Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Joseph's Unit
Name of provider:	Muiríosa Foundation
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	08 November 2023
Centre ID:	OSV-0002705
Fieldwork ID:	MON-0036102

About the designated centre

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

This designated centre is a single storey building set on a campus in Co. Kildare. It provides full-time residential care to two adults and is due to close in 2024. Each resident has their own bedroom, with double doors leading to a garden. The centre is staffed by nursing staff, social care workers and support workers. A bus is available to the service on a daily basis for appointments and social activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 8 November 2023	10:00hrs to 17:10hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place to monitor ongoing regulatory compliance. From what residents told us and from what the inspector observed, it was clear that residents were well supported and cared for in their home. Improvements were required in staff training and development, fire precautions and personal possessions. These are discussed in the body of the report.

The designated centre is a large old building set on a campus, which was once home to a large number of people but was now home to two residents who had complex health and social care needs related to ageing. Residents in the centre had lived in settings within the organisation for over fifty years. Since the last inspection, there had been a number of changes which had occured and impacted upon the residents' lives. A number of residents had moved out of the centre, including the respite service and the emergency convalescence bed. One resident had died in the months prior to the inspection. As a result of the reduction in numbers, there were a large number of unused rooms and spaces in the centre. However, the provider had made the areas which the current residents use as homely and welcoming as possible.The residents were reported to spent most of their day in a large dining and sitting room which had been decorated since the last inspection in order to make it a nicer environment. Residents bedrooms were spacious and nicely decorated. Residents' personal affects and photographs were on display, and they had ample storage space for their clothes and their belongings. There were a number of bathrooms which were accessible for residents available for use. Given the scale and age of the premises, only essential works were carried out as required in the centre. The provider had purchased a property nearby which was in the process of being renovated for these residents to move in 2024. Residents, staff and residents were aware of this upcoming move.

Since the last inspection, the central kitchen on the campus had closed and there was now a chef in the centre during the week. Staff also cooked in line with residents' preferences and dietary requirements. A number of new kitchen appliances had been purchased. The kitchen area had a large open serving hatch onto the dining room but the kitchen remained inaccessible to residents. The central laundry had also closed and this meant that residents clothes were laundered within their own home. Residents had requested that labelling of their clothes was discontinued and this had been actioned. Both of these changes within the centre had reduced the impact of institutionalised living on the residents.

Residents in the centre had a variety of communication support needs. One resident was verbal while the second resident largely communicated through words, vocalisations, facial expressions and body language. On arrival to the centre, the two residents were seated in the living and dining room area. One of them greeted the inspector and was sorting out beads, which they told the inspector they "loved" doing. They said they were happy with their home having less people in it. They

spoke about how they could now leave their belongings out and that 'no-one will touch them'. They no longer locked their bedroom door. They told the inspector that they liked to go out when there was transport available. Staff reported that the reduction in numbers had a positive effect on one of the residents. They now spent more time in the dining room area socialising and chatting to staff.

The second resident was seated in their wheelchair and dozing and vocalised in response to brief interactions with the inspector. They were well presented and appeared to be comfortable. The inspector had the opportunity to observe residents for the duration of the inspection due to the location of the nurses station where they reviewed paperwork. They noted that for one resident, there was little engagement evident outside of care routines. They spent the majority of the day listening to the television and was supported to go to their room during the afternoon. Staff were observed to be kind and respectful in their interactions and were responsive to residents' needs.

To gain further insight into residents' views, the inspector reviewed results of the residents' survey for 2023. Consultation had taken place with a staff member external to the unit to gain feedback from residents. This noted positive feedback from residents. Issues were raised in relation to the management of their laundry which is discussed above in addition to accessing finances. One resident had been noted to be distressed due to part of this consultation was some issues with a resident accessing their finances in a timely manner on one occasion which had caused distress. However, on the day of this inspection, the provider was in the process of working with local banks to enable residents to have their own bank accounts.

Residents meetings occured every week and included discussions on meal planning, safeguarding, rights and activities. Transition planning was due to commence in January 2024. Residents had been informed that the centre was due to close, and one of them pointed to the sky and said that they were "going up there" before moving out of the centre they had been resident in for over fifty years. Residents had been supported to discuss and document their end-of-life care wishes and for one resident, these were found to be extremely detailed and included their preferences around their funeral arrangements such as music, place of burial and choice of clothing. For those who had recently died, a memory book had been made for other residents. The provider had run a " Seasons for Growth" course which had involved discussions around end-of-life care preferences.

Family questionnaires had also been sent out as part of the annual review. These indicated that families were satisfied with the service that their family members received. One family stated "she is cared for at the highest level and staff are all immaculate, friendly and knowledgeable". Another family member stated that their family members' needs were "being met with great sensitivity and my family and I appreciate very much all that is being done for their welfare". Another stated that their relative was getting an "excellent service all around, they are well taken care of and in the best hands"

While the staff on duty on the day of the inspection had not completed training in a

human rights based approach to health and social care, the training matrix indicated that a large number of staff had completed this training. It was evident on staff meetings that rights formed part of the agenda and that rights were being discussed with the residents as part of their own meetings.

