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

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| Name of designated centre: | Community Living Area 15 |
| Name of provider: | Muiríosa Foundation |
| Address of centre: | Kildare |
| Type of inspection: | Unannounced |
| Date of inspection: | 21 February 2025 |
| Centre ID: | OSV-0003753 |
| Fieldwork ID: | MON-0046458 |

## About the designated centre

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

This designated centre comprises two houses in Co. Kildare. The designated centre provides support for up to seven residents with an intellectual disability. One of the houses is a large bungalow in a rural setting. There are three bedrooms in the house, with two sitting rooms and a kitchen dining area. The other house is a large bungalow situated in a small cul-de-sac. There are four bedrooms with two en-suites. There is a bathroom, a kitchen dining room and two sitting rooms. There is a large garden to the rear and front of each house. The person in charge shares their working hours between both houses. Each house is resourced by a separate team of social care workers and support workers. One house in line with one resident's specific needs, as outlined in the centre's statement of purpose, although registered to accommodate four residents, was designated to house only this individual for the duration of their residency.

**The following information outlines some additional data on this centre.**

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| 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 |
|---|---|---|---|
| Friday 21 February 2025 | 11:30hrs to 16:00hrs | Erin Clarke | Lead |

## What residents told us and what inspectors observed

The purpose of this safeguarding inspection was to assess the safeguarding measures in place within the designated centre, ensuring compliance with regulations and national policy, and that residents' rights and wellbeing were promoted and protected. The inspection examined governance structures, staffing, risk management, training, compatibility factors, and the experiences of residents. Findings from this inspection found high levels of compliance in these areas, and improvements were made concerning residents' lived experiences since the last inspection.

The centre comprises two houses; one is registered for three residents and the other for four residents. On the day of the inspection, there was only one resident living at each location, with five vacancies. This safeguarding inspection primarily focused on one house due to the safeguarding and compatibility concerns found in the previous inspection of the centre in February 2023.

Following that inspection, the provider reviewed compatibility concerns and placements to ensure all residents were happy with who and where they lived. As a result, one resident moved to another location to live with residents they knew from the day service. One resident remained in the house, and due to their needs and preferences, the provider had resolved that no other residents would move into the four-bedroom house as long as the resident lived there. This was clearly laid out in the centre's statement of purpose, an important document for registered centres that outlines how a centre operates and is linked to the centre's registration.

The residents were supported in having input on the running of the centre and their preferences for the week ahead in choosing daily activities and social outings. For example, for one resident, knowing when staff were scheduled to be on duty was extremely important, as it provided them with a sense of stability and security. They also valued being informed about household checks but preferred that personal paperwork related to them not be completed openly. These expressed preferences were incorporated into the centre operations, with the person in charge holding a meeting with the resident every two weeks to discuss the rostering arrangements for the following fortnight.

Information was available at the centre in an easy-to-read format, including details of the complaints officer, the designated officer responsible for dealing with safeguarding concerns, and the contact details for the Office of the Confidential Recipient, a national free service that acts as an independent voice and advocate for vulnerable adults with disabilities.

Residents were actively involved in various community groups, including local day services, art classes, a tenancy group, and the library. One resident was supported in maintaining personal relationships with members of the community they grew up in by attending different community events and sending cards for significant

occasions throughout the year. One-to-one staffing is in place at both locations to meet residents' needs.

Residents have access to the positive behaviour support (PBS) team if required, with a senior clinical psychologist providing regular support. There is a clear process for managing behaviours of concern. The model of care has transitioned to a collaborative problem-solving (CPS) model to support emotional wellbeing, with markedly positive outcomes for residents.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

## Capacity and capability

The inspection identified that the provider has established mechanisms to monitor, review, and assess actual or potential safeguarding concerns and risks. These processes are formally evaluated through the provider's annual reviews and six-monthly audits, ensuring continuous oversight and improvement in safeguarding practices. An area identified for improvement is the implementation of regular staff re-vetting procedures to ensure ongoing adherence to provider policy.

