

**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 Gheel Autism Services
<b>Centre ID:</b>	OSV-0005301
<b>Centre county:</b>	Dublin 3
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Gheel Autism Services
<b>Provider Nominee:</b>	Peter Byrne
<b>Lead inspector:</b>	Anna Doyle
<b>Support inspector(s):</b>	Conan O'Hara
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	20
<b>Number of vacancies on the date of inspection:</b>	2

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

**Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
12 January 2016 10:00	12 January 2016 19:30
13 January 2016 09:30	13 January 2016 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was the first inspection of this centre. The inspection was announced and formed part of the assessment of the application for registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs and fire safety procedures.

As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (the Authority). All documents submitted by the provider for the purpose of application to register were found to be satisfactory with the exception of the A2 form which

needed to be amended to reflect the actual number of residents residing in the centre.

The centre is operated by Gheel Autism services and comprises of two community residential homes located in North Dublin. The centre primarily supports nine residents with Autism and supports both male and female residents. One resident is in the process of transitioning to another centre belonging to the service. This person was not present on the day of the inspection.

Six residents' questionnaires were received by the Authority. These had been completed by staff in consultation with residents. Two family members were spoken to over the course of the inspection and six family questionnaires were received from family members by the Authority. The opinions expressed through the residents questionnaires found that residents were broadly satisfied with the services and facilities provided. Residents stated that they felt safe and liked living in the centre. Some residents did not wish to meet with the inspector in a formal way and this was respected. However, the inspector did meet with four residents over the course of the inspection.

Family members spoken to expressed their complete satisfaction with the centre and stated that they knew who to raise a concern with if they needed to. Family members also confirmed that they attended a family forum each year organised by the centre.

The person in charge was present throughout the inspection as was the location manager who is also a person participating in management for the centre. The provider nominee, along with a service manager for this centre attended both the opening meeting and the feedback session.

Overall the inspector found that residents healthcare and social care needs were met. The centre was homely, clean and well maintained. It was accessible to the local community and transport links. However significant improvements were required in health and safety, medication management and the records maintained in the centre. In addition improvements were required in the contracts of care, residents' finances, and the record of complaints and the notification of incidents to the Authority.

The action plan at the end of this report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

**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 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Inspectors found that residents' rights and dignity were maintained and there were opportunities for residents to contribute to how the centre was run. However improvements were required in relation to the management of residents' finances.

There was a policy in place for residents' finances, personal property, personal finances and possessions. However residents did not have direct access to their own finances in that all residents' monies were located in the head office of the organisation. Inspectors acknowledged however that the provider was addressing this matter. Three residents' financial records were reviewed by inspectors who were satisfied that there were systems in place to safeguard residents' monies, however not all balance checks were countersigned by two staff in line with the centre's own policy. In addition the centre's policy stated that a financial agreement is in place for all residents. However this was not available on inspection but inspectors were shown a draft financial passport that was intended to be used for all residents. This was in an accessible format for residents.

Residents were consulted on the day to day running of the centre. Weekly residents meetings were held and residents who did not wish to participate had one to one meetings with staff if they wished. The residents' questionnaire distributed by the Authority prior to inspection had been amended by the provider into a user friendly format for residents. Five residents had completed this with support from staff. All residents stated that they knew who to make a complaint to, were aware of who the person in charge was and stated that they felt safe in their home.

The centre had policies and procedures for the management of complaints. The procedures were publicly displayed and written in an accessible format. Relatives who

completed the Authority's questionnaire stated that they would know who to complain to if they had a concern. Three residents' family members were spoken to on the days of the inspection. They expressed their satisfaction with the centre and stated that they felt they could raise concerns with any member of staff. Some residents stated that they would like to do more activities and would like to have the opportunity to manage their own medication.

There were three complaints logged in the centre on the day of inspection that had been followed up on satisfactorily. One resident spoken to talked about a complaint that they had recently raised and stated how this had been addressed and how they were satisfied with the outcome. There were two complaints officers who were staff members in the centre and who all residents were familiar with. All complaints were logged on a computer generated form that was escalated to the next level if it could not be resolved at local level. Residents had access to an advocacy service if required and on the day of inspection, one resident had a meeting with an external advocate.