The inspector found that while there were preferred activities for residents documented, these had not taken place in the eight weeks prior to the inspection taking place. For example, one resident was documented as enjoying doing the lottery and enjoying people watching in a shopping centre nearby. However, the inspector did not find evidence that either of these activities had taken place in that period of time. Staff reported that residents engaging in activities outside of their home during the week was a challenge due to their care and support needs. On the day of the inspection, it was not evident that a resident was supported to engage in activities of their choice during the day.

In summary, while the centre presented some physical challenges, it was evident that residents were receiving safe and good quality care in the centre. Residents appeared to be well cared for and comfortable in their home. The next two sections of the report will present the inspection findings in relation to governance and management and how governance and management arrangements affected the quality and safety of the service being delivered.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to the residents' needs. However, improvements were provided in staff training and development.

There was a clear management structure in place, with the person in charge reporting to an area director, who in turn reported to a regional director. The provider had carried out six-monthly unannounced inspections and an annual review in line with regulatory requirements. Six-monthly unannounced visits were found to be detailed in nature and included clear quality improvements plans where required. An annual review had also been completed. There was an audit schedule in place to ensure that key service areas were monitored at defined intervals. Action plans were completed following these audits.

There had been a number of changes in the person in charge since the last inspection.The person in charge was based on the campus and split their time between two centres. The person in charge was suitably qualified and experienced in their role. The inspector did not have the opportunity to meet with the person in charge on the day of the inspection due to leave. The inspection was facilitated by the staff team and the area director. The person in charge had monthly supervision with their line manager and weekly check-ins also occured. Staff meetings took place on a monthly basis and there was a standing agenda for these meetings which included discussions on progress with the new property, staffing, residents, training,

assisted decision making and infection prevention and control. Night staff meetings also took place and covered the same topics. The person in charge and the clinical nurse manager tasked with management of the night staff team both attended monthly meetings with other members of management locally. These forums were used to give and exchange information related to a number of service areas

The provider had adequate numbers of staff to meet residents' assessed needs. There were two staff teams operating in the centre - one day team and one night team. . The person in charge was responsible for rostering, supervision and support of the day staff. Responsibility for night staff lay with a clinical nurse manager. In order to ensure that information was shared between teams, handovers took place. The clinical nurse manager attended staff meetings and worked some shifts by day. There was an increase in the number of staff on duty at the weekends to ensure that residents were afforded the opportunity to go out. However, during the week there were mostly two staff on duty. Staff reported that this made it difficult to get residents out due to the need for both residents to have two staff members present to support them with their personal care needs.

The inspector viewed staff training records for both teams. These indicated that day staff had completed mandatory training in areas such as fire safety, safeguarding, manual handling and food safety. Staff had completed additional training in feeding, eating, drinking and swallowing difficulties, infection prevention and control. For the night staff team, some gaps were identified in the areas of fire safety, food safety and feeding, eating , drinking and swallowing difficulties and infection prevention and control. Some staff had completed training in human rights. There was a schedule in place for supervision and all staff had received at least one supervision session this year.

The provider had notified the Office of the Chief Inspector of adverse events in the centre and submitted quarterly notifications in line with regulatory requirements.

Regulation 15: Staffing

The provider had an appropriate number of staff by day and night to provide for residents' care and support needs within the centre. However, during the week staff reported that residents were unable to get out of the centre with the exception of medical appointments due to residents' personal care needs and the ratio of staff this required.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Some gaps were evident on the training matrix. For example 28% of staff were due

refreshers in fire safety, 35% were due refresher training in infection prevention and control and one staff member was due to complete food safety. These gaps largely pertained to night staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were suitable governance and management arrangements in place in the centre to monitor and oversee the quality and safety of care which residents received. There was a clear management structure in place. Six-monthly unannounced provider visits and the annual review had taken place in line with regulatory requirements.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had given the chief inspector notice in writing of adverse incidents and submitted quarterly notifications where appropriate in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Residents' well being and welfare was maintained by a good standards of evidence-based care and support. However, improvements were required in the areas of fire safety and personal possessions.

Residents had complex healthcare needs and they were well supported to have best possible health. There were healthcare plans in place and regular monitoring of various aspects of their health such as weight, skin integrity and blood pressure. Records of appointments were kept which detailed any follow up actions required. Residents had access to a range of health and social care professionals including a GP, occupational therapist, psychiatry, speech and language therapy and medical consultants in different areas. It was evident that residents were supported to receive information about their healthcare and any procedures they were due to have. This was used to enable the resident to understand and to give consent to these interventions. Residents were supported to access National Screening

Programmes such as Breastcheck where they were eligible to do so. Hospital passports were in place for residents to ensure that key information relating to them was available to give to medical staff in the event of a hospital admission. End-of-life care discussions had taken place and the residents' wishes in relation to their funeral plans, their preferences about their burial and music and poems were all clearly documented.