The centre demonstrated compliance with staffing requirements by maintaining an appropriate number of staff members to meet the safeguarding needs of residents. Relief staff were in place to cover any absences, ensuring continuity of care. The provider revised and updated its policy on recruitment, selection, and Garda vetting in November 2024 to clarify the requirement for re-vetting during employment. The previous policy did not outline the process for re-vetting, but it has now been updated in line with best practice, requiring re-vetting every three to five years. Some gaps in completion of Garda re-vetting was found on inspection.

All staff members had completed mandatory safeguarding training, with scheduled updates every three years. Additional centre-specific safeguarding information sessions were provided, and a staff supervision schedule for 2025 was in place.

## Regulation 15: Staffing

The staffing levels in the centre were adequate, with a consistent one-to-one staffing ratio. The centre is staffed on a full-time basis, and a sleepover staff member is present at all times. Rosters reviewed on inspection demonstrated continuity of care, and that familiar staff members work within the centre to maintain consistency for residents.

To strengthen staff vetting procedures and formalise re-vetting processes, addressing a gap in the previous policy, which lacked a defined re-vetting process, the provider updated its Schedule 2 policy in November 2024. This revision aimed to ensure that all information required under Schedule 2 aligns with best practices. Notably, the updated policy now mandates re-vetting of staff every three to five years, addressing a gap in the previous policy, which lacked a defined re-vetting process.

A review of Garda vetting status received post-inspection found that while re-vetting email links had been sent, there were some gaps in lapsed vetting in line with the updated policy.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

Staff meetings were scheduled regularly to support the team in decision-making regarding safeguarding measures. New staff members received appropriate safeguarding training during induction, and an ongoing training schedule ensured that staff could effectively identify and respond to safeguarding concerns. A training matrix was maintained to track training needs, though a six-monthly provider audit identified that some safeguarding training had expired. This issue has since been addressed, and a new training system is due to be introduced in 2025 to enhance tracking and compliance.

?It had been reported that staff found the centre-specific safeguarding training they had received highly beneficial. This tailored safeguarding training aimed to enhance staff members' understanding of the unique challenges and risks within their specific environment, enabling them to identify and address potential issues more effectively. ?In addition, staff members who had completed de-escalation training were scheduled for follow-up meetings with a psychologist to reinforce their learning and discuss application in practice.

Regular supervision meetings ensured that safeguarding responsibilities were upheld and that staff had opportunities to discuss any challenges encountered. From a sample of six supervision records reviewed, discussions on safeguarding concerns and their impacts had taken place. Staff also had completed applying human-rights in social care training.

Judgment: Compliant

## Regulation 23: Governance and management

The management systems in place ensured that safeguarding practices were consistently monitored. The leadership team promoted a culture of openness and accountability, encouraging staff and residents to raise concerns without fear of negative repercussions. Safeguarding incidents were documented in accordance with regulatory requirements and reported to relevant authorities where necessary. The inspector was informed of a pending leadership transition, with a person in charge change scheduled for March 2025. The transition plan was well-structured, with appropriate handover procedures in place to ensure continuity of safeguarding oversight.

?The inspection identified that the provider has established mechanisms to monitor, review, and assess actual or potential safeguarding concerns and risks. These processes are formally evaluated through the provider's annual reviews and six-monthly audits, ensuring continuous oversight and improvement in safeguarding practices.

Judgment: Compliant

## Quality and safety

The inspection found that the centre demonstrated strong safeguarding structures, with clear policies, staff training, and resident engagement in place. Governance structures supported a culture of transparency and accountability. The transition to a new model of behavioural support was a positive development, contributing to a reduction in incidents related to behaviours of concerns.

Residents were kept informed about safeguarding processes, with staff and the person in charge actively encouraging open discussions. Residents reported feeling comfortable raising concerns and were aware of who to approach if they had any safeguarding issues. Staff maintained a proactive approach to ensuring that residents understood their rights and available support mechanisms.

