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:	Mullingar Centre 1
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	10 January 2019
Centre ID:	OSV-0004090
Fieldwork ID:	MON-0023378

About the designated centre

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

The provider describes the service as supporting 8 individuals with moderate to high intellectual disability and specific support needs in relation to behaviours of concern and autism. The service is offered to both male and female adults and is a 24 hour service.

The provider aims to provide people with an intellectual disability and their families a service which promotes individuals best interests, choices and that optimally captures the balance of empowerment and necessary safe guards.

The designated centre comprises two community houses in close proximity to the local town, and each resident has their own bedroom, as well as access to the communal areas and garden areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
10 January 2019	10:30hrs to 19:00hrs	Julie Pryce	Lead

Views of people who use the service

On the day of inspection there were eight residents living in the centre and the inspector met and engaged with all the residents.

Residents communicated in different ways according to their ability and preference. Some residents spoke to the inspector, others communicated by gesture or by physically moving others to indicate their meaning.

Residents in the first house visited by the inspector were getting ready for various activities, and family members of residents also arrived to accompany them on activities. One of the residents quietly observed the inspector for a while before approaching, and was clearly at ease taking his own time with the supportive presence of staff. Facial expressions indicated that the resident was happy and enjoying the interactions with staff.

At the second house, a resident answered the door to her home and took the inspector by the hand into the living area, and then down to her bedroom. Others told the inspector about activities they had been engaging in and enjoying.

Family members told the inspector that this was their relative's home, and that they all felt like part of the family. Any minor issues raised were followed up by the inspector during the course of the inspection, and had been taken under consideration by the provider. Family members had only positive comments about the staff support received.

Capacity and capability

The inspector found the centre to be effectively managed, with a clearly defined management structure in place with clear lines of accountability, with appropriate governance processes to ensure consistency of oversight.

The provider had ensured that appropriate arrangements were in place for key management roles in the centre. The person in charge was on leave at the time of the inspection. There were appropriate deputising arrangements in place to cover this absence. The area director was now the person in charge, and was supporting and mentoring locally a team leader who was undertaking an accredited management course with the view of to support them to carry out the role.

The current person in charge demonstrated a detailed knowledge of the needs of residents, and had clear oversight of the care and support in the centre. She was well known to the residents, and staff and family members were aware of the management structure.

The provider demonstrated the capacity to identify and address areas for improvement. Various audits had been undertaken, and whilst not all audit reports were retrievable at the time of the inspection, there was a system of oversight of audit results and required actions in the form of a monthly return to senior management. This report included a synopsis of all outstanding actions identified by audit. Required actions reviewed by the inspector had been completed or were in progress within the identified timeframe. The report also provided information relating to various aspects of service provision in the centre, including personal plans, issues raised at house meetings and any significant events. This system provided clear oversight of the centre.

Staff team meetings were conducted at which various aspects of the running of the centre were discussed and documented, including personal plans for residents, accidents and incidents including medication errors, complaints, health and safety and maintenance. There was as system whereby staff not present at these meetings signed off as having read the minutes. Minutes included documentation of required actions and persons responsible for completing the actions. Communication in relation to these and other actions took the form of monthly key worker reports, together with a communications diary. These systems ensured that information was effectively shared with staff so they could deliver effective care.

The centre was adequately resourced to provide the required care and support in accordance with the needs of residents. There were appropriate staffing arrangements in place and the numbers of staff and the skills mix ensured that the needs of residents were met. Continuity of staff was managed by a core staff team and a system of relief staff that ensured that all staff were known to the residents.

Staff had received mandatory training, and training in specific areas pertinent to the needs of residents such as management of dysphagia and epilepsy. Staff were able to demonstrate knowledge of these needs and the management and support of them. There were appropriate recruitment practices, and regular supervision of staff was in place in a clearly structured format including performance management, so that staff were supported to engage in good practice.

There was an appropriate complaints procedure in place, and families of residents were aware of who they should approach if they had a complaint. A complaints log was maintained which included a record of any actions taken following a complaint, and the satisfaction of the complainant. For example a review of fire safety at night had taken place following concerns of a relative.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were effective monitoring systems in place.

Judgment: Compliant

Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place which was available in an accessible version. A complaints log was maintained, and residents and their families were aware of the procedure if they wished to make a complaint.