Inspectors observed residents being treated by staff in a respectful and dignified manner and residents were encouraged to maintain their own privacy and choices over the course of the inspection. For example all residents were consulted with before speaking to inspectors or whether they were happy for inspectors to view their bedrooms. Inspectors were given information on the specific communication needs of residents prior to meeting with them so as to ensure their dignity. All residents had detailed intimate care plans, however some terminology used in the plan was not age appropriate so as to maintain a resident's dignity. This was discussed with the provider nominee at the feedback meeting.

The centre was managed in a way that maximised resident's capacity to exercise choice in their daily lives. Individual residents were seen to engage in their own specific interests outside of the centre.

**Judgment:**  
Substantially Compliant

## **Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**  
Individualised Supports and Care

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

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

### **Findings:**

Overall, inspectors found that residents' communication needs were being met and that the centre was part of the local community.

Staff were very knowledgeable about the communication needs of residents and there was a comprehensive user friendly personal plan for residents that was individual to their needs. Inspectors observed staff communicating with some residents using Irish sign language that had been adapted to the residents' needs. In addition inspectors were shown a video developed by staff on the communication needs of one resident. This was to guide any potential new staff to support this resident.

Inspectors found good evidence of information that had been developed into a user friendly format for residents including the centres complaints form, the resident's questionnaire distributed from the Authority, residents meetings, staff rosters, weekly schedules and pictorial menus.

Residents had access to the internet and all residents in the centre had access to iPads. Inspectors were informed of upcoming training for staff on a computer application that would enhance communication for residents using an iPad. Residents had access to televisions, radios and one resident used an iPhone through which to communicate with staff.

Inspectors saw evidence that residents were part of the local community. For example one resident was observed returning to the centre with their shopping and another resident was going to a local coffee shop in the evening. Residents spoke about places they liked to visit in the community and inspectors saw photographs of residents participating in a range of activities in the community.

**Judgment:**

Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Overall inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community.

The questionnaires completed by residents and family members showed evidence that families were actively involved in the residents lives. Residents had regular visits home and family members attended residents' annual review meetings. Relatives spoken to felt that they could visit the centre anytime and told inspectors that they were always

informed of their family member's wellbeing.

There were no restrictions on visitors to the centre unless requested by residents. Five residents had their own apartment in the centre and all other residents had their own bedrooms. There was adequate communal space for residents to receive visitors.

Residents were supported to maintain links with their wider community based on their individual choices. One resident volunteered at a local charity shop.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**

Effective Services

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

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

**Findings:**

Overall inspectors found that there were procedures in place for the admission and discharge of residents to the centre and each resident had a written agreement contained in their personal plan. However improvements were required in this area.

There was an admission policy in place that was reflected in the statement of purpose. One resident had recently been admitted to the centre and inspectors viewed the transition plan for this resident. The original transition had begun early last year, however the resident had to transfer quicker than anticipated due to health concerns. The inspectors were satisfied that this had been done in line with the regulations and the provider had recently supported the resident to access an external advocate to ensure the resident was happy with the process.

Agreed written contracts set out the fees to be charged to residents. However it did not fully outline the services included in the fee and the additional fees to be charged were not outlined in the contract. This had been an action from another designated centre belonging to Gheel Services and inspectors saw that progress had been made in this area. The centre had drafted an addendum to the contract outlining the services included in the fees and any additional fees that residents may incur. The provider was in the process of informing residents and their representatives. Contracts were signed by representatives of the centre, the resident, where possible, and their representatives.

**Judgment:**

Substantially Compliant

**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:**

Inspectors found that resident's wellbeing and welfare was being maintained, however improvements were required in the assessment of residents needs and the development and review of social care needs.

A sample of residents' personal plans were reviewed by inspectors and personal plans had been developed into an accessible format for residents.

An annual review meeting had taken place for residents and from this, goals for the forthcoming year had been identified some included; to go on holiday, to increase road safety awareness and to launder clothes independently. Family members attended these reviews and one resident had written up the details of their own annual review. However the goals had no action plans and it was not clear who was responsible for supporting the resident through the process. In addition there was no review to assess their effectiveness. One annual review that inspectors reviewed had no goals identified as it stated that the resident had 'medical ailments'. Inspectors recognise that this resident had increased health needs at the time and did see evidence of goals that had been identified since the annual review for this resident.