Residents in the centre were protected from abuse through policies and procedures in relation to the delivery of personal care, management of personal possessions and on safeguarding vulnerable adults. Safeguarding was regularly discussed with both staff and residents to ensure sharing information and continual learning in relation to safeguarding. Residents had personal and intimate care plans in place which were detailed to guide staff practices in a manner which was respectful of their rights' to privacy , dignity and bodily integrity.

Residents in the centre now had control over their clothes, and laundry management. Residents' bedrooms had ample space for them to store their belongings. Photographic inventories of each residents' possessions were kept for each resident and these were audited as part of the provider visits to ensure that they remained up to date. Residents' finances were held in Private Property Account in line with the providers' guidance on protection of service users' personal possessions, property and finances. Access to his account was through an accounts office which was on the same campus as the centre. Following a recent inspection of another centre, the provider had changed the frequency which residents could access their money to weekly. The organisation was exploring avenues to give residents' more control over their finances. Each resident had a financial decision making ability assessment carried out. These assessments asked key questions on the residents' ability levels in relation to their finances. However, it was unclear how each of these abilities were assessed and if that assessment was in line with the Assisted Decision Making (Capacity) Act 2015.

As outlined at the beginning of the report, the building is a large old building which was now home to two residents. There were large sections of the building no longer in use to to a significant reduction in numbers since the last inspection. There was wear and tear evident in a number of areas in the centre. This included damaged flooring, some cracks in a wall and damage to parts of the ceiling. The heating system was working but in the event this broke , there was a contingency plan in place for residents. While it was evident that staff and the provider had made every effort to make the areas which residents used as homely as possible, the premises was no longer suited to enable residents to have full access to all areas of their home and to enable and promote community inclusion.

The provider had a risk management policy which met regulatory requirements. There were systems for the identification, management and review of risk within the centre, including a system for dealing with emergencies. There were gaps in documentation relating to risk assessments and the risk register. These required review to ensure that ratings were proportionate and reflective of the levels of risk in the centre. Adverse events were appropriately documented and reported.

Learning from adverse events was shared with the staff team.

The provider had fire safety management systems in place.The building was suitably equipped with fire fighting equipment, fire doors and bed evacuation was possible from both of the residents' bedrooms. Each resident had a personal emergency evacuation plan in place. The inspector viewed records from fire drills and these noted reasonable evacuation times. However, on the day of the inspection, fire containment measures had been compromised due to the use of two door wedges , one of which was the kitchen door leading into the dining area.

Regulation 17: Premises

As outlined in the opening section of the report, the premises was an old building which was no longer suited to meet residents' assessed needs. There was wear and tear noted in various parts of the centre such as flooring, roof tiles, cracks in the walls. However, due to the imminent closure of the centre, only essential maintenance works were being carried out at the time of the inspection.

Judgment: Not compliant

Regulation 26: Risk management procedures

While there was a risk management policy and appropriate practices in place, there were some gaps evident in documentation. The risk register and risk assessments for both residents and the centre required review to ensure that they were reflective of actual risks in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had fire fighting equipment, emergency lighting and detection systems throughout the centre. Fire drills demonstrated reasonable evacuation times and residents had personal emergency evacuation plans in place. However, fire containment was compromised in the centre by the use of two wedges on fire doors.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to have best possible health in the centre. They had access to a range of health and social care professionals in line with their assessed needs. They were supported to access health information to enable them to give informed consent to procedures. One of the residents had made a detailed end-of-life care plan with their preferences documented.

Judgment: Compliant

Regulation 8: Protection

Residents in the centre were protected from abuse through staff being trained, policies and procedures and ongoing sharing of knowledge and information. Residents were spoken to about feeling safe. Residents' personal care plans were detailed to guide staff practise and to ensure that care was delivered in a manner which respected the resident's dignity and bodily integrity.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for St Joseph's Unit OSV-0002705

Inspection ID: MON-0036102

Date of inspection: 08/11/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There are currently 1-1 staffing levels in this designated centre that allow for individual activities. The provider will look at ensuring that people are afforded the opportunity to experience new opportunities within existing resources, however there is also a formal process in place whereby the Regional Director has discretion to approve additional resources as required to ensure activities of choice can be facilitated.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training matrix is now in place and updated for both day and night staff. Out of date training has been sent to the training department and scheduled to be completed before March 2024. All training available on HSeLanD has been scheduled with a large number of courses completed since the inspection. Training will be an agenda item at each team meeting going forward.	
Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: A new premises has been purchased by the Muiriosa Foundation for the residents living in this centre. Building works have commenced and are expected to be completed by end of Feb 2024. An NF35 has been completed and submitted to HIQA on the 14th Dec 2023

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A meeting was held with the Person in Charge, the Occupational Therapist and staff team on the 14/11/2023 to review and update the risk assessments and the risk register. All risk assessments were reviewed and agreed at this meeting to ensure that they are reflective of actual risks in the centre. The risk register was updated to reflect all changes made.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Wedges on fire doors have been removed. All staff were informed that wedges are not to be used within the designated centre. To be discussed and reinforced again at next team meeting scheduled for January 2024.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	13/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/03/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/06/2024

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/06/2024
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.	Substantially Compliant	Yellow	14/11/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	08/11/2023