

**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 Cork Association For Autism
<b>Centre ID:</b>	ORG-0011052
<b>Centre county:</b>	Cork
<b>Email address:</b>	dos@corkautism.ie
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Cork Association For Autism
<b>Provider Nominee:</b>	Ronan O'Murchu
<b>Person in charge:</b>	Ronan O'Murchu
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	Breeda Desmond;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	6
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

**Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 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 announced and took place over 1 day(s).

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

From: 13 May 2014 10:00 To: 13 May 2014 17:30

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce

**Summary of findings from this inspection**

The monitoring and compliance inspection of this centre was announced. As part of the inspection the inspectors met with residents, the person in charge who was also the provider, the centre co-ordinator, social care leaders and other staff members. Inspectors spoke with the provider/person in charge and discussed the management and clinical governance arrangements for supporting staff in their roles. Inspectors reviewed the policies and procedures in the centre and examined documentation which covered issues such as medication management, accidents and incidents, complaints and the emergency plan. The person in charge informed inspectors that he endeavoured to provide a person-centred service to effectively meet the needs of residents. On the day of inspection there were six residents in the centre and the person in charge told the inspectors that up to three residents used the residential service while there were 27 residents using the respite service, on a rotational basis.

The action plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. These areas include among others:  
- health and safety issues

- staff training
- person centred care planning
- policy development
- governance issues
- consultation with residents.

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 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

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

The centre's statement of purpose stated that each resident was actively engaged in developing and implementing their individual person centred plans. However, the inspectors did not find evidence to support this in either the residential house or the respite house. The inspectors were informed by staff that the residents were not included in meetings with the psychologist or meetings to review their progress. The personal plans contained input from members of the multidisciplinary team (MDT) but this MDT input was done on an individual team member basis.

There were two residents living in the residential house on the day of inspection. A third resident joined them every Wednesday. The inspectors viewed the care plans of the residents in this house and found that they contained detailed personal plans and relevant important information on the daily routine of the person. There were notes of monthly review meetings at which the team discussed goals and progress as well as any challenges which may have arisen. The personal plans contained implementation dates and the responsible person was named on them. Review dates were identified and the minutes of previous case conferences were retained in the file. Not all documentation was dated however and some care plans needed to be reviewed to reflect the changing needs of the residents. A staff member who spoke with the inspector said that residents were not included in these meetings or given the option to be included.

There were no risk management plans in place for those with complex psychological needs. One resident, who had displayed behaviour that challenges, had a plan in place which advised that all staff would have appropriate training in crisis prevention. This

training was not implemented for all staff. Medical information retained in the file, for use in the event of transfer to a medical facility, was last updated in 2012. The inspector noted that one resident had access to an advocate, the other person did not have any details on file of this service being offered. This was confirmed by the staff member on duty. There were detailed written and pictorial 'social stories' available for both of these residents and copies of some of these were to be seen on the walls of their bedrooms. It was unclear from the documentation if these social stories were discussed with the residents. As one resident was non verbal there was a system in place to train staff in PECS (Picture Exchange Communication System). The inspector was informed that some staff were trained in the basic level of this system. The toileting routine for one resident was displayed on a notice board in the kitchen. This was removed when the inspector pointed out that it was a privacy and dignity matter. The issues which caused increased anxiety were outlined for one resident and a plan was in place to alleviate this. There were pictures of the dentist and other medical personnel available in the plan to enable orientation and reduce anxiety levels. Staff had identified hospital/medical visits as a source of great distress for this resident.

In the respite house there were four residents on the day of inspection. Each respite resident had a file, but it lacked a person centred plan with set goals and identified implementation dates, with a named responsible person. The application pack for the respite residents was informative and person centred. The important daily routines, for example, personal hygiene and clothing, mealtimes, manual handling, social interests and activities were accompanied by a plan but these were not signed or dated. There was no date on the documentation as to when it was last reviewed. It was unclear if residents were consulted with, or participated in, the development of these personal care plans. There was detailed narrative information about the resident but this was written from the perspective of the psychologist and not the resident. There was no documentation to indicate that a resident had declined to engage in the care planning process or of any attempts made to engage them in the process.