Residents social care needs were individualised to their choices and needs. Activity schedules were available in each resident's personal plan and residents had pictorial versions where appropriate. However one resident's activity plan included a drive or a rest from 10am - 1pm every day. Inspectors reviewed the daily records and found that the resident had only went for a drive on three occasions over a two week period. There was no documentation to support whether alternative activities had been offered to the resident each day. The person in charge informed inspectors that they were addressing this issue. Inspectors observed residents being involved in varied activities during the inspection that included; attending day services, shopping in the local community, going out for dinner, to local coffee shops and drives. In addition activity schedules that

included one to one activities for residents with staff once a week were in place.

One resident had transferred from another designated centre within the service to this centre in December of last year. Inspectors reviewed the transition process for this resident and were satisfied that the resident had been included in the process. The provider had also made provisions for familiar staff from the resident's previous residential placement to work with the resident until the transition was complete. A staff member spoken to stated that plans were in place for the resident to visit their previous residential placement to see friends. In addition the resident had met with an advocate on the first day of the inspection as a support in the transition process.

**Judgment:**

Substantially Compliant

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

Overall inspectors found that the location, design and the layout of the centre was suitable to meet the needs of the residents.

The design and layout of the centre was in line with the statement of purpose for the centre. The centre was clean and suitably decorated, however the floor tiles in bathroom and shower areas in three of the areas in the centre needed to be replaced. The inspectors saw evidence of one area where tiles had already been replaced and the person in charge informed inspectors that a plan was in place to replace other flooring.

Five of the residents had their own apartments that were modern, spacious and suitable to the residents needs.

All other residents had their own bedrooms that were spacious, suitably furnished and had adequate storage space for personal belongings. Bedrooms were personalised in line residents' wishes. There were adequate toilets, bathrooms and showers to meet the needs of the residents. The kitchens had enough cooking facilities and the dining areas were spacious. There was adequate communal space in all areas of the centre for residents to spend time or meet visitors.

The garden areas were well maintained and a small vegetable patch was evident in one

area along with large poly-tunnels in another area which one resident assisted with maintaining.

Residents had access to assistive technologies to promote residents independence. For example one resident had an epilepsy monitor blanket. Maintenance records were in place for equipment maintained in the centre.

**Judgment:**

Substantially Compliant

**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:**

Overall, inspectors found that there were systems in place to protect the health and safety of residents in the centre. However some areas of improvement were required in relation to fire safety and the risk management.

The centre had a health and safety statement in place that outlined the responsibilities of various staff within the organisation and referenced a wide range of policies and procedures to guide staff in their work practices. Staff carried out monthly health and safety checks as part of their responsibilities in this statement.

There were adequate fire safety precautions in place. A fire evacuation plan was displayed in a prominent area of each unit of the centre and an easy read version of the plan was also present in the units. However the fire procedures were not detailed enough to guide staff and did not outline their roles and responsibilities in the event of an evacuation. In addition the alarm system to alert staff in the event of a fire was not adequate in one area of the centre. This was discussed with the person in charge on the first day of the inspection, who promptly contacted the alarm company to rectify this issue.

Suitable fire fighting equipment was provided throughout the centre and there was evidence that they had been serviced appropriately. However inspectors were not able to determine if fire doors and self closers had been serviced or checked. This was addressed by the person in charge by including a check of fire doors in the health and safety checklist and by contacting the external service company to organise a date for these to be serviced. Fire escapes and exits were marked clearly and were not obstructed. A visitor's book was also maintained in the hall of each unit to show who was in the building in the event of an emergency.

Inspectors reviewed a sample of the personal emergency egress plans (PEEPs) for residents and found them to be concise and informative. The PEEPs included information on mobility, awareness and supports needed. However the level of detail was inconsistent across the PEEPs sampled.

The centre held monthly fire drills and reports showed that the fire drills occurred at different times. The drill records recorded the time taken to evacuate and issues identified. However, it did not record the names of staff and residents involved in the fire drill and did not consistently record the details of the fire drill if there were 'no issues identified'. There was evidence that issues identified by the fire drills were managed and residents' PEEPs were updated to reflect this.

There were procedures in place for the prevention and control of infection. A colour coded cleaning system was in place for mops, chopping boards and towels and equipment was stored appropriately. There were adequate hand-washing facilities and sanitising hand gels were available in key areas throughout the centre. Pictorial signage was also on display to promote good hand hygiene practices. Personal protective equipment was available throughout the units for staff. There were arrangements in place to dispose of clinical waste generated in the centre. Daily, weekly and monthly cleaning schedules were in place.

