

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Muiriosa Foundation
<b>Centre ID:</b>	OSV-0002760
<b>Centre county:</b>	Westmeath
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Muiriosa Foundation
<b>Provider Nominee:</b>	Brendan Broderick
<b>Lead inspector:</b>	Eva Boyle
<b>Support inspector(s):</b>	Jillian Connolly
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	2
<b>Number of vacancies on the date of inspection:</b>	3

## **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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From:	To:
29 July 2014 10:30	29 July 2014 18:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 12: Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

The first inspection of this mixed respite centre was unannounced and was carried out by two inspectors over one day. As part of the inspection, inspectors met with the centre manager (person in charge), staff members and observed the two residents in the centre. The regional director and area manager were present for feedback at the end of the inspection process. Inspectors reviewed policies and procedures, as well as personal plans, behavioural support plans, fire records and staff files. Overall, the inspection identified 2 moderate non-compliances and 5 major non-compliances in the centre.

The centre was located in a bungalow in a residential setting on the outskirts of a town in the Midlands. The centre provided planned and crisis respite care for 35 adults and 14 children with varying degrees of intellectual disabilities and/or on the autistic spectrum. The centre originally provided respite on alternative weeks to children and adults. However, for the 19 months prior to inspection, there were periods when one or more residents were residing on a full time basis within the centre. On the day of the inspection, there were two residents, an adult and a child, who were resident on a full time basis. Respite services had been suspended due to this situation days prior to the inspection. The residents had one to one staff supervision during the day.

Inspectors observed the two residents within the centre, and they received close

supervision on the day of the inspection. Staff interacted warmly and were respectful in their interactions with the residents. The management team had implemented some audits in the centre and had completed an internal audit of quality in the centre.

There were deficits in the assessment of resident's needs and in their personal plans. There was insufficient evidence of multi-disciplinary assessment and input into the personal plans of residents.

On the day of the inspection, two potential risks were identified by inspectors. The first potential risk was the staffing level at night time was not sufficient to meet the evacuation plans of the residents. The second potential risk was that the assembly point was at the front of the centre, adjacent to the front entrance, and both residents were assessed to be at risk of absconcion, but the entrance gate was opened. These potential risks were brought to the attention of the manager, regional director and area manager for their attention.

The management systems in place within the centre varied in their quality. The senior management team was aware for a considerable period of time that the centre was not operating in accordance with its statement of purpose as a child and adult were resident on a full time basis. It was not clear from individual residents' files how the senior management team had attempted to address this situation at a multi-agency level. While safeguarding measures were in place at the time of the inspection, there had been delays in the implementation of these measures.

The centre had no formal systems in place in relation to the supervision of staff. However, staff were positive about the support that they received from their manager.

**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 05: Social Care Needs**

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

**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

Resident's needs were not comprehensively assessed as required by regulation 5 (1). Staff were in the process of using a new format for personal plans at the time of the inspection, and the personal plans sampled by inspectors were in the new format. Personal plans did not meet with Regulation 5 (4) (b) and (c). There were no formal systems in place in relation to the review of personal plans. The quality of planning of transitions for residents varied within the centre.

The quality of the assessment of residents needs within the centre varied. Not all of resident's individual needs and choices were comprehensively assessed by the staff team. Inspectors reviewed a sample of resident's files and found some needs had been identified but this was not a comprehensive assessment of all their needs. There was limited multi-disciplinary input into the assessment. Parents had been consulted but resident's views were not always apparent. Inspectors found evidence of input from incontinence nurses, these assessed needs were incorporated into plans, while in other situations there was little evidence of multi-disciplinary input.

Resident's personal plans did not comprehensively outline all the supports required for resident's to maximise their personal development in line with their wishes. The personal plans of residents that were reviewed by inspectors had a health focus and did not adequately focus on the resident's specific social, emotional and participation needs. Inspectors found that in the sample of files that were reviewed by inspectors that the majority of identified ongoing and short-term life events focused on the resident's diagnosis and illness, rather than key significant events that occurred in the resident's life. Not all aspects of resident's personal plans had specific goals identified. For example, in one personal plan under eating and drinking, there was a specific goal

outlined in relation to a resident's diet. However, in two of the person centred plans sampled by inspectors, residents required a permanent home, yet this goal was not explicit in one of the plans. In the minutes of a multi-disciplinary meeting in July 2014, it was not minuted that there was any discussion about the need for a permanent home or future planning in this regard for the resident. Inspectors found that it was documented in a person centred plan, that some of the living arrangements that had been in place for the resident in the recent past were not 'optimal'. The actions that were taken to reach the goal of a permanent home for this resident was not clear, while in the second resident's file, there was a comprehensive transition plan in place to another centre. An accessible format of personal plans were not available to residents and their families.

There was no formal system of review of personal plans in place in line with regulation 5 (6) (a), (b), (c) and (d). Inspectors found that some specific elements of plans had been reviewed and updated by the staff members but the process of review was unclear and was not always signed off by the manager. Some multi-disciplinary meetings occurred around specific needs. However, there was no overall multi-disciplinary review held where residents and their representatives participated in reviewing the overall effectiveness of the personal plans.

The preparation for residents to transition between services varied. In one person centred plan as referenced above, there was a transition plan in place for a resident to move to another centre. At the time of the inspection, the resident was being supported in this move and had commenced visits to the centre. Whilst the plan was in place, it was unclear that the plan took on board the impact that the transition may have had on the resident. While in a second person centred plan, the resident had in the recent past moved on a weekly basis to an alternative centre for two nights per week, it was not clear from the person centred plan how the resident was supported for this transition on a weekly basis. The centre manager described how she met with potential residents and their families in advance of them attending the service for respite, in order to assess how they would best transition into the service.