One care plan had review dates for a follow up meeting which had been held in 2010. There was no indication in the file that this meeting had taken place in April 2011 as planned. There was a separate filing cabinet which contained a daily report book of interactions and activities for each individual in the centre as well as a narrative account of their daily routine.

Inspectors were informed by residents and staff that there were a number of options available for all residents in relation to activities and work. Inspectors noted that residents were involved in the day to day running of the homes including the cooking and shopping where appropriate. Inspectors saw and spoke to one resident who explained his interest in the garden and that he enjoyed working alongside staff members when he was on respite.

Residents to whom inspectors spoke detailed a number of off-site activities which they enjoyed, including shopping and going out to a local restaurant. On the day of inspection residents visited a local pub after the morning activities. Residents informed inspectors that they had a good choice of activities from which they could choose each day. Residents stated that they enjoyed attending the day care centre. One resident outlined for inspectors how she always has access to her favourite food as well as

enjoying the beauty therapy sessions during the day. Some residents also outlined how they enjoyed relaxing at the end of the day, sometimes baking or watching television and listening to music. There was a good supply of board games, CDs, books and DVDs on offer.

The residents attended a day care facility within the centre. Staff from the residential and respite houses were present in the day care centre also.

### **Outcome 06: Safe and suitable premises**

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

#### **Theme:**

Effective Services

#### **Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

#### **Findings:**

The centre was located in a country setting with scenic views of the surrounding countryside and consisted of two detached houses on the same grounds. There was a day care centre located within the complex which the residents attended during the day. The services of the day care were shared with other residents from outside the centre. The gardens were very well maintained and the inspectors saw that on the day of inspection the gardener was working with one of the residents who was watering the plants. Inspectors spoke with the resident who was very proud of the contribution he made to maintaining the garden.

Both of the houses were modern, bright, well ventilated and in good repair overall. The furniture was comfortable and there were sufficient fixtures and fittings which contributed to the homely atmosphere. There were large couches and armchairs in the sitting rooms as well as cabinets and cupboards in which the residents' DVDs, books and games were stored. Each sitting room had a television and a music centre.

The residents had separate bedrooms with en suite facilities. The residential house was a bungalow and in that house the bedrooms were individualised with evidence that the residents had been consulted in the décor. The furniture in these rooms consisted of a double bed, a wardrobe, a chest of drawers and a locker. There were pictures and posters on the walls with a bedside lamp on the locker. All en suite facilities consisted of toilet, shower and wash-hand basin. Residents spoken with by the inspectors were happy with the accommodation and there was evidence of residents' personal possessions and photographs throughout the centre.

The house used by the respite residents was a two-storey building. On the day of inspection four residents were staying overnight and the inspectors saw that throughout the morning the bedrooms were being cleaned and the bed linen changed. Residents in this house had a supply of linen in the hot press and there were notices reminding staff of the preferences of each resident as regards their bedding.

In addition to en suite facilities, each house had a bathroom with a shower, toilet and wash-hand basin for use by residents and a staff bathroom. There were laundry facilities which were adequate to meet the needs of the residents and each house had a kitchen that was suitably equipped with good cooking facilities and sufficient equipment. Each house also contained overnight accommodation for staff.

There was adequate communal space, separate from the residents' bedrooms, in which they could spend some time in private or meet with visitors. Inspectors were satisfied that the design and layout of the centre were compatible with the aims and objectives of the Statement of Purpose and the design and layout promoted the dignity, independence and wellbeing of the residents.

There were some issues to be addressed in the premises, however. A section of the wall in the utility room needed to be repaired and the wallpaper needed to be replaced in one sitting room. Windows upstairs in the respite house were not secured. An unlocked cupboard upstairs had hanging wires which needed to be tied-up, out of reach. There were glass panelled doors in the sitting rooms in the respite house, these had not been risk assessed. The worktop in the kitchen needed to have the sealant replaced under the window.

### **Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

The centre had a health and safety statement but it was not updated since August 2007. It did not identify, assess or outline the controls required for risks in the centre.

