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:	Delvin Centre 2
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Short Notice Announced
Date of inspection:	27 April 2021
Centre ID:	OSV-0003956
Fieldwork ID:	MON-0032057

About the designated centre

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

The designated centre provides a full time residential service to four adults,with a moderate intellectual disability, autism and behaviours that challenge. The centre comprises a large bungalow on its own grounds on the outskirts of a small town in Westmeath. Each resident has their own bedroom and there are suitable shower rooms, and bathrooms and communal facilities including sitting room, open plan kitchen and dining area. Wheelchair accessible vehicles are available to the designated centre to assist residents attend social activities and day services are provided from within the organisation. The centre is staffed by social care staff at all times, and some residents have one to one staffing, with nursing oversight available as this is required.

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 - 2015 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
Tuesday 27 April 2021	09:30hrs to 16:30hrs	Noelene Dowling	Lead

What residents told us and what inspectors observed

This centre is a small house and in order to comply with public health guidelines and minimise the risk of infection to residents and staff, the person in charge requested that the inspection be carried out in two locations, the main office in the nearby town and in the centre later in the day,

The inspector met with three of the residents when they returned from their activities and before they went out to get their COVID -19 vaccinations. The staff ensured that they had a hot snack and their preferred food available to them. The residents looked well cared for and staff were observed using pictures and stories to help them prepare for their upcoming vaccinations and were heard gently reminding them of this.

The residents were unable to communicate verbally with the inspector, but used gestures and expressions with the support of the staff. They were observed doing their preferred activities and chores, for example, carefully making the compost for the chickens, and spending time on their table-top activities.

Residents had their own preferred comfort and sensory objects and staff were very familiar with how important these were to them. Staff supported residents to be independent with their needs in so far as possible, and they each had iPads which staff assisted them with. The staff were attentive and respectful in their communication and interactions and respectful of residents needs for space or quiet.

At the time of the inspection, and in line with the public health restrictions, residents had a wrap-around day service from the centre. This involved a number of individually chosen activities, supported by their individual staff, these included working on the farm/allotment, minding the chickens and growing vegetables. In addition, staff supported residents with crafts, cookery, growing salads, and helping with community projects such as the "green mile" outside the centre. In normal times, some residents attended day services and also went swimming, visited local animal shelters, had coffees out, while taking their need for quiet environments into account. Care was taken to ensure the residents had continued contact with their families. For example, family visits, short visits home or outside had been managed safely and contact was maintained via phones and video calls.The staff were familiar with the residents individual needs and the preferences.

In carrying out this inspection the inspector reviewed a range of documentation, spoke with staff, the person in charge and the area manager. The inspector also spoke with the regional manager regarding the plans to address the impact of the different needs of the residents which was found at the previous inspection.

The staff advised the inspector that the introduction of waking night staff, which had been initiated in February 2021, had mitigated some of the concerns noted at the previous inspection, namely the impact of inadvertent behaviours on other residents

and the suitability of the centre therefore to meet the needs of the residents. The inspector found that while the immediate impact had been reduced, this was an interim measure. It was heavily dependant on a high degree of separation of the residents, immediate and successful intervention by staff, which in the house's small environment may be difficult to sustain.

The findings in the quality and safety section of this report indicate that despite good practice found in a number of areas, improvements were still required to ensure that the needs of all residents could be met in their living environment. Some minor improvements were also required in adherence to the Health Service Executive (HSE) policy on safeguarding vulnerable adults and adequate screening for agency staff.

The following two section of this report detail how the governance and management systems in place impact on the quality and safety of care in the centre.

Capacity and capability

This risk inspection was carried out at short notice, in order to ascertain the providers compliance with the regulations and to inform the decision in regard to the renewal of the registration of the centre. The centre was last inspected in January 2020. That inspection identified that there were improvements needed in safeguarding, mainly concerned with the impact of the compatibility of the residents to live together based on their different needs. This had impacted on the quality of lives of all of the residents.