The centre had an organisational risk management policy in place however it did not adequately detail the measures and actions in place to control violence and aggression and it did not describe the arrangements in place for the investigation of, and learning from, serious incidents or adverse events involving residents.

The centre maintained three risk registers including a corporate, centre specific and service and care register. Individual risk management plans were in place for all residents, however one residents risk management plan for staying alone in their apartment did not include all potential environmental risks. All incidents were recorded on a computer generated form and collated on a monthly basis and reviewed by the person in charge. The person in charge discussed incidents with the location managers; however it was not clear if feedback on the incidents was given to all staff.

Inspectors found that the vehicles used by staff was appropriately taxed, insured and had a national car testing certificate.

**Judgment:**

Non Compliant - Moderate

**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:**

Overall inspectors found that there were measures in place to keep residents safe and protect them from abuse.

All staff spoken to were knowledgeable about what constitutes abuse and what to do in the event of an allegation of abuse. There were two designated persons in the centre and all staff knew who they were. However the policy on safeguarding in the centre was not in line with the Health Service Executive (HSE) policy and would therefore not guide practice. In addition while all staff had received training in this area, the training did not reflect the new policy from the HSE.

There was a policy in place for the provision of behavioural support. This had been updated as part of an action from another inspection carried out in another designated centre belonging to this service. Inspectors reviewed this policy and found that more information was required on when behaviour support plans should be reviewed in order to guide staff practice. A psychologist was available in the centre by referral. The inspector reviewed a sample of behaviour support plans. They had been developed with the support of a psychologist and were detailed enough to guide practice. However some behaviour support plans did not have commencement dates included. This is actioned under Outcome 18. All staff had received up to date training in positive behaviour support.

There were two restrictive practices in the centre that had been notified to the Authority as required. Inspectors viewed restrictive practice assessments for one resident, however parts of the assessments were not completed in full. This is actioned under Outcome 18. In addition while the restrictive practice procedures did impact on other residents in the centre, inspectors were satisfied that the provider was taking steps to address this issue.

Residents had intimate care plans in place and staff were observed to treat residents with dignity and respect throughout the inspection.

**Judgment:**

Substantially Compliant

**Outcome 09: Notification of Incidents**

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

<p><b>Theme:</b> Safe Services</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.</p> <p><b>Findings:</b> A record of all incidents occurring in the designated centre was maintained, and where required notified to the Chief Inspector. Quarterly and six monthly returns had also been submitted to the Authority.</p> <p>One follow up report to a notification was outstanding but the centre manager resubmitted this report on the day of inspection.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 10. General Welfare and Development</b> <i>Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.</i></p>
<p><b>Theme:</b> Health and Development</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.</p> <p><b>Findings:</b> Overall inspectors found that residents were supported to access new experiences and opportunities while respecting residents' needs and wishes.</p> <p>Residents were engaged in social activities and inspectors saw evidence of teaching new skills to promote independence. For example increasing road safety awareness, meal preparation and laundering clothes. One resident volunteered in a local charity shop. Another resident showed inspectors a certificate they had achieved for their participation in a project. While there was limited evidence of formal educational opportunities for residents outside of the centre, inspectors acknowledge that this is based on the residents' complex needs and individual choices.</p>
<p><b>Judgment:</b> Compliant</p>

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Overall inspectors found that residents' healthcare needs were being met. However improvements were required in healthcare assessments and health action plans to guide staff practice.

Inspectors saw evidence that residents' healthcare needs were being addressed and residents had access to appropriate allied healthcare professionals and treatments as required. However the healthcare assessments for residents did not include all health care needs.

Inspectors were shown new healthcare assessment forms that had been developed, however they did include all healthcare needs. For example mental health issues. In addition there were some health action plans in place on residents file to guide staff practice, however they were not comprehensive enough. Inspectors acknowledge that the provider was in the process of reviewing this and saw one health action plan that had been developed that was comprehensive and would guide staff practice.

Residents had access to health information in the centre. For example there was information on healthy eating displayed in the centre and one of the themes for residents meetings for January was healthy eating. In addition one resident who spoke with inspectors informed them of one health action.

All meals were prepared in each unit in the designated centre with the exception of lunch. This meal was prepared centrally from an onsite kitchen. However the person in charge informed inspectors that this practice was to cease from March 2016. Inspectors observed one meal in one unit and the food was observed to be nutritional and varied.