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There were some measures in place that promoted and protected the health and safety of residents, visitors and staff. There was a health and safety statement in place and some precautions to monitor fire safety. Not all risks within the centre had been identified, assessed and mitigated against. The risk management policy did not meet the

requirements of Regulation 26 (1) (a), (b) and (d).

The centre had a health and safety statement dated April 2013 which was centre specific. There was a designated local safety representative in place. The centre had policies and procedures in place for use of personal protective clothing, accident and incidents, chemical agents, risk of falls, first aid, and transport policy. The centre had completed health and safety audits which reviewed the work environment, floor surfaces, electrical safety, housekeeping and emergency readiness. The centre had systems in place in relation to chemical agents that were held within the centre.

The centre had some procedures in place for the prevention of infection, however not all practices were optimal. The centre had protective preventative equipment in place such as gloves and aprons. There was guidance in relation to good hand hygiene, and all bins in the centre were pedal operated. However, inspectors found that towels were stored in the bathroom of the centre, which was not good practice in infection control.

The organisation had a risk management policy "Guidance on the management of risk and the individual service user" (April 2014). The policy did not meet the requirements of Regulation 26 (1)(a), (b) and (d), as it did not include the hazard identification and assessment of risks throughout the designated centre or the measures and actions in place to control the risks identified. The arrangements for the identification, recording and investigation of and learning from, serious incidences or adverse events involving residents was not outlined in the policy document. The policy outlined that it focused on the risk assessment and management of the individual, and referenced the organisation's health and safety policy statement 2012 in relation to environmental risk assessment. The risk management policy referenced the unexplained absence of an individual, accidental injury to children, visitors or staff, aggression and violence and self-harm, and also referenced the organisation's policy document 'Listening and responding to individuals who demonstrate behaviours of concern'.

The centre had a local risk register, which identified hazards, the number of people affected, existing control measures and a risk rating. The risk register did not include all specific hazards within the centre, such as the location of the assembly point which was close to the gate to the centre, which exited to a road, and on the day of the inspection, the gate was opened. The residents were both risk assessed as being at risk of absconson. Not all risks within the risk register were risk rated.

Not all fire safety measures were adequate in the centre. The centre had carried out fire drills during the day on a monthly basis from May 2014. Staff and service users had participated in the fire drills which took place during the day. However, there was only one staff member on duty at night, and in the event of a fire, both residents required assistance in exiting the building. None of the fire drills that had taken place reflected the ratio of staff to residents at night. This was drawn to the attention of the management team when feedback was given to the service at the end of the inspection. Staff conducted monthly checks of fire extinguishers. Emergency lighting was in place. Fire extinguishers were serviced in February 2014, while the fire alarm was serviced in April 2014. All staff had received fire training in March 2014. Staff completed daily checks of the fire door, monthly checks of the fire extinguisher. There was inadequate signage in place to highlight the fire exits. Inspectors found that there were keys

hanging at the side of the sleepover room and back door, while the front door was not an official fire exit, there was no key readily available. There were automatic doors on the kitchen and sitting room. There was a fire assembly point at the front of the centre.

**Judgment:**

Non Compliant - Major

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre had policies in place in relation to child protection and the protection of vulnerable adults. Staff had been briefed in the organisation's policy, and had a good knowledge of child protection. The centre had not reported all child protection concerns to the Child and Family agency. Behavioural support plans were inadequate and had not outlined sufficiently the steps that staff were required to take to manage resident's behaviours. Systems in relation to the identification, recording and reviewing of restrictive practices were not robust within the centre.

Some safeguarding measures had been introduced in the days prior to the inspection. The Authority became aware at a regulatory meeting with the organisation on the 15th of July 2014 that a child and adult were resident on a full time basis in the centre. The provider nominee after the meeting arranged for one to one staffing to be put in place for both residents during the day as part of a safeguarding approach.

Staff had not received timely briefing in child protection and safeguarding given the needs of residents within the centre. Not all staff in the centre had up-to-date training in safeguarding. Staff had been briefed on the organisation's child protection policy at meetings in the week prior to the inspection. The centre had a comprehensive child protection policy which was dated the 23 July 2014. Inspectors found that staff had a good knowledge of safeguarding children and vulnerable adults. The organisation's policy on child protection referenced the additional vulnerabilities that children with a disability had in relation to the potential risk of abuse. Staff were aware of what steps to take should they have child protection or welfare concerns, and were aware that the social workers within the organisation were the designated liaison officers with the Child and Family Agency (CFA). The centre had a comprehensive policy on intimate care, and while the policy referenced the organisation's policy on vulnerable adults, there was no



reference to child protection or safeguarding.

The centre had not directly reported child welfare concerns to the Child and Family agency at the time of the inspection. There were documented child welfare concerns, where there had been multi-disciplinary and agency meetings. There was a social history report on one child's file completed by a social worker from the organisation, which referenced child welfare concerns, and referenced 'liaison with "Tusla" welcomed'. The provider nominee informed inspectors that in August 2013, they had reported child welfare concerns to the funding body, who in turn contacted the relevant child protection authorities. However, there was no correspondence on file to this effect.

Behaviour support plans were not adequate in outlining the actions that staff should take to manage resident's behaviours. For example, In one resident's file, the behaviour support plan on file dated January 2014 was from the resident's educational facility. Since this date, the resident had been prescribed medication to be administered to manage his/her behaviours when required, however the behaviour support plan was not amended to reflect this or had not described the behavioural presentation that warranted the administration of the medication. A behaviour support specialist had visited the centre in the days prior to the inspection. Not all staff had training in behaviour management.

