Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Maynooth
Name of provider:	Gheel Autism Services Company Limited by Guarantee
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	25 October 2018
Centre ID:	OSV-0003498
Fieldwork ID:	MON-0021792

About the designated centre

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

Maynooth Designated Centre specialises in providing residential and respite services in a personalised homely atmosphere for service users. Ballycurraghan house is owned and maintained by Gheel Autism Services and Railpark house is owned and maintained by the HSE. The remainder of the locations, Laragh House, Forest Gate House and Coolcarrigan House, are rented accommodation, maintained by the landlord and management company. The service user homes in Maynooth all have bathroom facilities, kitchen/dining room, living room areas, bedrooms, laundry facilities and access to Large Gardens. Each service user has their own bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
25 October 2018	09:50hrs to 19:30hrs	Andrew Mooney	Lead
25 October 2018	09:50hrs to 19:30hrs	Conan O'Hara	Lead

Views of people who use the service

In response to the needs of residents, the inspectors did not engage verbally with residents for any extended time. The inspectors judgments in relation to the views of the people who use the service, relied upon brief interactions with residents, documentation such as questionnaires, discussions with staff and a meeting with a family representative.

The residents that did speak to the inspector said they were happy in their home. Residents also appeared very comfortable in the company of staff. Residents had busy lives and were supported to attend local day services and meaningful activities within the community. Residents individual support needs were clearly identified and the support they received were modified to best support them.

Capacity and capability

Overall, the registered provider and person in charge were ensuring a very good quality and safe service for residents in the centre. Care and support was found to be person-centred and in line with individual choices, needs, and wishes.

A statement of purpose was in place and it included all information set out in in Schedule 1 of the regulations. A copy of the statement of purpose was available to residents and their representatives.

There were clearly defined management structures in place which identified the lines of authority and accountability within the centre. There was a suitably qualified and experienced person in charge, who demonstrated that they could lead a quality service and develop a motivated and committed team. Residents and staff could clearly identify how they would report any concerns about the quality of care and support in the centre. There were arrangements in place to monitor the quality of care and support in the centre including an annual review of the quality and safety in the centre and six monthly visits by the provider or their representative.

The provider maintained a directory of residents as required by the regulations. On review of this directory, inspectors were satisfied that it was up to date and contained all information set out in Schedule 3 of the regulations.

Staff had the required competencies to manage and deliver person-centred, effective and safe services to the residents within the centre. Staff were observed to treat residents with respect and warmth. Staff were supported and supervised to carry out their duties to protect and promote the care and welfare of the residents within the centre. Staff in the centre had access to training and refresher training in line with the statement of purpose. However, there were insufficient contingencies in place to cover staff annual leave and training. On review of a sample of rosters, inspectors noted that one unit within the designated centre used 4 relief

staff to cover 11 shifts in a ten day period. Furthermore, management meeting notes noted that "an unavailability of relief staff" was impacting on their ability to allocate sufficient time to meet with staff.

On review of incidents, inspectors were satisfied that all appropriate notifications of incidents were being notified as required by the regulations.

One residents representative outlined a number of concerns to inspectors on the day of inspection, including the centres approach to visitors. The provider was aware of these concern and was proactively working with this person to address their concerns. There was a suitable complaints procedure in place and the provider managed complaints in line with its own policy. Inspectors reviewed the complaints log within the centre and found that these were being managed in line with the regulations. Each person's complaints and concerns were listened to and acted upon in a timely, supportive and effective manner. There was a user friendly complaints procedure displayed in a prominent position. Residents and their representatives were made aware of the complaints procedure and all complaints were taken seriously. When residents or their representatives were dissatisfied they were encouraged to use the complaints procedure. If they choose not to use it, alternative processes were used to try and address these concerns.