This inspection found that this matter had not been resolved and until February 2021 no substantive actions had been taken to do so. However, a more robust review of the situation had taken place in February 2021 as a result of further incidents. The provider, at that time, implemented a number of changes to alleviate the situation as an interim measure. This included the provision of waking night staff which commenced in February 2021. This arrangement had mitigated the most critical elements of the situation.

The provider advised the inspector that they were actively reviewing placement options within the organisation and were aware that this was not a suitable environment for one resident, based on the resident's assessed needs. However, these plans were not definitive at the time of the inspection.

Overall, there were governance arrangements and a defined organisational structure in place to support the residents care. The person in charge was suitably qualified and familiar with the needs of the residents. Since the last inspection a team leader had been appointed one day per week, to support the person in charge in managing three designated centres.

There were systems for oversight, including monthly reports and audits undertaken

on issues such as medicines errors, accidents and incidents. These supported the ongoing monitoring of the service and the welfare of the residents. The provider's unannounced inspection visits and the annual report for 2020 were also carried out with actions identified for completion.These included the views of the residents and also their relatives, which were positive regarding the overall care. Records reviewed showed that complaints made for, or on behalf of, residents, had been addressed satisfactorily.

The skill mix and numbers of staff reflected the residents need for support. Additional staff were available at various times during the day to assist in the activities and maintaining the separation of the residents.

The recruitment practices were not reviewed on this inspection, as the records were maintained in another location. The provider submitted an assurance that the staff had been appropriately vetted. However, the inspector saw that information available in regard to the agency staff employed had not been adequately reviewed by the person in charge, to provide assurance of suitability to support the residents.

According to the training records reviewed, staff had the skills and knowledge to support the resident with mandatory training completed or rescheduled if necessary due to COVID-19 and. One of the day service staff however, reassigned to provide support to the residents during the pandemic, had no training specific to the COVID-19 infection prevention and control and this could have opposed a risk to the residents wellbeing.

The staff were knowledgeable as to the supports necessary for the residents and there were supervision and communication systems in place to support consistent care for the residents.

Regulation 14: Persons in charge

The person in charge was suitably qualified for the role and as the person was responsible for three designated centre had the support of a team leader in this centre for one day per week.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staff to meet the needs of the residents, with a waking night staff employed in March 2021 to support the residents at this time.

A review of recruitment practices was not undertaken on this inspection as the information was stored elsewhere Information in regard to agency staff was sourced

by the person in charge and was available. However, on review of this, the inspector found that clarification in regard to a matter noted in a personnel file had not been sought, in order to provide assurances of suitability to support the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The records indicated that staff had the required mandatory training, including fire safety, safeguarding, manual handling and behaviour support. However, a day service staff redeployed to work in the centre during the pandemic had not received any infection prevention and control training in relation to COVID - 19.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a defined governance structure in place and systems for oversight and monitoring.

In order to address the impact of behaviours of concern on residents the provider had put some remedial actions such as a waking night staff in place. However, the provider had failed to act in timely manner, as agreed following the previous inspection, to address the incompatibility of the residents and the impact this was having on their quality of life. While a plan was submitted at the time of this inspection to meet residents needs and provide a more suitable environment for all residents this plan had not been agreed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required amendments to ensure it met the requirements of the regulations.

These changes included the arrangements for the person in charge to manage three designated centres, identification of others involved in the management of the centre, arrangements for the absence of the person in charge, and the arrangements for admissions to the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider was forwarding all of the required notifications to the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a policy on the management of complaints and these were seen to be addressed and resolved.

Judgment: Compliant

Quality and safety

Overall, the inspector found that strategies had been implemented to improve the overall quality and safety of the resident's lives. Definitive plans were still required however, to ensure the centre was suitable to meet the different needs of all residents.