The centre had no comprehensive systems in place in relation to the identification and review of restrictive practices . The centre had a policy on restrictive practices and held a record of restrictive practices. However, not all restrictive practices that were used were identified on this record. Inspectors found that a child used a waist strap on their wheelchair and the buckle was covered, and there was a half door, that restricted entry into the kitchen. The restrictive practice log listed that there were two restrictive practices used in the centre – the front and back doors were locked to safeguard specific individuals from the main road and chemical restraint was prescribed by a psychiatrist for one resident when required. There was evidence that the locking of the front and back door had been reviewed by centre staff and management, however it was not evident that all restrictive practices were reviewed to ensure that the least restrictive practice was used. From the centre's records, it was apparent that family members were aware of these practices.

**Judgment:**

Non Compliant - Major

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

Medication management in the centre was adequate. The centre had an organisational medication management policy dated 2010.

The centre had an organisational medication management policy dated March 2010 which was reviewed in 2011. The manager told inspectors that she had reviewed the policy and was satisfied that it was fit for purpose. The policy covered prescribing, ordering, supplying, storing and disposal of medications. Appendix 6 of the policy included an appendix on the supply and administration of medication in respite/family support/short-term care services, which referenced the responsibility of the manager or registered nurse on duty to check the medication form and contents of drug containers. However, it did not outline the procedure for when the resident was discharged after their respite placement. Inspectors found that when resident's families were advised of the dates of respite, that they were requested to inform the manager of any change to the resident's medication, this was an additional process that the manager had in place to ensure that staff were up to date with any changes in the resident's situation.

Medication in the centre was administered by registered nurses and social care workers who had received training in the administration of medication. A registered nurse was on duty during the day.

The storage of medication within the centre was good. Inspectors observed that all medication was securely stored in a locked cupboard which was held in a locked room. The centre had a locked refrigerator within this room, and held a register for controlled medication. The centre manager informed inspectors that there was no controlled medication in use in the centre at the time of the inspection. Inspectors reviewed medications that were stored within the centre on the day of the inspection. Inspectors found that all residents medication were stored separately within the cabinet, however non-prescription medications were not labelled separately for each resident.

Prescription sheets were generally of good quality. A sample of prescription sheets viewed by inspectors included the resident's name, date of birth, the name of the medication, the dose, route of administration, the time of administration and there was a general practitioner's (GP) signature for each medication, including discontinued drugs. No photographs of the residents were included on the prescription sheets, which would ensure that the correct resident was being administered the correct medication.

The administration of medication was not always consistent with the times outlined in the prescription. The administration sheets contained the medications identified on the prescription sheet and the signature of the member of staff administering the medication. There was a space to record if the resident withheld or refused medication. However, inspectors found that the time on the administration sheet did not match the time on prescription sheet consistently. PRN medications were recorded separately on a separate administration sheet.

Some audits of medication management had been completed. Medication management had been included in the area manager's audit of the quality of services, and some identified actions had been completed, such as prescriptions sheets were completed by GP. The manager outlined that medication audits were assigned to members of the staff

team and she reviewed copies of the audits.

**Judgment:**

Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The statement of purpose did not reflect the arrangements in place in the centre on the day of inspection and did not contain all the requirements of schedule 1 of the regulations.

The statement of purpose did not reflect the arrangements that were in place in the centre on the day of inspection, or for a significant period of time prior to inspection, as there were residents who had been resident on a full time basis from 4 to 19 months. Inspectors found that the statement of purpose did not meet all of the requirements of schedule 1 of the regulations. The statement of purpose contained information in relation to the number and dependency levels of children and adults who accessed the respite service. In addition, it outlined the vision and mission statement of the service. The staffing team, organisational structure and accommodation facilities which included the dimensions of each room were outlined. Information on how to make a complaint was also included along with information on privacy and dignity within the centre. The statement of purpose outlined information on health promotion, assessment and medication management.

The statement of purpose had been reviewed by the manager or provider nominee, but it did not reflect the current arrangements within the centre. Not all aspects of the mission statement and practices outlined in the statement of purpose were reflected in the current practice of the centre, as the centre at the time of inspection was providing full time placements to two residents. It was not clear if all residents and their families had been provided with a copy of the statement of purpose.

Personal plans were referenced in the statement of purpose. However, there was insufficient information in relation to how plans were developed, who was involved in the review process nor was there an adequate emphasis on the multi-disciplinary nature of the review. The statement of purpose had not specifically outlined the criteria for accessing the service, transitioning and discharge from the service. The criterion for accessing the service on an emergency basis was not outlined. The activities or social opportunities offered to residents attending the service were not sufficiently described.

The arrangements for resident's participation in religious services were not outlined. The statement of purpose provided information regarding health and safety provisions including emergency evacuation plans but the specific information in relation to where residents would be evacuated to in the event of a fire, gas leak, electricity failure was not outlined. Staff were aware of the statement of purpose. Specific therapeutic techniques used in the centre were not outlined and described in the statement of purpose.

**Judgment:**

Non Compliant - Major

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

There were some systems of management oversight in place. An audit of the quality of the service had been completed and the manager had implemented some audits of specific aspects of care provision. However, there were deficits in how the senior management team had managed the overall respite service for the 19 months prior to inspection.