## Regulation 10: Communication

Residents were well-informed about their rights and had access to advocacy services to support decision-making. Staff demonstrated a commitment to upholding residents' autonomy and ensuring that they were empowered to make informed choices about their care. Efforts were made to accommodate individual communication needs, ensuring that all residents could fully participate in discussions about their care and safeguarding concerns.

The provider's annual review completed in December 2024 documented that one resident, who has limited verbal communication, had their preferences documented

in their care plan, ensuring their choices are respected.

Judgment: Compliant

## Regulation 17: Premises

The premises visited were found to be well-maintained, and due to the non-occupancy of vacant bedrooms, it was deemed appropriate to meet the needs of the resident living there. The environment was homely and accessible, with the resident having input into any modifications or improvements required. Recent upgrades included a new patio and garden furniture, enhancing the outdoor space for the resident.

Judgment: Compliant

## Regulation 26: Risk management procedures

Risk management policies were in place to safeguard residents. A clinical psychologist conducted a review in August 2024 to assess safeguarding allegations and inform risk mitigation strategies. Appropriate risk assessments were in place to address identified concerns and enhance overall safeguarding measures.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Each resident's safeguarding needs were assessed as part of their care planning process. Residents were actively involved in decision-making regarding their care, ensuring their preferences and rights were upheld. Risk assessments were conducted, and safeguarding concerns were documented in individual care plans. The service demonstrated a commitment to person-centred care, with regular reviews to update care plans in response to residents' changing needs.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The adoption of the collaborative problem-solving (CPS) model for managing

behaviours of concern has led to a noticeable reduction in incidents. Staff reported that the new model enhanced their ability to proactively address residents' needs while promoting positive behavioural strategies. This was reflected in a decrease in incidents of behavioural concerns from 46 in 2023 to just two in 2024 and 2025 to date. The CPS approach is currently being piloted in additional locations within the organisation, with initial feedback indicating improved outcomes for residents.

One rights restriction was identified regarding a resident's financial access, which is under review at the national level to ensure the least restrictive approach is applied. One individual accesses their money from the Patient Private Property Funds (PPPA) on a weekly basis, with the option to access money outside of collection days. However, this arrangement is not optimum and has been recognised as a rights restriction by the organisation. It is currently under review by the senior leadership team and at a national level through an umbrella organisation for providers of disability services.

Judgment: Compliant

## Regulation 8: Protection

There are policies in place to protect individuals from abuse and neglect. These include trust in care, protection of vulnerable adults, and safeguarding personal belongings, including financial protection.

All staff members had completed mandatory safeguarding training, with scheduled updates every three years. Additional centre-specific safeguarding information sessions were provided to ensure staff had a better understanding of location-specific safeguarding risks and concerns.

Safeguarding incidents were documented in accordance with regulatory requirements and reported to relevant authorities where necessary. Safeguarding incidents are recorded through the National Incident Management System (NIMS) and reviewed at team meetings to identify any learning.

Judgment: Compliant

## Regulation 9: Residents' rights

The centre was found to promote a rights-based approach, ensuring that residents are supported in making decisions about their care and daily lives. Weekly resident meetings facilitate discussions about activities, meals, and social outings. Residents also have access to advocacy services and are supported in making complaints should they wish to do so.

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| Staff demonstrated a commitment to upholding residents' autonomy and ensuring that they were empowered to make informed choices about their care. Efforts were made to accommodate individual communication needs, ensuring that all residents could fully participate in discussions about their care and safeguarding concerns. |
| 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 | Compliant |
| Regulation 23: Governance and management | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Community Living Area 15 OSV-0003753

## Inspection ID: MON-0046458

## Date of inspection: 21/02/2025

**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:<br><br>In November 2024 the Recruitment, Selection and Garda Vetting Policy and Procedure was updated in line with best practice, requiring re-vetting every three to five years. The HR dept will continue to issue the re-vetting links and the Person in Charge will support and encourage staff to complete them in a timely manner.<br>The HR dept will follow up with the staff member and reissue the Garda Vetting links where necessary, and will liaise with the Person in Charge if required. | |

## 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(5) | The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2. | Substantially Compliant | Yellow | 30/04/2025 |