Judgment: Compliant

Quality and safety

The provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, and were supported to make choices.

Each resident had a personal plan in place which included detailed care plans in relation to any healthcare needs and information relating to the social care needs of residents. Residents were engaged in daily activities in accordance with their needs

and preferences, and many were supported to maintain personal relationships.

Personal plans included detail relating to various aspects of care, for example a social story to support an issue causing anxiety for a resident. While some information in relation to the maximising of the personal potential of residents was either vague, out of date, or related to a one off activity, there was clear evidence that residents enjoyed a good quality of life, and were supported in all aspects of both social and health needs The inspector found that the gaps in this area related only to documentation and discussed this with the person in charge who agreed to review the documentation. Residents were involved in a wide variety of activities individual to their needs and preferences. Residents were involved in planning and choosing activities. Staff supported residents both on daily activities and with short holidays.

Residents had various healthcare needs, and these were well managed and monitored. There were detailed healthcare plans in place, and practice was observed to be in accordance with these plans. Staff were knowledgeable about the healthcare needs of residents, and the interventions required. Any changing conditions or circumstances had been reviewed in a timely manner, and interventions had been implemented.

Family members were consistently involved in the daily lives of their relatives and various aspects of their care and support, and were regular visitors to the houses.

There was a risk register in place in which all identified risks were recorded and risk rated. Detailed risk assessments were also in place, both environmental and individual risk assessments. Each identified individual risk assessment had an associated risk management plan. Accidents and incidents, including mediation errors were robustly managed, and learning outcomes were discussed at team meetings, and documented in the minutes of these meetings.

However, while the risk of lone working had been acknowledged since the previous inspection, and a protocol had been put in place, the management plan was not effective to mitigate the risk. The protocol referred to a 'buddy system' whereby lone workers of nearby centres contacted each other, but this was only sporadically implemented. There were therefore no assurances that staff would always be available to residents in the event of an emergency situation.

There was appropriate fire safety equipment throughout the centre, including extinguishers, fire blankets, emergency lighting and fire doors throughout. Concerns about the safe evacuation of residents at night raised by relatives of residents were reviewed by the inspector and had been addressed. Fire drills had been conducted and the local fire officer had documented their assurances that evacuation could be conducted safely at night.

A register of any restrictions in the centre was maintained and reviewed both on a regular basis, and following any incidents. Detailed risk assessments and management plans were in place and restrictions were recorded. A recent restriction was documented in detail, and a record was maintained of all occasions of implementation of the restriction. Staff engaged by the inspector were aware of the

restriction and the requirement to document and review occasions where it was required. These processes were in place to ensure that the interventions were the least restrictive necessary to mitigate the risks.

The houses were appropriate to meet the needs of residents, each had their own room and access to various communal living areas and garden areas. Improvements had been made as required following the previous inspection including replacement flooring and panelling, and both houses now had Internet access. Some minor maintenance issues had been identified by the person in charge, and were being addressed.

Regulation 10: Communication

There was clear guidance relating to communication, and this was observed in practice.

Judgment: Compliant

Regulation 11: Visits

Visits were facilitated and welcomed.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were provided with appropriate care and support in accordance with their assessed needs and preferences.

Judgment: Compliant

Regulation 17: Premises

The design and layout to the premises was appropriate to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk policy in place, and the service maintained a risk register. However the risk of lone working had not been adequately mitigated.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

While residents had personal plan in place which were regularly reviewed. Families and residents were involved in planning support and care.

Judgment: Compliant

Regulation 6: Health care

Provision was made for appropriate healthcare.

Judgment: Compliant
Regulation 7: Positive behavioural support
Appropriate systems were in place to respond to behaviours of concern, Interventions were the least restrictive necessary to mitigate risks.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Mullingar Centre 1 OSV-0004090

Inspection ID: MON-0023378

Date of inspection: 10/01/2019

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 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The lone working risk assessment was reviewed and the following measures added 1. New protocol introduced to each house and placed on the agenda for the monthly meeting. 2. Contact between 'Buddy Houses' was increased to two hourly phone calls 3. All phone contact will be recorded. 4. Spot checks will be completed by the PIC to ensure effectiveness of the protocol.	

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 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	15/03/2019