There was a clearly defined management structure in place, which identified the lines of authority and accountability in the centre. Muiriosa Foundation was the registered provider. The person in charge held the position of local manager for respite services and he/she managed the staff of the centre in addition to other centres. The local manager reported directly to the area director for residential services, who in turn reported to the regional director. The regional director reported to the chief executive officer, who in turn reported to a board of management. Staff told inspectors that they were aware of the management structure and were clear about who they reported directly to.

Inspectors found that the person in charge was suitably qualified and experienced. She was a registered nurse in the area of intellectual disability and had 18 years experience in the area. The manager had taken over the management of the centre in 2011. Staff members were aware of the reporting structure within the organisation.

The senior management team had not been effective in its management of respite services within this centre, as the centre had two full time residents. As outlined earlier

in this report, there were two residents, a child and an adult who were residing on a full time basis within the centre, which was outside of the statement of purpose of the centre. While there were records of multi-disciplinary meetings on the individual residents files, it was unclear from the records that were reviewed by inspectors, the steps that were taken at a senior management level to progress the situation. The regional director told inspectors that the needs of one resident had been discussed at a multi- agency residential supports forum, however this was not reflected in the centre records of that individual resident. While one resident had a plan in place in relation to a future placement, the second resident remained without a permanent assigned placement, and had been in this situation for the 19 months prior to inspection.

The manager was experienced and suitably qualified for his/her role but was not fully implementing his/her responsibilities under the relevant legislation. For example, the manager had not complied with Section 31.3 of the regulations, as no written report had been provided to the authority in relation to incidents including the use of restrictive practices to residents. Staff had not received training in behavioural support as per standard 7.2. It was also not clear what information had been provided to another centre, when one resident had left the centre on a regular basis in the recent past. The centre manager had good knowledge of the needs of the residents who attended the service, and was aware that the current situation in the centre was not the optimum for either resident. The manager told inspectors she visited the centre daily, as she had responsibility for a number of centres within a five mile radius. A staff nurse was identified as shift leader, when the manager was not present in the centre during the day. There was an out of hours on call system in place and staff were very familiar with this process. Staff told inspectors that the manager was approachable and supportive.

The manager had implemented audit systems for some but not all aspects of the service. For example, the manager had implemented audits in health and safety and medication management. The manager explained that she assigned these audits to staff members to complete, and she reviewed the audits. However, not all audits that were completed were signed off by the centre manager. A system of regular audits was not in place for issues such as quality of personal plans.

An audit of the quality of care provided to residents was completed in May 2014 by the regional director under the following headings- resident's rights, dignity and consultation, health and safety, safe services, safeguarding and safety, medication management and responsive workforce. Actions were assigned to specific members of staff and specific implementation dates were assigned to each task. Inspectors found that many of the identified deficits had been completed such as staff had completed weekly checks of the fire alarm.

There was no performance management system in place where staff were held to account for their personal and professional responsibilities. The manager outlined that she observed staff's practice on a daily basis and that performance issues were discussed with staff. Inspectors found that these discussions were not documented. However, as staff were employed through an external agency, the manager outlined if staff were not performing to the expected standards that he/she would not continue to employ the staff member. Staff were unaware of a protected disclosures policy should they have concerns in relation to the quality of the service provided, however staff

outlined that if they had concerns they would speak to a member of the management team.

The service did not have a service level agreement in place with the Health Service Executive (HSE) at the time of the inspection. The chief executive officer outlined in writing to the inspector on 8 August 2014, that since 2012, the matter had been brought to the attention of the HSE, and had contacted the HSE as recently as May 2014 to regularise arrangements.

**Judgment:**

Non Compliant – Major

**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):**

This was the centre's first inspection by the Authority.

**Findings:**

The organisation had a recruitment policy. All staff, with the exception of the manager were agency staff and were not employed directly by the organisation. It was not clear how the manager was assured that agency staff held the required qualifications or garda clearance. New staff were inducted into the centre by the centre manager. There was insufficient staff rostered at night time to meet the assessed needs of residents. Staff had not received training in all mandatory areas such as behavioural management. There were no formal systems in place for the supervision of staff.

All staff with the exception of the manager were employed through an external agency. The organisation had a service level agreement in place with the external agency dated January 2011. This agreement included the facility for the organisation to audit the information held on the agency staff's files. However, inspectors found that within staff files held by the organisation, evidence of An Garda Síochána vetting or staff qualifications was not present on all files. It was not clear to inspectors how the manager assured herself that all relevant checks had been completed on the staff by the external agency. The manager outlined that she met with all agency staff prior to them commencing work in the centre to ensure their suitability, that staff were inducted into the centre and shadowed existing staff initially. There were dates of induction recorded in some staff files. A member of staff who was relatively new to the service told inspectors that during induction, he/she was introduced to the policies, procedures, the centre itself and the residents. He/she also outlined that for certain tasks, like person

centred planning, that they have benefited from learning from their colleagues. There had been some turnover of staff. However, the two residents had generally experienced continuity of care in line with regulation 15 (3), as the manager and two members of staff were employed in the centre since 2011, with the remaining staff were employed in 2013 and in 2014.

There was insufficient staff rostered to work at night to safely evacuate the two residents within the centre, given their individual evacuation plans. There was a roster in place which was an actual roster with a section to record if there was any variation. During the day, two members of staff were employed, one nurse and a social care worker. Staff worked a split shift, with a two hour break in the afternoon. The staff nurse on duty during the day had responsibility for the centre when the manager was not present. However, this was not indicated in the staff rota. At the time of the inspection, one resident engaged with another programme within the organisation for the two hour period. Each resident had one to one levels of supervision during the day at the time of the inspection. A social care worker was on duty at night. The manager outlined that all staff that were rostered to work at night would have had all relevant training, however it was not possible to ascertain this from the staff files.

