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:	Moonvoy
Name of provider:	Waterford Intellectual Disability Association Company Limited By Guarantee
Address of centre:	Waterford
Type of inspection:	Announced
Date of inspection:	17 May 2023
Centre ID:	OSV-0003284
Fieldwork ID:	MON-0031258

About the designated centre

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

Moonvoy is a designated centre that provides care and support for four adults with an intellectual disability, who have low support care needs- including some support with activities of daily living and intimate care. Residents are supported to attend work and recreational activities and to engage actively in their community. The facility is a two storey, five-bedroom, community-based house situated near a seaside town. Moonvoy was built in 2004 to include a sitting room, reception room and kitchen/dining area leading to the fully enclosed private garden. Each resident is provided with a single, en-suite bedroom in order to provide adequate privacy. Transport is provided by WIDA to assist residents in accessing work, education and recreational opportunities. The facility is a well lit, heated and ventilated space, which is appropriately maintained, serviced and cleaned by support staff. The aim for the residential service offered by WIDA is to provide a comfortable, homely and welcoming environment which meets individual service users needs, supporting and encouraging development. WIDA is committed to supporting service users to establish and maintain links within their community. Moonvoy is open all year round.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 17 May 2023	08:00hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to inform this centres registration renewal decision and to monitor ongoing compliance with the Regulations and Standards.

The findings of the inspection determined that there was a lack of robust oversight systems in place around the use of restrictive practices in the centre. The use of some restrictive practices had not been considered from a human rights perspective. In addition, some poor practices in terms of ensuring residents' needs were being met in a timely manner, were occurring within the centre. The inspection findings indicated that residents' choice and control within their home was limited at times. The systems around the management of risks associated with the use of restrictive practices had not been appropriately considered, identified, monitored, reviewed or managed. A number of concerns around a resident's safety and lived experience were immediately brought to the attention of the provider on the day of inspection. Subsequent to the inspection, the provider was required to submit written assurances identifying actions that were put in place to mitigate the identified issues.

This centre provided full-time residential care for four individuals. The inspector had the opportunity to meet and engage with all four residents on this inspection. Not all residents wished to engage with the inspector and this choice was respected. The inspector observed daily routines, interactions with staff, spoke with the staff team and reviewed all relevant documentation in relation to residents' care needs to gather a sense of what it was like to live in the centre.

On arrival at the centre the person in charge showed the inspector in and completed relevant COVID-19 checks and sign in measures. The house was a large detached dormer bungalow located near a town in Co. Waterford. All residents had their own individual en-suite bedroom. Three residents' bedrooms were located upstairs and one resident's bedroom was on the ground floor. In addition, there were two sitting rooms, an open plan kitchen/dining area, a utility room, a room allocated as an office and a small downstairs bathroom. Overall the home was well maintained and each bedroom had personal items and pictures on display.

At times, residents' access to all parts of their home was restricted due to a door being locked. This separated one residents' bedroom, sitting room, utility and downstairs toilet from the rest of the home. The provider referred to this side of the home as an apartment. When the resident was present on this side of the home, and the door was locked, they did not have access to the main kitchen. In the utility room there was a fridge, microwave, cutlery, sink and water bottles present. This room also had the washing machine, tumble dryer, and cleaning materials present. On the day of inspection there were pots of jelly, apple juice cartons and milk present in the fridge. Some items were stored beside cleaning products. The layout, items present, and general tidiness of this area meant it was not suitable for use as

an area for food storage. Therefore this premises design and setup was not in line with the requirements of the regulations as the resident did not have full access to the required facilities. There was also limited choice available in terms of food when the resident was on this side of the home and the door was locked, as there were only pots of jelly available.

The inspector was shown to the kitchen/dining room. It was early in the morning and some residents were up and about and other residents were still in bed. The first resident the inspector met, returned to the centre following their morning walk with their dog. They were seen to give their pet a treat following the walk and complete some household chores. They were ready for the day and heading out to get the bus to work. They worked five days a week. Staff explained that this person had a very busy active life and their independence was facilitated and encouraged.