Some procedures were in place for the prevention and control of infection. Alcohol hand gels and disposable gloves were available. Some staff had training in correct hand washing technique. Housekeeping duties were carried out by the staff. However, inspection control procedures required review in order to comply with the centre's



policy on the prevention of infection as:

- mops were used communally and not changed between rooms and bathrooms.
- a mop without any bucket was stored in the hallway outside the utility room.
- cleaning cloths were used communally.
- hand washing instructions were not displayed prominently.

The centre did not have a risk management policy or a risk register capturing potential risks (environmental, operational and clinical) associated with the centre. There were no measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents. There were no arrangements in place for investigating and learning from serious incidents/adverse events involving residents. The staff informed the inspectors that incidents were discussed at staff meetings and management meetings. The inspectors viewed minutes of these meetings which confirmed that these discussions had taken place.

An emergency plan was in place but it lacked detail and required updating. While a fire evacuation plan was in place, a safe placement for residents in the event of an evacuation was not identified. Regular fire drill training was documented and there were personal evacuation plans for some residents. Records reviewed by the inspectors indicated that the fire alarm was serviced on a quarterly basis, fire safety equipment was serviced on an annual basis, and fire drills took place periodically. The fire assembly point was identified and there was appropriate emergency lighting in place. The inspectors saw that the fire equipment had labels to indicate the dates of the most recent maintenance. There was evidence that arrangements were in place for reviewing fire precautions which included the alarm panel, the fire exits, and the testing of fire equipment. The fire safety certificate was displayed on the wall. The fire officer had highlighted the need for fire doors to be fitted and this process has commenced.

Inspectors noted that fire exits were unobstructed. Staff spoken with by the inspectors were aware of what to do in the event of a fire and were aware of the location of the fire exits and break glass panels. The procedure to be followed in the event of a fire was prominently displayed around the buildings.

In the residential house the risk of absconsion had not been assessed. The staff on duty in this house were required to go outside to do nightly checks because of the narrow hallways in the house. This practice had not been risk assessed. The upstairs windows of the residential house had no restrictors fitted and this had not been identified as a risk. The house had large television sets which were not secured in place and items such as the 'free to air' box and the DVD players were also unsecured. Staff with whom the inspector spoke confirmed that residents would attempt to pick these up if they were in a state of high anxiety.

**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

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

The person in charge and the centre coordinator informed inspectors that they were actively involved in the management of the centre. They said they were confident of the safety of residents through speaking with residents and their family members and observing the interactions between residents, and between staff and residents. Residents, spoken with by the inspectors, said that they liked the staff and the inspectors observed interactions between staff and residents which demonstrated a respectful and caring attitude. They said they felt safe in the centre and this was attributed to the fact that they were so familiar with the staff. The inspectors saw evidence that the staff and residents were very comfortable in each other's company and the staff were on the alert to protect the residents from unexpected events, which might increase their anxiety. When the residents were speaking with the inspectors the staff member sat in the vicinity of the resident to provide support. The residents were seen to ask the staff member for confirmation, when they were discussing their daily routine and their likes and dislikes, with the inspectors.

There was a policy on the management of allegations of abuse, however it was out of date and not centre specific. There was no named person identified as the person responsible for investigating allegations and the responsibility to report any allegation to the Authority was not identified. Training records indicated that none of the staff had received training on the prevention and detection of abuse.

There was a policy on the prevention of/use of restrictive interventions which outlined measures to promote a restraint free environment. The policy listed alternative measures to the use of restraint, however it did not provide adequate guidance on the alternative measures listed. It was not centre specific and was no evidence of review of the policy. The policy did not offer sufficient guidance for staff on the consultation with residents if there is a requirement to utilise medication to relieve anxiety or other psychological need.

Some of the staff had not received training in positive behaviour support or in how to

manage behaviour that challenges. However, the provider/person in charge outlined his plans to deliver this training to all staff. He showed the inspectors a list of the staff members who will be undertaking training in the near future. He informed the inspectors that the policy will be brought up to date in line with the planned training.