Regulation 15: Staffing

The staffing whole time equivalent allowed for enough staff to meet the day to day needs of residents. However, there were insufficient contingencies in place to cover staff annual leave, sick leave and training. This led to an over reliance on the use of relief staff.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training available enabled staff to provide care that reflected up-to-date, evidence based practice.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was up to date with all the required information.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was clearly defined and identifies the lines of authority and accountability, specifies roles and details responsibilities for all areas of service provision.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was in place and included all information set out in the associated schedule.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the designated centre was maintained and notified as required.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a suitably complaints procedure in place and the provider managed complaints in line with its own policy.

Judgment: Compliant

Quality and safety

Residents were deemed to be safe but their safety was negatively affected as a result of inadequate fire containment in parts of the centre and parts of the

centre not being adequately maintained. Furthermore, not all risks were being suitably managed as they were not identified by the provider.

The centre had appropriate fire-fighting equipment, fire alarm, emergency lighting and fire safety checks in place. The centre carried out regular fire drills and followed up on any learning identified from these drills. However, during the inspection the inspectors were not assured that there was sufficient fire containment measures in place as not all fire doors were closing correctly. This was raised with the provider and immediate actions were taken to address these concerns. Furthermore, Inspectors were unclear if all fire doors were effective as there were gaps between the fire door and door frame that in the event of a fire could allow smoke to spread. Additionally, some fire doors had glass panels above them which the provider noted were not suitably fire resistant.

Risk was generally managed appropriately and there were policies and procedures in place to support this. The provider had initiated reasonable measures to prevent accidents. However, some hazards that required urgent attention were not identified. For example, some radiator temperatures with one house exceeding safe parameters, a radiator temperature was recorded as being 57 degrees.

The provider had a comprehensive visitors policy in place. However, this policy was not being implemented consistently and this led to some staff and some visitors being unclear as to the centres requirements regarding visiting the designated centre. Not all family members felt that they could visit the centre freely. Inspectors raised this concern with the provider and they outlined the steps they were taking to clarify this issue.

Parts of the premises were decorated in line with the wishes of residents and the living the environments were adapted to promote the independence of residents. However, not all areas of the designated centre were suitably maintained, as some bedrooms were in a poor state of repair due to the impact of residents' assessed support needs. While the person in charge was aware of this there was no clear plan in place to address these maintenance issues. Additionally, as identified during a previous inspection, there was an ongoing issue relating to subsidence in one building within the designated centre. There was a long term plan to move from this premises but to date no definitive timescale had been agreed.

There was a comprehensive assessment of the health, personal, social care and support needs of each resident in the centre. These assessments were used to inform associated plans of care for each of the residents. Residents' goals were planned and progressed through regular key worker meetings. However, while personal plans were reviewed annually, the reviews did not assess the effectiveness of the the plans. Inspectors were unable to establish if some elements of personal plans were effective, despite them being in place for numerous years. For example residents weight management plans were not assessed for effectiveness, despite residents body mass index indicating they were obese.

The centre was in the process of reconfiguring and this included the addition of some new houses to meet the assessed needs of residents. Inspectors reviewed a

sample of residents transition plans and were satisfied that planned supports were in place to support residents transferring between or moving to new services.

Residents experienced care that supported positive behaviour support and emotional wellbeing. This included the use of appropriate positive behaviour support plans and intensive coaching support for staff where required. Furthermore, residents were not subjected to any restrictive procedures unless there was clear evidence that it had been assessed as being required due to a risk to their safety and welfare.

In general the safeguarding of vulnerable residents was assured at all times, through the implementation of good organisational policies and procedures. All staff had received appropriate safeguarding training and all incidents were appropriately investigated. However, on one occasion the provider did not follow its own policy on safeguarding vulnerable adults. When the concern arose the provider did assure its self that there were no grounds for further concern but they did not complete a preliminary screening and report the findings of this screening to the national safeguarding office.

The practice relating to the ordering, receipt, prescribing, storing and administration of medicines was appropriate and staff had completed safe administration of medication training.

Regulation 11: Visits

The centre did not follow its own visitor policy and this led to some ambiguity as to when visitors could visit.

Judgment: Not compliant

Regulation 17: Premises

Not all parts of the designated centre were suitably decorated or in a good state of repair. Some bedrooms were in a poor state of repair due to the impact of some residents' assessed support needs.