The inspector reviewed incidents reports, impact reports and incidents reviews, completed by the behaviour support team. These indicated that there had been a reduction in the most severe disruptive incidents, as a result of intervention by the behaviour support specialist and the introduction of waking night staff. However, the type of incidents occurring such as taking drinks from other residents, entering residents' rooms when they were in bed,and therefore causing upset, invasions of privacy, albeit all unintentional. While the intervention from staff may have reduced the direct impact of this on the residents, it did not remove the risk of this occurring, or the fact that the shared environment may of itself be contributing to the behaviour.

A strategy evident at the last inspection, whereby a resident remained out of home for long periods, and so limited the group contact, was still occurring. While the inspector was informed that this was not the case, or that remaining out was the resident own choice, there was no evidence to support this. The daily records indicated that the resident returned home regularly at 20:00hrs. This pattern may have been long established to prevent incidents and thereby habitual, but had not been reviewed for its impact or suitability for the resident concerned. The inspector

acknowledges that the provider had initiated a process for seeking an alternative placement, based on the assessed needs of a resident as requiring a different type of environment. However, this had not been progressed since the previous inspection.

The inspector review three residents' records and support plans and found that they had good access to multidisciplinary assessments of their primary care needs and these were reviewed as necessary. These included access to speech and language, physiotherapy, dietitian and mental health. These primary and health care needs were reviewed frequently in consultation with the residents themselves, and their families, as appropriate.

Overall, there was an improvement evident in the provider's recognition of the impact of peer-to-peer behaviours and the acceptable threshold for responding to this, where it impacted on residents' personal feeling of safety. Safeguarding plans were implemented on this occasion.

The inspector also reviewed a number of investigation reports initiated as a result of information received externally. These were managed appropriately and all reporting requirements were adhered to. One such concern resulted in a more robust system for decision making regarding the spending of the residents money by staff. This served to protect the residents, who all needed full support with their finances. However, from discussion, the inspector was concerned at the lack of clarity regarding the appropriate policy to be used in such cases, and the purpose of the screening process. The inspector was informed that anonymous allegations were not investigated, which was contrary to the HSE policy on the safeguarding of vulnerable adults. While this had not impacted directly on residents at the time of inspection, this could place residents at risks in future situations.

There had been a reduction in the restrictions in the centre, in particular the locked kitchen and bathroom doors to prevent unsafe access to water. This benefited all of the residents as they now had free access to their kitchen and bathroom should they choose to use either of those rooms.

The systems for the management of risk protected the residents. The risk register and the individual risk assessments and management plans were specific to the environment and the clinical risks for these residents. They included detailed guidelines of monitoring of fluids, chocking risks, personal safety, with detailed strategies to manage such risks.

The residents were protected by the fire safety and evacuation procedures implemented with a range of suitable fire safety systems in place and seen to be serviced as required. Staff had training in fire safety and regular drills were held to ensure that they could be evacuated.

The policy and procedure for the prevention and management of infection had been revised to prevent and manage the COVID-19 pandemic and to protect the residents. There were clear lines of responsibility for the oversight and management of this.

The centre had experienced and outbreak of infection In January 2021 with the virus detected on routine testing for three of the residents. The procedures were upgraded and the provider's isolation house was used to prevent one resident from contacting the virus, as they were unable to self-isolate. Staff outlined the revised procedures implemented at this time and all had recovered well. This had been difficult for the resident who could not self-isolate and whose daily routines were very important to them.There were on-going procedures for monitoring and ensuring the guidelines were adhered to and the inspector observed the staff adhering to these. On the day of the inspection two of the residents were leaving to get their COVID-19 vaccination.

The residents were supported by the systems for consultation and the staff used a number of mediums, such as pictures and objects to enable them to make choices in their daily lives.The systems for ensuring that they were consulted regarding the spending of their monies had been strengthened and they had been prepared for the vaccination process. However, their right to a peaceful environment and enjoyment by all residents of their own home was impacted on by the the shared living arrangement.