**Judgment:**

Substantially Compliant

**Outcome 12. Medication Management**

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

**Theme:**

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

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

**Findings:**

Overall inspectors found that there were policies and procedures for the safe administration of medication in the centre.

Medications were supplied by a retail pharmacy business in individual 'pouches' where appropriate and all medications were stored in a locked press. There were procedures in place relating to the ordering, prescribing, storing and administration of medication. The medications were checked by a nurse when they were delivered to the centre. A stock take of PRN (as required medication) was completed and when inspectors checked stock with staff the balance was correct. Unused or discontinued medication was stored separately and documents showed that these medications were returned to the pharmacy in a timely manner.

PRN medications prescribed had indications for use on the prescription sheet and there were clear PRN protocols to guide staff practice.

A sample of prescription sheets and medication administration sheets were viewed by inspectors and found to be in line with the policies and procedures of the service and best practice. A monthly medication audit was completed by the location manager or the person in charge and an annual audit was completed by a nurse. Any issues raised from these had been addressed.

All staff were trained in the safe administration of medication. None of the residents within the centre self administered medication, however there was evidence in each residents plan that an assessment had been carried out on the self administration of medication to explore this.

The pharmacy was available to meet with residents if they wished to discuss their medication. One resident spoken to, told inspectors about their medication and were aware what their medications were prescribed for.

**Judgment:**

Compliant

**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

<p><b>Outstanding requirement(s) from previous inspection(s):</b> This was the centre's first inspection by the Authority.</p> <p><b>Findings:</b> Overall inspectors found that a written statement of purpose was available that broadly reflected the services provided in the centre. On review it was found that the document contained all of the information required in Schedule 1 of the Regulations. A copy was made available for residents.</p>
<p><b>Judgment:</b> Compliant</p>

**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:**  
Overall inspectors found that effective management systems were in place to support and promote the delivery of a safe, quality care services.

There were clearly defined management structures in place that identified the lines of authority and accountability in the centre. The person in charge reported to the provider nominee who is also the director of services. The person in charge was also responsible for another part of the service however each centre had a location manager in place who supported the person in charge in their role. The person in charge was relatively new to the centre and was interviewed on the first day of the inspection. They were found to be suitably qualified and had the necessary skills to carry out their role. They had a very good knowledge of the residents needs in the centre and were very responsive to any issues that were raised over the course of the inspection.

The location managers met with the person in charge every two weeks and staff meetings were held every four to six weeks in each unit of the centre. Inspectors saw evidence of the person in charge's attendance at these. Informal debriefing sessions were also held after incidents of behaviours that challenge however there were no

evidence that learning from these incidents were discussed at staff meetings.

The provider had nominated a person to complete unannounced safety and quality audits in the centre. A sample were reviewed by inspectors and found that the actions identified had been addressed or were in the process of being addressed. A quality and safety officer, who had been newly appointed to the service, also produced monthly quality and safety reports on incidents and complaints in the centre.

An annual review had taken place in the centre and the report was available for inspectors. However it was not evident that family members' views had been included in this review. Inspectors acknowledge however that family forums are held yearly within the centre and that feedback is sought at this forum for representatives' views. Families spoken to also confirmed this.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Inspectors were satisfied that the person in charge had not been absent from the designated centre for more than 28 days. There were satisfactory arrangements in place to cover any absences of the person in charge.

The provider was aware of the requirements to notify the Authority in the event of the person in charge being absent.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

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

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

**Findings:**

Overall inspectors found that the centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Inspectors found that sufficient staff were available to meet the assessed needs of the residents. However one unit within the centre had a number of residents with significant health needs. One resident had just transitioned from another centre. As part of this transition additional staffing had been employed to assist with this for a period of time.

**Judgment:**

Compliant

**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:**

Overall inspectors felt that there was a skilled mix of staff to meet the residents' needs, however it was difficult to assess whether there was adequate staff to meet the social care needs of residents in one unit within the designated centre.

Staff were observed to have a very good knowledge of the residents and their needs and responded to residents in a timely, respectful and dignified manner. Only regular relief staff who knew the residents were employed within the designated centre in order to ensure consistency for residents.