Judgment: Not compliant

Regulation 26: Risk management procedures

The radiator temperatures in one house were recorded as in excess of 57 degrees. This is considerably above industry standard tap temperature (43 Degrees).

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced when required. There was adequate means of escape, which included emergency lighting. There was also a a procedure for the safe evacuation of residents.

However, during the the inspection inspectors observed fire doors that did not close correctly. Furthermore, Inspectors were unclear if all fire doors were effective as there were gaps between the fire door and door frame that in the event of a fire could allow smoke to spread. Additionally, some fire doors had glass panels above them which the provided noted were not suitably fire resistant.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The practice relating to the ordering, receipt, prescribing, storing, including medicinal refrigeration, disposal and administration of medicines was appropriate.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need in place and the outcome of the assessment was used to inform a plan of care, this was recorded as the residents personal plan. Personal plans were reviewed annually, however, the reviews did not assess the effectiveness of the the plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Appropriate supports were in place for residents with behaviours that challenge.

Judgment: Compliant

Regulation 8: Protection

On one occasion the provider did not follow its own policy on safeguarding vulnerable adults. The provider did not complete a preliminary screening and report the findings of this screening to the national safeguarding office.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

Planned supports were in place to support residents transfer between or move to new services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant

Compliance Plan for Maynooth OSV-0003498

Inspection ID: MON-0021792

Date of inspection: 25/10/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To address the services reliance on the use of relief staffing to cover annual leave, sick leave and training, the service will complete a review of the frequency relief staff are used to cover these occurrences over a 6-month period. Following this review the service will escalate this requirement for additional funding for contingency staffing required to enable the service to recruit for these posts to HSE. This meeting is scheduled to take place by 30/04/2019	
Regulation 11: Visits	Not Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: The Visitor's Policy was added to the team meeting to discuss with staff. A meeting was facilitated with the parent concerned to also discuss the Visitors Policy. A review of the visitor's policy is due to take place to add additional detail and guidance to the reader. This is due for completion by 11/01/2018	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A meeting is being scheduled with the lease holder to discuss the issues with the premises. A plan is to be put in place to relocate occupiers of this home while extensive works are completed on the building. Relocation of the residents of the home is expected to take place by the 30/04/2019 A monthly review of service user bedrooms and environment will commence by keyworkers in addressing any impact which service users assessed support needs have on their environment. Keyworkers will then escalate any required actions for maintenance issues to Location Managers to action.	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: An assessment of all radiator temperatures in the location will be completed for compliance to temperature guidance. Radiators will be adjusted to the required temperatures or fitted with covers where additional heating output is required. This will be complete by 04/01/2019.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A full assessment of fire doors was complete in this home by a suitably qualified professional. This assessment was escalated to the Lease holder to action. The lease holder has communicated an intention to rehome occupants to alternative accommodation while extensive works are completed on the property. This rehoming is expected by end of quarter 30/04/2019. Priority issues to remove glass fittings above doors are actioned for removal. Works are due completion by 04/01/2019.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Actions resulting from Annual Review Meetings will commence being added to the Team meeting agenda. These actions will be reviewed on a monthly basis at these meetings to ensure adequate review until actions are closed to completion. The service user's dietary needs will be tailored to the individual's dietary requirements following his upcoming planned move to an individualized living environment. This is planned for completion by the end of 28/02/2019. A referral has also been made to the clinical team for additional input into reviewing how the service users transition into Individualized living can be further tailored to meet his needs, in considering diet and lifestyle improvements.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: A Preliminary Screening Report was completed by the Safeguarding officer in the area and submitted to HSE Safeguarding Team. Complete.

Section 2: Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(1)	The registered provider shall facilitate each resident to receive visitors in accordance with the resident's wishes.	Not Compliant	Orange	21/12/2018
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	21/12/2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	21/12/2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	21/12/2018
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/11/2018
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually	Substantially Compliant	Yellow	21/12/2018

	or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	21/12/2018