Another resident was in their room and up for the day. The person in charge stated they were a early riser. The person in charge knocked on their bedroom door and explained that the inspector was here. The resident came to the kitchen door but did not enter the kitchen area. They smiled when spoken too, however did not answer direct questions. They were observed to stay at the kitchen door and go back and forth to their bedroom and a separate sitting room. The resident seemed reluctant to leave this space. There was a restrictive practice in place for this resident where there was no access to the kitchen, second sitting room and upstairs areas over periods of time. There was a key present in the kitchen door. This door separated this resident's living space from the rest of the home.

The final two residents came to the kitchen/dining room and sitting area to have their breakfast. One resident was very keen to chat with the inspector. Staff members present helped with this process as at times the inspector required help with understanding the resident's clarity of speech. The resident was animated when telling stories about past staff members. With staff support they answered some direct questions. For example, they told the inspector what they liked to do which included family visits, swimming, socialising, attending their day service, going out for coffee and attending a local gym. They were seen to help with some household chores and they were comfortable in staff presence. Staff had a good understanding of the resident's communication abilities.

The final resident in the home sat with the inspector when they were having their breakfast. They were seen to request items from staff and staff responded accordingly. They spoke to the inspector about a new medical device they had just received. They asked some questions around the purpose of the inspection and seemed satisfied with the response they received.

The three residents left for their day service, which they attended five days a week. Later in the day the residents returned. During this part of the day two residents were relaxing in a sitting room with a staff member present in the kitchen area. The third resident was in the other part of the home. The door in the hall that separated these two spaces was closed. They key was present in the lock at this time. Earlier in the day it had been explained to the inspector that this door was locked at this

time to allow residents to relax.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered. The inspector found that substantive improvements were required in relation to residents rights, ensuring residents' safety and the oversight of restrictive practices in this centre.

Capacity and capability

The arrangements in place to ensure effective governance were found to be inadequate and posed a risk to ensuring residents were safe at all times. Resources, such as staffing had not been reviewed to ensure it was in line with the requirement of residents' assessed needs.

There were clear lines of accountability and authority within this centre. There was a full-time person in charge assigned to this centre. They also had responsibility for a second designated centre and also held the role of day service manager. The inspector found that this person therefore had a very large managerial remit. Recently a Clinical Nurse Manager (CNM1) had been appointed to assist this person in their role. They had just commenced in this role. The person in charge reported directly to the assistant director of nursing (ADON).

On the day of inspection, provider lead audits such as six monthly unannounced audits and annual reviews were requested by the inspector. It was found that for the most part these audits and reviews were occurring as required. However, the most recent unannounced provider audit was unavailable. Although a number of areas of improvement were identified in these documents, it was found that they were not effective oversight mechanisms in terms of identifying and improving practices in relation to restrictive practices and residents rights. While there were some systems in place such as policies and procedures and restrictive practice reviews; these systems were not effective in ensuring restrictive practices were appropriately assessed, reviewed and monitored. There was very limited managerial oversight evidenced on this inspection in this centre which had resulted in poor care practices occurring.

Regulation 23: Governance and management

Appropriate management systems were not consistently in place to ensure that residents' rights were respected and upheld at all times. A restrictive practice was in place that had not been identified as such. This took the form of locking a kitchen/hall door every night separating one resident from the main home. Of most

concern was that during this period of time, a resident's requests for support/assistance were not met and the resident had no means of leaving this area. Risks associated with this had not been identified, assessed or managed in an appropriate manner.

There was inconsistent identification, application and review of restrictive practices in the centre. For example, the systems in place had identified the use of locking a door between the kitchen/hall in the late afternoon as a restrictive practice but it had failed to identify the use of the same practice during the night time period as such. Therefore there was no evidence present to indicate if this practice had been reviewed in line with best practice.There were failures both at centre level and provider level to ensure this resident's rights to freedom and safety were considered at all times.

The provider's policy titled 'Use of Restraint and Restrictive Practices' listed a number of procedures that were required to be followed in the event of using a restrictive practice. These consisted of reviewing risks versus benefits, service user's views and considerations of alternatives. It was found that these procedures were not being used nor applied to any of the restrictive practices found in place.