Staff spoken felt that the units were adequately resourced to meet the needs of the residents. In one of the units additional staff were in place to assist a resident with their transition to the centre, however given the needs of the residents in the centre, inspectors were not assured that once this staff left that the social care needs of the residents could be adequately met. This was discussed with the person in charge, who advised inspectors that they intended to review the staffing levels in this unit.

One of the planned and actual rosters did not reflect the actual hours worked by staff however this was addressed by the person in charge, on the first day of the inspection.

Staff spoken to felt very supported in their role. Regular staff meetings were held however there were no formal supervision meetings for staff in place and the provider was currently in the process of developing a staff appraisal system for the centre. There was access to nursing staff as required and staff had access to a 24hr on call service should they require additional supports.

Inspectors did not review personnel files at this inspection, this is to be arranged at a future date to be organised by the Authority.

All staff had completed training in behaviour support, manual handling, medication management and safeguarding, however the safeguarding training provided did not reflect the HSE policy. Since the inspection all staff have received an update on the HSE policy. In addition staff had not received training in epilepsy management despite it being an assessed need for some residents.

**Judgment:**

Substantially Compliant

**Outcome 18: Records and documentation**

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**

Use of Information

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

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

**Findings:**

Residents' records were safely stored in the centre and were readily available to inspectors. Overall the policies and procedures outlined in Schedule 5 of the regulations were in place; however the policy on the management of behaviours that challenge would not guide practice and the safeguarding policy had not been updated to reflect the HSE policy. This has already been actioned under Outcome 8.

All of the policies required to be maintained under Regulation 4 and listed in Schedule 5

were available. The records listed in Part 6 of the Health Act 2007 ( Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained and easily retrievable.

Gaps were evident in some of the personal plans and in residents' daily records. For example PRN protocols had no signatures, behaviour support plans had no commencement dates and parts of restrictive practice assessments were not completed in full. In addition while a directory of residents was maintained it did not include the name and address of the body which arranged the resident's admission to the centre.

An up to date insurance policy was in place for the centre which included cover for resident's personal property and accident and injury to residents in compliance with all the requirements.

The information required under Regulation 21 and listed in Schedule 4 were maintained in the centre. Staff files were not reviewed on the day of the inspection as they were stored at different location. A review of these files is scheduled take place by the Authority at a later date. There were no volunteers working in the centre.

A resident's guide was maintained which included all the required information and was displayed in an easy read version for residents

**Judgment:**

Substantially Compliant

## 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:***

Anna Doyle  
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 Gheel Autism Services
<b>Centre ID:</b>	OSV-0005301
<b>Date of Inspection:</b>	12 and 13 January 2016
<b>Date of response:</b>	12 February 2016

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

Resident's did not have direct access to their finances and the policy in place for residents finances was not always implemented.

**1. Action Required:**

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an

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

account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

The organisation is developing a new Service User Finance Policy which will be operational by 31/03/2016. From this the organisation will implement a new finance system as part of an ongoing education around money management which will support the residents to apply for their own ATM cards and manage their finances locally with the support from staff and the PIC.

The Financial Support Agreement will be reviewed in line with the new Service User Finance Policy and implemented along with the policy.

The new policy will reflect actual practice, i.e. in lone worker areas where countersigning financial records is not always possible, the location manager will sign off on all balance checks on a weekly basis.

**Proposed Timescale:** 31/03/2016

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

The contract of care did not breakdown what services are included in the fee and the additional fees a resident may incur.

**2. Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

New addendum to contract for support services has been created outlining all expenses incurred by the resident in the contract. PIC has distributed this addendum to all service user's families and representatives for review and signature. Addendum will be discussed with residents at service user forums or individually according to resident's preference.

PIC will discuss the addendum with families and representatives at bi annual regional Family and Friend's forum in April 2016.

**Proposed Timescale:** 30/04/2016

**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:**

The goals identified for residents at their annual review were not being reviewed to assess their effectiveness.

**3. 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:**

Goal design, delivery and review training to be delivered to all key workers supporting residents in the designated centre.

This training will begin on 08/03/2016 and is proposed to be completed on 23/03/2016. There will be additional 'Key Worker Meeting' structure introduced to the week where the resident and their key worker will have a regular meeting in relation to developing their PCP and goal setting. These meetings will be recorded as part of their PCPs. Service user forum meetings will have agenda item for their input into how they would like to be consulted in relation to designing and monitoring goals.

**Proposed Timescale:** 31/03/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The floor tiles in the bathroom and shower areas in three units of the centre needed to be replaced.