There were measures in place for the management of residents' finances and there were records available of transactions made by and on behalf of residents. Not all transactions contained the signature of the resident and the staff member or alternatively of two staff members if a resident was unable to sign. There were some financial transactions which had not been verified with the resident involved. The policy in relation to residents' finances was in need of review, to guide staff in best practice.

### **Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

**Judgement:**

Compliant

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

No actions were required from the previous inspection.

**Findings:**

A record of all incidents which occurred in the centre was maintained. Where required, these incidents were notified to the Authority. The provider/person in charge was aware of his obligations in this regard.

### **Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

Residents had access to a general practitioner (GP) services and appropriate treatment

and therapies, such as, dentist, psychologist, dietician and speech and language therapist. There was evidence that residents in the residential house had availed of allied health care services and specialist consultants. Residents had been assessed by the speech and language therapist and the dietician. Documentation with regard to information from these reviews was detailed and informative. Regular multidisciplinary input from individual team members was evident. However, as outlined previously, the residents were not included in these reviews.

Inspectors noted that residents in both houses had access to refreshments and snacks with a selection of drinks and fresh fruit. Inspectors observed that there were adequate stores of both fresh and frozen food in both houses. Inspectors were shown the picture information charts which were used to assist some residents in making meal choices. There was a four weekly menu rotation on display. Residents, spoken with by the inspectors, indicated that there was a variety of choices available to them and that their individual likes and dislikes were taken into account. Staff told the inspectors that the residents would accompany them on shopping trips and be involved in writing up the shopping list when possible.

There were a number of centre-specific policies in relation to the care and welfare of residents but these policies were not centre specific and were out of date. Inspectors reviewed a selection of residents' files in the respite house and noted the absence of personal plans which meant that the health information for each resident was not up to date or subject to regular review.

Inspectors observed that the care delivered encouraged and enabled residents to make healthy living choices in relation to exercise, weight control and dietary considerations. Staff informed inspectors that the level of support which individual residents required, varied. However, this information was not formally documented. By reviewing the daily diary, in the respite house, inspectors saw that the residents were supported in aspects of their daily lives. This included, eating and drinking, personal cleansing and dressing, toileting, daily interactions in the day care centre and their social life in the house. This information, however, was not included in an individualised personal plan for each person in the respite house.

Generally residents' health and social care needs were met. Individual risk assessments were not in place however, with the result that not all residents' care was supported by documentary evidence. Risk assessments and controls were not in place to guide staff in, for example; the use of restraint; managing behaviour that challenges; the risk of choking; falls; food and nutrition; oral care; continence; communication, absconsion and the administration of medications for residents with complex needs and challenges. Staff however, were knowledgeable about residents' health and social care needs and were observed attending to residents in a caring and gentle manner. They gave detailed information to the inspector on each resident and how their medical and social needs were met. It was evident to the inspectors from talking to staff and residents that each person had ample opportunity to participate in activities which included reading, walking, watching television and DVDs, cooking, art, regular outings, music and shopping.

The privacy, dignity and confidentiality of the residents were safeguarded as information

and documentation, relating to residents, were stored in a locked office.

## **Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

### **Theme:**

Health and Development

### **Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

### **Findings:**

All residents' medication administration records reviewed had photographic identification in place. There was training for staff in medication management and the inspectors spoke to staff who demonstrated an understanding of medication management. Recent training had taken place in the administration of a specific type of medication.

Staff were aware of the system for reporting medication errors and the inspectors saw medication error forms which had been used by staff. However, there was no system in place to minimise risk by reviewing and monitoring safe medication management practices. Residents had not been assessed for the ability to self-administer their medications or any risk associated with this practice had not been identified.

Residents' medication was stored in a locked cupboard in a locked room in both houses. However, on the day of inspection the inspectors noted that in the residential house the key to the medication cabinet was left in the medication cupboard door, thereby leaving the medication cabinet unsecured. The medications were packed in single dose units and the prescriptions were sent to the pharmacist on a monthly basis. There were regular reviews of the prescriptions depending on the needs of the residents.