Resources in terms of staffing had not been reviewed, considered, or assessed to a meaningful degree. There were documented occasions for example, whereby a resident was up from 5am and was left unsupervised until 7am. Staffing resources had not been reviewed in light of this resident's specific, changing and complex assessed care, supervision and support needs.

Judgment: Not compliant

Quality and safety

The inspector was not assured that all residents were safe at all times. To address an identified safeguarding risk, a restrictive practice in terms of locking a door was put in place. There was limited evidence of other measures being considered to address this. The use of the restrictive practice was not in line with best practice and there was documented evidence of it having a negative impact on a resident. Risk management around this practice was not comprehensive and failed to address the significant risks associated with this practice.

Some restrictive practices were documented in the providers restrictive practice register that pertained to the locked door. Recently, one of these practices was being applied daily, whereby the door was locked for a period of time when the resident returned home. There was no evidence to indicate that this was a least restrictive approach. In addition, the inspector found that this door was locked every night, separating the resident from the main part of the house. This had not been identified as a restrictive practice.

Due to the practice of locking the door, the resident was required to communicate their needs by shouting to staff or by using their mobile phone. Staff were not always responding to the resident when they requested support and assistance. It was documented in the daily notes that the door to the resident's side of the home was to only be opened at seven in the morning. There was no formal guidance in relation to this practice. The resident had no access to the main kitchen at this time and the utility room was not fit for purpose as a kitchenette. It was found that the resident's right to freedom and right to choice was impacted to a significant degree due to these poor practices.

Regulation 26: Risk management procedures

Overall it was found that risk management in this centre was not effective.

Effective recording and reporting of incidents was not occurring. Although incident logs were present, it was found that a number of incidents were recorded in daily notes and not being reported in line with organisational policy and procedures. This included incidents that described property destruction and self-injurious behaviour. These incidents were not reviewed or responded to in an effective manner to inform risk assessments and risk management procedures.

Locking an internal door at night had not been risk assessed. There was no documentation around this or any system to evaluate the associated risks with this practice, such as risks if a fire broke out or the risk of a resident being unsupervised for large periods of time. One resident had a stress support plan in place due to assessed needs around certain behaviours that challenge. It was documented that a resident engaged in property destruction and self-injurious behaviours. Recent incidents described these behaviours occurring over the last number of weeks. There were no risk management systems around these assessed needs which was of concern as the resident had limited supervision and access to staff due to te restrictive practices in place.

It was explained to the inspector that the rationale for the use of the locked door was to ensure safeguarding risks were minimised. The current risk rating, according to the providers risk register in the centre, was low, therefore it was unclear how this practice was assessed as needed. The risk rating present was not proportional to the measures that were in place.

Judgment: Not compliant

Regulation 7: Positive behavioural support

A least restrictive environment was not in place for the residents within this home. There was no clear rationale or assessed need present or evidenced on the day of

inspection indicating the use of a locked internal door in this centre. This practice and how it was being implemented and managed was negatively impacting on the residents care and support. A review of this practice had not occurred to any meaningful degree.

In addition, there was limited evidence that other assessed restrictive practices were applied in line with national guidance and best practice. For example, the use of a restrictive practice had been increased and was now in place on a daily basis. Again, there was a lack of evidence to the rationale of its use or the reason it had been increased to daily. There were no systems in place to record when it was used. There were no systems in place to ensure all residents were safe during this time. A least restrictive approach was not in place.

The impact of the use of restrictive practices had not been considered for all residents in the home. For example, when the door between the hall and the kitchen was locked, three residents could not access their front door, their laundry facilities and they could not access the downstairs bathroom.

Judgment: Not compliant

Regulation 8: Protection

The cumulative findings of this inspection did not assure the inspector that residents were safe at all times. There was an absence of systems in place to ensure a resident's safety when they were left unsupervised. There was evidence of self-injurious behaviour and property destruction occurring during these times and no plans on how to address this to a meaningful degree.

There was evidence of staff not responding to residents seeking care and support which did not ensure residents were appropriately safeguarded at all times.