There were no arrangements in place for the formal supervision of staff. Staff told inspectors that they sat down with their manager and discussed work and goals were identified. However, there were no records of these meetings available. The absence of formal supervision meant that staff did not have formal confidential support by the manager or an opportunity for the manager to formally identify positive practice or development needs or areas of improvement or concern to staff. Inspectors reviewed minutes of staff meetings, which discussed policy and procedures within the organisation. However, inspectors did not find any record of staff being made aware of the regulations and standards. Staff working in the centre on the day of inspection had some knowledge of the regulations and standards.

There was no formal training needs analysis completed in the centre and staff had not received mandatory training in all areas. The manager outlined that recently in the organisation, agency staff were offered the same training opportunities as staff employed by the organisation. There were significant training deficits within the centre, as not all staff members had received training on behavioural management, first aid, manual handling, safeguarding vulnerable adults and child protection. The centre manager had held staff meetings with staff to discuss safeguarding policies with staff members.

No volunteers were used within the centre.

**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:***

Eva Boyle  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Muiriosa Foundation
<b>Centre ID:</b>	OSV-0002760
<b>Date of Inspection:</b>	29 July 2014
<b>Date of response:</b>	17 September 2014

### 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 05: Social Care Needs

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Personal plans did not adequately outline the supports required to meet the resident's specific social, emotional and participation needs.

**Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident

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

no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

Actions Planned:

- A plan will be devised to review the existing personal plans of all the recipients of the respite service (36 adults and 12 minors). The reviews will be done on a phased basis prioritising individuals who avail of the service most frequently. The person in charge will ensure that the updated plans outline the supports required to maximise the resident's personal development in accordance with his or her wishes and will facilitate the maximum participation from the individual, family members and relevant others. Action to commence with effect from 5th September 2014 and to be completed by the 28th February 2015
- All future referrals to the centre will have a personal plan in place within 28 days of admission which adequately outlines the supports required to meet the resident's specific social, emotional and participation need. Maximum input from the individual family members and relevant others into the plan will also be supported. Action to be implemented with effect from: 5th September 2014.

**Proposed Timescale:** 28/02/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Resident's views were not always apparent in personal plans.

**Action Required:**

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Actions Planned:

- The person in charge will prepare A Participation and Engagement Plan for all current and future individuals with a view to ensuring their effective input into the planning process. Action to be implemented with effect from: 5th September 2014.
- The person in charge will ensure that updated plans outline the supports required to maximise the resident's personal development in accordance with his or her wishes and will facilitate the maximum participation from the individual, family members and relevant others.

Action to commence with effect from 5th September 2014 and to be completed by the 28th February 2015.

All future referrals to the centre will have a personal plan in place within 28 days of admission which adequately outlines the supports required to meet the resident's specific social, emotional and participation need. Maximum input from the individual family members and relevant others into the plan will also be supported. Action to be implemented with effect from: 5th September 2014.

**Proposed Timescale:** 28/02/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

No formal multi-disciplinary reviews were held of personal plans where residents and their representatives participated in reviewing the overall effectiveness of the personal plans.

**Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- At the formal review meetings the effectiveness of each plan, changes in circumstances and new developments will be taken into account and formally documented.

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all residents had a comprehensive assessment of need which outlined their social, emotional and participation needs.

**Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

- The person in charge will ensure that all residents have a current assessment of need based on a comprehensive assessment by an appropriate health care professional (which in most instances will be a social care worker or a registered nurse) as required by regulation 05 (1) (b).

**Proposed Timescale:** 28/02/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Two of the residents required a permanent placement, and were placed in a respite service.

**Action Required:**

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

- A written communication has been sent to local senior management of the funding body profiling the pros and cons of the options being considered by the funding body. Date action completed: 29th July 2014
- A written communication has been sent to the local senior management of the funding body informing them that this situation has been documented on the organisation's risk register and asking that this particular risk be escalated to the risk register of the funding body. Date action completed: 9th September 2014

**Actions taken in relation to minor:**

- An executive-level planning meeting between Muiríosa Foundation and the funding body managers regarding the future living arrangements of the minor in question took place. The focus on this meeting was on co-ordinating the various clinical inputs in the interests of securing the most comprehensive and broadly-based assessment plan and also in the context of agreeing a set of actions to establish in another designated centre an exclusive children's residential service. Date action completed: 16th September 2014
- A funding framework to underpin the co-ordinated actions necessary to secure an appropriate long-term placement for the minor was agreed at the executive-level planning meeting between Muiríosa and the funding body. Date action completed: 16th September 2014
- An individualised arrangement (i.e. family-based weekend respite) has been put in place for alternative weekends. The minor's family have been actively involved with the implementation of this new arrangement. Date action commenced: 13th September 2014

**Actions Planned:****Actions Planned in relation to minor:**

- A comprehensive assessment of the minor's immediate, short-term, and medium-term needs will be undertaken. A Muiríosa Foundation senior psychologist will liaise with the multidisciplinary team who have been involved with the minor in recent years. (This "School Age Team" is a funding body-led team which consists of a psychologist, occupational therapist, clinical nurse specialist, speech and language therapist, case manager and Muiríosa Foundation social worker.) Date action commenced: 16th September 2014
- A transitioning plan for the minor, informed by the above assessment, will be developed and implementation of same will commence. Date action to be commenced: 23rd October 2013.
- Due to the various components that have to be managed, (i.e.: individualised funding from the funding body and the transitioning of other individuals, to facilitate the minor's move to a child specific designated centre), the transition will be completed by the 15th December 2014.