**4. 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:**

Broken floor tiles in the 3 bathroom areas will be replaced.

**Proposed Timescale:** 18/03/2016

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

**Theme:** Effective Services

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

One residents risk management plan did not have all environmental risks assessed in

their plan.

**5. 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:**

This will be addressed using an environmental risk assessment template as an additional measure. Guidance from Occupational Therapy will be sought in the creation of additional control measures if required.

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

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

The risk management policy did not adequately detail or cross reference the measures and actions in place to control violence and aggression.

**6. Action Required:**

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

The risk management policy has been changed in draft which includes the measures and actions to control violence and aggression and is in a process mapping phase.

**Proposed Timescale:** 29/02/2016

**Theme:** Effective Services

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

The fire evacuation plan did not provide guidance to staff on the breakdown of their roles and responsibilities during an evacuation.

**7. 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:**

Emergency Response plans for all locations and individual Personal Emergency Evacuation Plans will be amended accordingly to include the roles and responsibilities of staff during an evacuation.

**Proposed Timescale:** 19/02/2016

**Theme:** Effective Services

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

The risk management policy did not describe the arrangements in place for the investigation of, and learning from, serious incidents or adverse events involving residents.

**8. 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:**

The risk management policy has been changed in draft to include the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Proposed Timescale:** 29/02/2016

**Theme:** Effective Services

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

The names of staff and residents involved in the fire drill were not recorded in the report of the fire drill.

The fire drill report did not consistently record the details of the fire drill if there were 'no issues identified'

**9. Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Fire drill recording document has been amended to ensure that there is adequate space to record the names of the staff and residents involved in the fire drills.

Guidance document on 'Fire Drill Protocol' developed and distributed in all Fire Registers. The training on completing the report has also been added to the Report Writing Training sessions.

**Proposed Timescale:** 29/02/2016

**Theme:** Effective Services

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

The fire alarm in one unit was not adequate to alert staff in the event of a fire.

**10. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

Fire relay sounder to be installed in one of the houses onsite and also in the Day Centre to ensure that the alarm would alert staff in the event of a fire. The work has commenced on this installation, due to finish on the 29/02/2016.

**Proposed Timescale:** 29/02/2016

### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

The safeguarding policy within the centre was not reviewed to reflect the new HSE guidelines on safeguarding vulnerable adults.

**11. 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:**

This policy has now been updated in line with new HSE guidelines on safeguarding vulnerable adults.

**Proposed Timescale:** 12/02/2016

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

**Theme:** Health and Development

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

The healthcare assessments and health action plans were not comprehensive enough to guide staff practice.

**12. 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:**

Final draft of Health Action Plan (HAP) Template is being process mapped by clinical and services team (including input from Health Psychologist in Training). This will be supported by the clinical team to ensure any health concern arising will have an associated comprehensive HAP.

**Proposed Timescale:** 31/03/2016

**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 annual review did not reflect family members views or contributions to the running of the centre.

**13. Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

New questionnaire was process mapped at the February 2016 Services Team Meeting. This questionnaire for families to be distributed to at the upcoming April 2016 Family Forum by the Regional Manager and information gathered from this will be used in the annual review for 2016.

**Proposed Timescale:** 30/04/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There was no staff appraisal systems in place in the centre.

**14. 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:**

Performance Appraisal Policy and Procedure has been drafted and will be introduced following the appointment of Location Managers in all areas to ensure effective implementation of this system.

**Proposed Timescale:** 30/06/2016

**Theme:** Responsive Workforce

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

Staff did not have access to training in epilepsy management.

**15. 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:**

Epilepsy training to be provided to homes where a person with epilepsy resides as a standalone training session, completed by onsite nurse in Gheel. Epilepsy management training to be added to the Safe Administration of Medication training sessions.

**Proposed Timescale:** 31/03/2016

## **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Not all Schedule 05 policies were dated.

**16. Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:**

All Schedule 5 policies have now been dated.

**Proposed Timescale:** 12/02/2016

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

There were gaps in residents records stored in the centre.

**17. Action Required:**

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

PIC is currently in the process of reviewing all PCPs and daily records to identify gaps that need to be amended.

Agenda item on all February 2016 team meetings of the importance of maintaining accurate records pertaining to the residents.

Directory of Residents updated as requested.

**Proposed Timescale:** 29/02/2016