There was a reliance on the use of significant restrictive practices to keep residents separated. There was limited evidence to indicate if other methods had been considered or trialled. The compatibility of the residents required a comprehensive assessment to ensure that all residents were safe to live together and that their living environment was capable to meet all of their assessed and complex needs.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector identified very poor practices in relation to residents' rights. The inspector found practices in the centre whereby staff did not respond to a resident if they called for help, either verbally or by phone. This resident could not leave their

side of the home due to a locked door and there were no staff providing support in this part of the centre. Over a recent 10 day period, it had been recorded that on five separate days the resident had called for assistance and staff had not responded to them. This was found to demonstrate very poor practice.

In addition, the resident did not have free access to the kitchen at all times. On the day of inspection limited snacks were available in the utility room. This utility room was not fit for purpose as a kitchenette as it was not set up adequately. The systems in place were not adequate to ensure that the resident had a variety and choice of food available to them at all times.

Judgment: Not 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 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Moonvoy OSV-0003284

Inspection ID: MON-0031258

Date of inspection: 17/05/2023

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Staffing has been increased Monday to Friday to provide two staff until 21:00. A review of the frequency that staff on sleepover in the service are being disturbed will continue for a period of three months. Following that management will consider whether a waking night duty is required. Clarity has been provided to staff around the door being open, closed not locked and locked. Two recording forms have been implemented to record the door being closed and the door being locked. An investigation into how the non-compliances occurred and were not identified and corrected by management is ongoing. Date to be complied with: 17th August 2023	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A full review of all risk assessments and associated restrictions will be completed by the multi-disciplinary team and the rationale for all decisions will be documented. A review of WIDA procedures and documentation related to risk and restrictive practices will be completed and training will be provided at staff meetings to ensure that all staff are	

aware that restrictions must be appropriate to assessed risk. The Statement of Purpose will identify the centre as one house. The PIC will ensure that staff have completed incident forms as per procedure.
Date to be complied with: 17th August 2023

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The stress support plan in place has been reviewed and updated so that it clearly identifies the door in question being either open, closed not locked and locked. Documentation to record the door being closed not locked or locked is in place for staff to complete. The times the door will be closed not locked and locked are clearly identified in the resident's stress support plan along with who can authorise the door being locked.
The Statement of Purpose is being updated to identify that the house is not separated into two apartments. A review of WIDA procedures and documentation related to risk and restrictive practices will be reviewed and training will be provided at staff meetings to ensure that all staff are aware that restrictions must be appropriate to assessed risk. Staff received refresher training on Studio 3 low arousal support.

Date to be complied with: 17th August 2023

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Refresher training has been provided to staff in Studio 3 low arousal training and the PPIM has met with staff to ensure that there is clarity that they must respond to residents. Documentation is in place to record any incident that a door separating one area from another is locked. Staffing during the day has been increased to ensure residents are supervised. A review of staffing at night time is in progress for a period of three months to identify if a waking night staff is required.
The PPIM, PIC and the Social Worker are meeting with individual residents to ensure that they are happy within their home.
Compatibility assessments are being completed to identify if the residents are in the most suitable service.
The stress support plan has been reviewed and updated to provide clear direction for the

staff team. The implementation of significant restrictions can now only be implemented with the authorisation of management and is recorded appropriately.

Date to be complied with: 17th August 2023

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Statement of Purpose is being amended to register the centre as one house so that all residents have access to all areas. A consultative review of this change will be conducted by the Social Worker and PPIM and will involve individual meetings with all residents and staff and the PIC, the PPIM will attend resident's house meetings.
The relevant stress support plan has been updated and provides clear guidance to staff on what circumstance the separating door may be locked. The PPIM has met with the staff team and they have received refresher training in Studio 3 low arousal supports to ensure that they know that all staff are aware that they should never not respond to a resident.

Date to be complied with: 17th August 2023

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	17/08/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	17/08/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Not Compliant	Orange	17/08/2023

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	17/08/2023
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	17/08/2023
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	17/08/2023
Regulation 08(2)	The registered	Not Compliant	Orange	17/08/2023

	provider shall protect residents from all forms of abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	17/08/2023