**Actions Planned in relation to adult:**

- An individualised transitioning plan has been prepared and implemented in relation to

the adult who has been residing in the respite house with a view to moving to a more suitable alternative service. Date for completion: Proposed date of move is 31st October 2014.

**Proposed Timescale:** 15/12/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Personal plans were not available in an accessible format to residents and their representatives.

**Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

- Personal plans are currently being developed in an easy to read format, unique to each individual, using appropriate alternative and augmentative communication and objects of reference as relevant and in consultation with each individual's families and other relevant stakeholders. Action to be completed: 30th March 2015

**Proposed Timescale:** 30/03/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

It was not apparent that there was multi-disciplinary involvement in the review of personal plans.

**Action Required:**

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

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

- Members of the relevant multidisciplinary team will be formally invited to input into the review process in line with the organisation's policy "Involvement of multidisciplinary practitioners " August 2014

**Proposed Timescale:** 29/08/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Residents participation or involvement in the review of their personal plans was not always evident.

**Action Required:**

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Actions Planned:

- An individualised Participation and Engagement plan will be developed (along the lines as set out in the action plan linked to 5 (4) (b)) to ensure that the person or his/her representative is as fully involved in the review process as they are in the development of the plan.

**Proposed Timescale:** 28/02/2015

**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:**

The risk management policy did not outline the measures and actions in place to control the risks identified.

**Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

Actions Taken:

- Since the inspection the organisation has developed a document entitled "Risk management policy: Overarching framework" which specifies how all of the elements of the risk management policy fit together. The overarching framework details the role of the Safety Statement, Location Specific Safety Statement, Policy and guidance on the management of risk individual service user and the various risk registers (local, regional and organisational). Action completed: 29th August 2014
- A common Risk Assessment and Management Plan applies to assessing and managing all categories of risk. This risk assessment and management plan requires the specification of the agreed risk-control measures and their corresponding risk ratings.
- Using the new Risk Assessment and Management Plan a review has been undertaken of local and individual risks identified within the designated centre. Action Completed: 10th September 2014.
- Going forward all risks identified will have the appropriate control measures identified and the subsequent risk rating applied documented using the Risk Assessment and Management Plan.

**Proposed Timescale:** 10/09/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include the arrangements for the identification, recording and investigation of and learning from serious incidents or adverse events involving residents.

**Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

Actions Taken:

- All accidents and incidents are directly reviewed by the person in charge/local manager and included in the local risk register, where they become the focus of appropriate risk-control measures. They are subsequently overviewed by the both the person in charge and the area director when populating the regional risk register – accidents and incidents are mined for their learning potential at regional and organisational levels. (Further details on this process are detailed in the Risk Management Policy: Overarching framework August 2014).
- All serious incidents and adverse events are recorded in the local accident incident books, investigated as required and discussed at both a local level and at senior management team meetings so that learning from same are identified and required actions taken are documented.
- Following a serious incident/ adverse event the associated risk assessment is reviewed as per the Risk assessment and management plan (Appendix 1 of Risk Management Policy: overarching framework)
- Any learning emerging from the review by the Person-in-Charge / Local Manager will be profiled in the written reports of these reviews which will be sent to the area director (these reports will issue at six-month intervals).
- The area director will review Risk Assessment and Management Plans on an annual basis.
- Risk management will be a standing item on the agenda of all local team meetings and senior management team meetings. Date action completed: 3rd September 2014

**Proposed Timescale:** 03/09/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management policy did not include the identification of hazards throughout the centre.

**Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management

<p>policy includes hazard identification and assessment of risks throughout the designated centre.</p> <p><b>Please state the actions you have taken or are planning to take:</b>  Actions Planned:</p> <ul style="list-style-type: none"> <li>• Local hazards are identified via the location specific safety statement and are profiled and risk rated in the local risk register. (See page 11, 5.1 of Risk Management Policy: overarching framework.</li> </ul>
<p><b>Proposed Timescale:</b> 29/08/2014</p> <p><b>Theme:</b> Effective Services</p> <p><b>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</b>  The signage to fire exits was inadequate in the centre.</p> <p><b>Action Required:</b>  Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.</p> <p><b>Please state the actions you have taken or are planning to take:</b>  Action taken:</p> <ul style="list-style-type: none"> <li>• Fire Orders are displayed on the wall beside the front door.</li> <li>• The fire register which contains individual evacuation plans is located inside the front door.</li> <li>• Fire safety signage is ordered and will be fitted in the centre upon delivery. Action completed: 6th August 2014</li> </ul>
<p><b>Proposed Timescale:</b> 06/08/2014</p> <p><b>Theme:</b> Effective Services</p> <p><b>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</b>  Arrangements at night to evacuate all persons in the designated centre was not adequate.</p> <p><b>Action Required:</b>  Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.</p> <p><b>Please state the actions you have taken or are planning to take:</b>  Actions taken:</p> <ul style="list-style-type: none"> <li>• A satisfactory night time fire evacuation drill was completed on the 31st July 2014.</li> <li>• Weekly evacuation drills continue to be undertaken and the outcome of same documented.</li> </ul>
<p><b>Proposed Timescale:</b> 31/07/2014</p>



## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Behaviour support plans were not adequate to support staff in managing behaviour..

**Action Required:**

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

- All behaviour support plans will be reviewed and updated by the person in charge with input from the psychologist and behaviour therapist where necessary to ensure that they are adequate to support staff in managing behaviours of concern.
- All relevant staff will attend training on the organisation's behavioural management policy "Listening to and Responding to Individuals who Demonstrate Behaviours of Concern (April, 2014)"
- At local team meetings any concerns regarding how to respond to individuals with a particular behaviour of concern will be discussed as required. All team meetings are documented.

