: Risk management procedures

Appropriate systems were in place for the identification, assessment and mitigation of potential and actual risks in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

In general, systems were in place to prevent fire and protect against fire. However, the inspector noted that there was no emergency lighting in one area of the designated centre which was used by one resident and one staff member as an emergency exit route in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Safe procedures were in place for the the storage, ordering and administration of medication. All staff had received appropriate training and were competent to administer medication safely.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

All residents had a comprehensive assessment and personal plan in place that guided the care and support that was provided. The registered provider and person in charge had ensured the designated centre was suitable for the purposes of meeting the needs of each residents in line with their comprehensive assessments.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and had appropriate access to multi disciplinary healthcare professionals. However, the use of some environmental restrictive practices were not in line with the service policy at times and their use was not appropriately recorded.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were appropriately safeguarded. Staff had received training in the safeguarding and protection of vulnerable adults. There were no safeguarding concerns noted on the day of inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Community Living Area J OSV-0002722

Inspection ID: MON-0022494

Date of inspection: 22/01/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A new emergency light is now fitted in the corridor.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The restrictive practice as outlined and the bedrails have been reviewed by behavioural support team. A monitoring form has been developed and be signed off by staff on each application of the restrictive practice. The monitoring device in the residence room has been submitted on the portal in quarter 4 2019, as part of the NF 39 returns.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	12/02/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/01/2020