Regulation 26: Risk management procedures

Risk management procedures were satisfactory and each individual resident had a risk management plan for identified risks to their safety and well being.

Judgment: Compliant

Regulation 27: Protection against infection

The systems for the prevention and management of infection, with particular reference to COVID - 19 were satisfactory with contingency arrangements in place.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety systems were satisfactory to protect the residents and ensure they could be evacuated in such an event.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The residents needs were frequently assessed via multidisciplinary teams. However, the inspector was not assured that the needs of all residents could be met in the most appropriate and person-centred manner, or that appropriate arrangements were made to meet these needs, within the environment of the designated centre. This was therefore having a negative impact on the quality of life and well-being, of all residents, despite the efforts of all concerned.

Judgment: Not compliant

Regulation 6: Health care

The residents healthcare needs were identified, prioritised and monitored. with good support plans implemented and regular reviews evident.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of improved intervention by the behaviour support specialists and more robust monitoring of incidents of concern.

Restrictive practices had also been reduced and were also been monitored more carefully.

Judgment: Compliant

Regulation 8: Protection

There was evidence that incidents which may constitute abusive interactions, between the residents, if inadvertent, were now being recognised by the provider with safeguarding plans implemented, reports made to the appropriate agencies and appropriate actions taken to address of concerns raised.

However, the provider had failed to ensure that the HSE national policy and procedure for the protection of vulnerable adults, and responding to any allegations

made, was clearly understood in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were supported by the systems for consultation and the staff used a number of mediums, such as pictures and objects to enable them to make choices in their daily lives. Systems for safeguarding the spending of their monies had been improved. There was also evidence of consultation with the residents and in this instance, their parents or guardians, in their care, which was appropriate.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Delvin Centre 2 OSV-0003956

Inspection ID: MON-0032057

Date of inspection: 27/04/2021

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: PIC will clarify the matter highlighted in relation to one staff. PIC will link with HR and ensure that a review of staff files is completed in line with schedule 2. Date to be complied with: 30th June 2021.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Action Taken: All staff will complete refresher training in infection prevention and control in relation to COVID 19. Day service staff has recompleted infection prevention and control training in relation to COVID 19 on the 30th April 2021. Date to be complied with: 30th June 2021.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
It has been identified that one residents' needs are not being adequately met in the centre and that this can contribute to compatability and suitability issues amongst the residents. The support of psychology and behavior support team has been engaged and a record is maintained of the impact of living with others in this environment. As part of the interventions in place, an interim plan was introduced to provide extra staffing support for the residents with cognizance of the need for a comprehensive long term solution.

An alternative designated centre has been identified as being more suitable to adequately meet the needs of the resident.
The following action plan has been developed to support this transfer:
1. Support for the residents in the identified alternative designated centre around transitioning will be put in place.
2. Upgrading works of the Kitchen in the designated centre will be completed.
3. A review of the environment will be completed and it will be adapted to become self-contained to provide an individualized service to meet the needs of the resident.
4. A transition plan will be completed with the resident and appropriate staffing supports will be identified and provided

Date to be completed by: 17th October 2021.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of Purpose was reviewed and updated with information identified by inspector and resubmitted to HIQA on the 7th May 2021

Action completed: 7th May 2021

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
An interim plan is in place to meets the needs of the individuals within the current environment. A review of compatibility was completed and a transition plan has been identified for one resident. Actions have been identified to support the transition of the individual to another designated centre.

Date of action completed: 17th October 2021

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The HSE national policy for protection of vulnerable adults and particularly the response to allegations is implemented by all management and staff within the designated centre. Staff have completed the HIQA module on HSELAND in relation to Safeguarding. Safeguarding is a permanent item on the monthly team meeting agenda.

Actions completed 15th June 2021.

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	30/06/2021
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	30/06/2021
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	Not Compliant	Orange	17/10/2021

	to residents' needs, consistent and effectively monitored.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	07/05/2021
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	17/10/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	15/06/2021