There was a system in place to store and return unused and out of date medications to the pharmacy and the staff member, with whom the inspector spoke, outlined the process in place. The maximum dose in 24 hours for PRN (when necessary) medication was not stated for some medications which were prescribed. This would support safe medication practice. Residents on PRN medication had supporting documentation on file for the administration of these medications but there was no information entered in the column headed "effect" of the medication, which would have indicated to staff if the resident had benefitted from the administration of the medication or not. This documentation was discussed with the staff with improvements suggested for clear recording

The medication management policy was effective since 2007 and there was no indication that a review had taken place. The policy was not centre specific. It did not

outline procedures necessary for the storage and use of controlled drugs.

#### **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

#### **Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

#### **Findings:**

There was a governance structure in place. However, as the person in charge ( who was also the provider) was newly appointed he had yet to notify the Authority of the identity of a PPIM (person participating in management). He informed the inspectors that he would be applying to the Authority to formalise this.

The provider and the centre coordinator told the inspectors that processes were being developed to ensure that Regulatory requirements were fulfilled, as regards monitoring the safety and quality of care in the centre. The provider/person in charge told the inspector that audit tools were being sourced for this and that a member of the management team would be nominated to carry out the review as required.

Regular management meetings were held between the provider/person in charge and the centre coordinator. Staff were facilitated to discuss issues of safety and quality of care at weekly team meetings which the provider/person in charge also attended. Inspectors saw minutes of these meetings and staff spoke to the inspectors about the sharing of information and the learning which these meetings supported.

The provider/person in charge was suitably qualified, experienced and demonstrated good leadership and organisational skills. He was involved in the operational management of two centres. The post of the person in charge was full time. Staff and residents were able to identify him as the person in charge and staff told inspectors that he was an approachable and supportive manager. Inspectors spent some time in conversation with him and he outlined his plans to update the policies, initiate a training programme and evaluate the quality and safety of care in the centre. Based on interactions with the person in charge during the inspection, the inspectors were of the opinion that he had adequate knowledge of the Health Act 2007 (Care and Support of Residents in 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 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Minor

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

No actions were required from the previous inspection.

**Findings:**

There were no formal arrangements in place for the management of the designated centre in the absence of the person in charge. As the person in charge was newly appointed he had not attended to this requirement at the time of inspection. However, he told the inspectors that he had planned to notify the Authority of the appointment of a PPIM (person participating in management) as required under Regulation 33.

**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

**Judgement:**

Non Compliant - Moderate

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

No actions were required from the previous inspection.

**Findings:**

A sample of staff files reviewed by the inspectors did not comply with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013 . Not all the documents required were available in the sample of files seen. Inspectors viewed

the policies on staff recruitment and saw that staff had fulfilled the required vetting procedures.

Records reviewed indicated that staff had attended training on fire prevention, manual handling, medication training and hand washing procedures. Some of the core staff had training in crisis management. However, not all staff spoken with by the inspectors had the above training relevant to their role and had not been trained in the mandatory areas of:

- how to manage behaviours that challenge and positive behaviour support:
- the prevention of abuse:

Inspectors saw a list of planned training events to include the above.

The person in charge and the centre coordinator demonstrated a willingness and strong commitment to the delivery of high quality, safe, person-centred care and to work towards meeting regulatory requirements.

Rosters were arranged to meet the needs of the residents. Inspectors found that staff had very good knowledge of their roles and of the needs of the residents. Staff were able to demonstrate an awareness of the centre's policies and had access to a copy of the Regulations and National Standards. The staff were found to be well qualified, enthusiastic about their role and committed to the ethos of the centre. The residents were familiar with the staff in the centre which indicated to the inspectors that there was continuity of care for the residents.

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

### ***Report Compiled by:***

Mary O'Mahony  
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 Cork Association For Autism
<b>Centre ID:</b>	ORG-0011052
<b>Date of Inspection:</b>	13 May 2014
<b>Date of response:</b>	25 June 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 and the National Standards for Residential Services for Children and Adults with Disabilities.

### 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:**

All residents in the centre did not have a personal plan in place which contained an assessment of the resident's needs.