**Proposed Timescale:** 30/10/2014

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had received training in behaviour management.

**Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Actions Planned:

- All relevant staff will attend training on the organisations behavioural management policy "Listening to and Responding to Individuals who Demonstrate Behaviours of Concern (April, 2014)" Action to be completed: 30th September 2014
- The person in charge will undertake an analysis of the training requirements of staff in this area having particular regard to the type of interventions recommended in the various behaviour support plans. The person in charge in consultation with the psychologist and behaviour therapist will devise an appropriate training plan. Options for online training and mentor-mediated training will be explored alongside traditional classroom based approaches. All relevant staff will have received training in this area by the 31st December 2014

**Proposed Timescale:** 31/12/2014

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no comprehensive system in place around the identification and review of restrictive practices.

**Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

Actions Taken:

- The person in charge undertakes a monthly review of the restrictive practices in place in conjunction with the area director and psychologist.
- The review is conducted in line with the organisation's Policy guidance on reducing the need for Restrictive Procedures September 2014.

Action Planned:

- The person in charge will undertake a review of documentation including notification documentation submitted to the Health Information and Quality Authority to ensure that all restrictive procedures are documented appropriately.

**Proposed Timescale:** 19/09/2014

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had received formal training in child protection.

**Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

- All staff have attended training on the organisation's policy "Child Protection and Welfare July 2014" and Trust in Care January 2014
- Contact has been made with the relevant statutory body to arrange training for staff to attend training on children's first guidelines as soon as possible. Action taken: 25th July 2014
- While awaiting training dates from the statutory body, Muiríosa Foundation social worker delivered training on Children's First guidelines to all but one relevant staff Date completed: 30th July 2014
- The remaining staff member will attend training with the Muiríosa Foundation social worker on the children's first guidelines on the 9th September 2014.

**Proposed Timescale:** 09/09/2014

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Child Welfare concerns had not been reported directly by the centre manager to the relevant organisation.

**Action Required:**

Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

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

Action Taken:

- Prior to the visit the centre had reported child welfare concerns to the funding body who had subsequently reported the concerns to and sought support from the Child and Family agency. Date action completed: 28th August 2013

Actions planned:

- The person in charge/area director:
  - a. Will ensure that all staff are fully briefed on those concerns and issues which should be reported directly and without delay to the Child and Family Agency.
  - b. Will carry out a six monthly audit of practice in this area.

**Proposed Timescale:** 31/10/2014

**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 times of administration of medication recorded on administration sheets did not always match the prescription sheet. No photographs of residents were included on the prescription sheets.

**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:**

Action Taken:

- Photographs of individuals are attached to their prescription sheets to ensure that prescribed is administered to the resident for whom it is prescribed and to no other resident. Date completed: 30th July 2014.

- Revised medication policy "Medication Management policy and Guidelines" Issue 3 August 2014 has been issued to all designated centres. Date issued: 19th August 2014
- The person in charge has met with the relevant GP in order review the prescription records and to ensure that all relevant information is documented on prescription sheets. Date action completed: 15th August 2014
- The area director has met with local pharmacist in terms of ascertaining the support that the pharmacy can provide in terms of prescription sheets and the inclusion of all relevant information. Date action completed: 27th August 2014

**Action Planned:**

- The revised medication policy will be discussed at the next staff meeting. The importance of good practice in ordering, receipt, storage and administration of medication will be emphasised.

**Proposed Timescale:** 07/10/2014

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The statement of purpose did not contain all of the information set out in schedule 1 of the Regulations.

**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:**

- A review of the current statement of purpose and function document will be undertaken and an updated version will be prepared in line with the requirements using the document Guidance for Designated centres: Statement of Purpose and Function November 2013 as a guideline. Particular attention will be given to ensuring that it contains all of 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.

Date for completion: 30th September 2014

**Proposed Timescale:** 30/09/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not clear that all residents and their families had received statements of purpose. The statement of purpose was not available in an accessible format for residents.

**Action Required:**

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

- A review of the current statement of purpose and function document will be undertaken and an updated version will be prepared in line with the requirements using the document "Guidance for Designated centres: Statement of Purpose and Function" November 2013 as a guideline. Particular attention will be given to ensuring that it contains all of 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.

Date for completion: 30th September 2014

- Once the review and update of the statement of purpose and function document has been completed it will be sent to the next of kin of all individuals. Date for completion: 6th October 2014

- An accessible format of the updated statement of purpose function documents will be made available to all individuals. Date for completion: 28th November 2014

**Proposed Timescale:** 28/11/2014

**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 management team had not been effective in its management of respite services, as two residents were residing on a full time basis in a respite service.

**Action Required:**

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

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

Actions Taken:

- A written communication has been sent to local senior management of the funding body profiling the pros and cons of the options being considered by the funding body.

Date action completed: 29th July 2014

- A written communication has been sent to the local senior management of the funding body informing them that this situation has been documented on the organisation's risk register and asking that this particular risk be escalated to the risk register of the funding body. Date action completed: 9th September 2014

Actions taken in relation to minor:

- An executive-level planning meeting between Muiríosa Foundation and the funding body managers regarding the future living arrangements of the minor in question took place. The focus on this meeting was on co-ordinating the various clinical inputs in the interests of securing the most comprehensive and broadly-based assessment plan and also in the context of agreeing a set of actions to establish in another designated centre

an exclusive children's residential service. Date action completed: 16th September 2014

- A funding framework to underpin the co-ordinated actions necessary to secure an appropriate long-term placement for the minor was agreed at the executive-level planning meeting between Muiríosa and the funding body. Date action completed: 16th September 2014
- An individualised arrangement (i.e. family-based weekend respite) has been put in place for alternative weekends. The minor's family have been actively involved with the implementation of this new arrangement. Date action commenced: 13th September 2014

#### Actions Planned:

- Formalising with the funding body the agreed actions to be taken if and when it becomes apparent that an individual will not be returning home at the end of an agreed respite break. Action to be completed: 28th November 2014
- To agree with the funding body whether the respite service into the future should operate to support either minors or adults, not both. Action to be completed: 28th November 2014
- Formalising with the funding body circumstances under which an individual can be supported to avail of emergency respite. Action to be completed: 28th November 2014

#### Actions Planned in relation to minor:

- A comprehensive assessment of the minor's immediate, short-term, and medium-term needs will be undertaken. A Muiríosa Foundation senior psychologist will liaise with the multidisciplinary team who have been involved with the minor in recent years. (This "School Age Team" is a funding body-led team which consists of a psychologist, occupational therapist, clinical nurse specialist, speech and language therapist, case manager and Muiríosa Foundation social worker.) Date action commenced: 16th September 2014
- A transitioning plan for the minor, informed by the above assessment, will be developed and implementation of same will commence. Date action to be commenced: 23rd October 2013.
- Due to the various components that have to be managed, (i.e.: individualised funding from the funding body and the transitioning of other individuals, to facilitate the minor's move to a child specific designated centre), the transition will be completed by the 15th December 2014.

#### Actions Planned in relation to adult:

- An individualised transitioning plan has been prepared and implemented in relation to the adult who has been residing in the respite house with a view to moving to a more suitable alternative service. Date for completion: Proposed date of move is 31st October 2014.

**Proposed Timescale:** 15/12/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were no formal performance management systems in place in relation to staff performance.

**Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

Action taken:

- The organisation's performance management process has been reviewed and updated. The document "performance conversations template" which was issued on the 30th June 2014 is now used to guide and document performance conversations with staff members. Date action completed: 30th June 2014
- Using the updated performance management process the person in charge will conduct performance management conversations with the relevant staff. Date action to be completed: 30th September 2014
- Performance management conversations will take place on at least a six monthly basis with all staff members in line with the organisations performance management process.

**Proposed Timescale:** 30/09/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff were unaware of whether there was a protected disclosures policy in place in the organisation.

**Action Required:**

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

Actions taken:

- The organisation's document "Protected Disclosures of Information Policy" was issued on the 27th August 2014.

All staff within the centre have read the policy and documentation is in place within the centre to show that all staff have read and understand the Protected Disclosures of Information policy.

**Proposed Timescale:** 08/09/2014

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There were insufficient staff rostered to work at night, to evacuate the residents in the event of a fire, given the information documented in their individual evacuation plans.

**Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

Actions Taken:

- A successful night time fire evacuation drill was carried out on the 31st July 2014.
- Weekly evacuation drills continue to be undertaken and the outcome of same documented.

Actions Planned:

- Individual fire evacuation plans will be reviewed by the person in charge to ensure that they can be carried out safely by the number of staff on duty. Date action to be completed: 31st October 2014
- When future respite breaks are being offered the person in charge will take cognisance of the compatibility of the individuals support needs of individuals and the available staffing support levels.

**Proposed Timescale:** 31/10/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Not all staff had received mandatory training in behavioural support, child protection, manual handling and first aid.

**Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

Actions Taken:

- A review of manual handling training was undertaken, one individual staff member, who's manual handling training records were not available on the day of inspection, have now been made available in the centre. The review of staff training records found that all staff have up to date training in manual handling. Action completed: 29th July 2014
- The person in charge has conducted a briefing session with all staff on duty on the implementation of organisations Policy & Procedure for Adult Protection and Welfare, Children's Welfare and Protection and Trust in Care Policy. Date action completed: 30th July 2014
- Muiríosa Foundation Social worker has delivered detailed training to relevant staff on the children's first guidelines while awaiting training dates from the statutory body. Date action completed: 30th July 2014

Action Planned:

- A review of staff first aid training records was undertaken. Staff who were found to



have out of date training were scheduled to attend training and will complete same by 31st October 2014. Date action to be completed: 31st October 2014.

- All relevant staff will attend training on the organisations behavioural management policy "Listening to and Responding to Individuals who Demonstrate Behaviours of Concern (April, 2014)" Action to be completed: 30th September 2014
- The person in charge will undertake an analysis of the training requirements of staff in this area in conjunction with the behaviour support plan review. The person in charge will ensure that arrangements are made to ensure all staff attend the training required. Action to be completed: 28th February 2015

**Proposed Timescale:** 28/02/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

No formal staff supervision was held within the centre.

**Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

Actions planned:

- Individual supervision meetings will take place monthly with each staff member. Supervision meetings and actions agreed at same will be documented. Date Action to be completed: 30th September 2014
- The organisation's performance management process has been reviewed and updated. The document "performance conversations template" which was issued on the 30th June 2014 is now used to guide and document performance conversations with staff members. Date action completed: 30th June 2014
- Using the updated performance management process the person in charge will conduct performance management conversations with the relevant staff. Date action to be completed: 30th September 2014
- Performance management conversations will take place on at least a six monthly basis with all staff members in line with the organisations performance management process.

**Proposed Timescale:** 30/09/2014