**Action Required:**

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

1. Develop template for Personal Plans for residential service users by end of July 2014
2. Pilot and review the Personal Plans by the end of August 2014

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

3. Have all Personal Plans for residential service users in place by the end of October 2014
4. Review these Personal Plans annually

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

**Theme:** Effective Services

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

Not all personal plans were reviewed on an annual basis or more frequently when there were changing needs and circumstances.

**Action Required:**

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

1 When developing Personal Care plans a review process will be put in place with a review date to ensure that these are reviewed at least annually.

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

**Theme:** Effective Services

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

There was no documentation to indicate that residents or their representatives were involved in drawing up the personal plan.

Staff indicated to the inspector that the residents were not present when the plans were drawn up.

**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:**

The participation of residential service users in their Personal Care planning and review of this will be documented and included in the Personal Care plan.

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

**Theme:** Effective Services

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

There was no evidence to indicate that personal plans were reviewed following a change in the circumstances or assessed needs.

**Action Required:**

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

Personal Care plans will be reviewed on an annual basis and when required. Changes made will be documented in the Personal Care plan (both the review date and the changes)

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

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

A section of the wall in the utility room needed to be plastered and repainted. The worktop in the kitchen required sealant to be applied where the worktop joined the wall, to maintain a hygienic environment.

**Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

All necessary repairs are being attended to as outlined.

**Proposed Timescale:** 01/09/2014

**Theme:** Effective Services

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

In one sitting room the wall paper was peeling from the walls and internal painting needed to be renewed.

**Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

Redecorating is underway at present.

**Proposed Timescale:** 01/09/2014

### **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 centre did not have a risk assessment policy in place in line with the requirements set out in Regulation 26 sections (1), (2), and (3). Risks, identified by the inspectors had not been risk assessed and there was no system in place to continuously identify, assess and minimise all risks in the centre.

The Health and Safety Statement was not updated and it did not include a robust system for the management of Health and Safety for staff, residents and visitors to the centre.

**Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

1. Risk Assessment Policy and Procedure to be developed by the end of August 2014
2. Risk Assessment Policy and Procedure to be approved and education sessions provided to staff by the end of September 2014
3. Implementation of the Risk assessment policy and procedure will commence on 1 October 2014

**Proposed Timescale:** 01/10/2014

**Theme:** Effective Services

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

Infection control in the centre was not in line with best practice as outlined in the standards for infection control published by the Authority.

The infection control policy for the centre was in need of review;

-mops were not stored properly.

-cleaning cloths were not segregated.

-hand washing technique signs were not prominently displayed

**Action Required:**

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with

the standards for the prevention and control of healthcare associated infections published by the Authority.

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

1. Health and Safety Policies & Procedures, and Health and Safety Statement to be updated, this to be completed by end of August 2014
2. Health and Safety Policies & Procedures to be presented to staff by the end of September 2014
3. Health and Safety Policies and Procedures to be in practice by 1 October 2014
4. Handwashing signage to be prominently displayed by end of July 2014
5. Specific cupboards/areas to be in place for cleaning products and equipment by end of July 2014
6. Updated Infection Control Policy and Procedure completed and approved by the end of September 2014
7. Updated Infection Control Policy and Procedure to be in place by the end of October 2014

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

**Theme:** Effective Services

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

The emergency policy for the centre did not outline a safe location for residents to be accommodated in the event of the evacuation of the centre.

The emergency plan was not detailed and comprehensive.

**Action Required:**

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.

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

Updated evacuation plans to be included in the Health and Safety Policy and Procedures and in place by the end of August 2014

**Proposed Timescale:** 31/08/2014

**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:**

All staff had not received training in the management of behaviours that challenge to include de-escalation and intervention techniques as required under Regulation 7 (2)

**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:**

1. All staff at the designated centre to be trained in Management of Actual and Potential Aggression

**Proposed Timescale:** 31/08/2014

**Theme:** Safe Services

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

There was a policy in place but it was not up to date and did not offer sufficient guidelines to staff in the management of residents' finances. The procedure for reporting any allegation of abuse to the Authority was not documented.

**Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

Updated policy regarding the management of residential service users finances to be completed by the end of August 2014 and education provided to staff.  
Policy regarding the management of residential service users finances in place by end of September 2014

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

**Theme:** Safe Services

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

Training records revealed that staff did not have any training in safeguarding residents and in the detection, prevention and response to abuse.

**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:**

1. Source Train the Trainer course in Intellectual Disability and Abuse by the end of July 2014
2. One staff to be trained by the end of September 2014 (if training sourced)
3. All staff in the designated centre to be trained by the end of December 2014

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

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

There was no evidence that the residents' right to refuse treatment had been ascertained or that it would be taken into account in ascertaining their care needs.

**Action Required:**

Under Regulation 06 (2) (c) you are required to: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

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

A section of the Personal Care plan will include documentation regarding the right to refuse treatment. This will be completed when required.

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

**Theme:** Health and Development

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

There were no personal plans available for the respite residents. This would enable staff to have access to a documented protocol for information on providing for the health and social care needs of each resident.

**Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

1. Personal Care plan template for respite service users will be developed by end of July 2014.
2. Pilot of Personal Care Plan for respite service users will be completed by end of August 2014
3. Personal Care Plans for respite service users will be in place by end of December 2014
4. Personal Care Plans will include a section for a regular review of the respite service users' medical status and an update of their emergency care plan

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

**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 policy did not offer guidance on the storage and disposal of used or out of date controlled drugs in accordance with the relevant provisions in the Misuse of Drugs Act 1988 (S.I. No. 328) as amended.

**Action Required:**

Under Regulation 29 (4) (d) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

1. Medication Policy to be updated by the end of August 2014.
2. Staff to be educated on updated Medication Policy by the end of September 2014
3. Updated Medication Policy in place by the start of October 2014
4. Medication refrigerator to be in place by end of August 2014

**Proposed Timescale:** 01/10/2014

**Theme:** Health and Development

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

The option for residents to self-administer medication had not been risk assessed or their capacity to self-administer medications had not been documented.

**Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

Updated Medication Policy will include information regarding self administration. Risk assessment of all service users regarding self administration of medication to occur once the risk assessment policy and procedure is in place

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



## 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 centre did not have a defined management structure in place and the reporting structure in the centre lacked clarity.

**Action Required:**

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

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

1. New management structure has been developed and will be approved by end of August 2014.
2. Staff to be informed and educated regarding new structure and roles by the end of September 2014.
3. New management structure in place by 1 October 2014

**Proposed Timescale:** 01/10/2014

**Theme:** Leadership, Governance and Management

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

Staff did not have the mandatory training as required by the Regulations and a system of performance appraisal was not in place to highlight areas for staff development. This was necessary in order to enable the staff to exercise their personal and professional responsibility for the quality of care they are providing.

**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:**

1. Performance Development Reviews for all staff are currently in place and occur every six months.
2. A new Performance Development or Appraisal system is currently being devised and will be completed by end of November.
3. New Performance Development or Appraisal system will be in place by January 2015.

**Proposed Timescale:** 01/01/2015

### **Outcome 15: Absence of the person in charge**

**Theme:** Leadership, Governance and Management

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

The Authority had not been notified of the arrangements that had been put in place for the management of the centre in the absence of the person in charge.

**Action Required:**

Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

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

1. Chief Inspector to be advised in writing of procedures and arrangement regarding management of designated centre during the absence of the person in charge.

**Proposed Timescale:** 01/07/2014

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Not all documents required under Schedule 2 of the Regulations were contained in the personnel files viewed by the inspectors.

**Action Required:**

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

All staff files will be updated by the end of August and systems put in place for new employees

**Proposed Timescale:** 31/08/2014

**Theme:** Responsive Workforce

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

All staff did not have access to appropriate training to include refresher training as part of a continuous professional development programme.

**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:**

1. Training Calendar to be developed for the next 12 months and then rolling out by the end of September 2014
2. Train the trainers for some training to be sourced and external trainers to be sourced for other training by the end of September 2014
3. Training for all staff in the designated centre to be up to date by the end of December 2014

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