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:	Meath Westmeath Centre 3
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	04 May 2022
Centre ID:	OSV-0004590
Fieldwork ID:	MON-0035852

About the designated centre

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

The designated centre comprises three locations, all within close proximity to the nearest small town. There is a three storey house in a housing estate which provides a full time residential service with a social care staff to five adults with medium support needs. The house consists of an open plan kitchen/dining room and sitting area, utility room, sitting room, five bedrooms (three are ensuite), two bathrooms. There is a garden to the rear of the house. There is also a detached bungalow in another housing estate which provides a full time residential service with, social care workers and support workers to five adults with medium to high dependency support needs. The house consists of five bedrooms (one with an en-suite), one main bathroom, sitting room, kitchen/dining area and utility room. There is garden to the rear of the house. Lastly there is a detached bungalow which provides a full time residential service with social care staff to one resident with medium to high support needs. The house consists of an open plan kitchen/dining/living area, a separate living area, utility room, two bedrooms and a bathroom. There is a garden to the rear of the property. The organisation provides services to both male and females over the age of 18. All houses have 24 hour staff support with sleepover staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 4 May 2022	10:30hrs to 18:00hrs	Julie Pryce	Lead
Wednesday 4 May 2022	10:30hrs to 18:00hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This was an unannounced inspection to monitor and review the arrangements the provider had put in place in relation to infection prevention and control (IPC). During the course of the inspection, the inspectors visited all three houses, met with residents and staff and had an opportunity to observe the everyday lives of residents in the centre.

The centre comprised three locations, two of which were shared houses and one of which was an individualised service for one person. The inspectors visited all three locations, and on arrival at the first house, found a spacious and comfortable home, which at first sight appeared to be clean and well maintained. Some of the residents were making use of different areas of the house, and some were beginning their morning and getting ready for the day.

During the walk around of the houses, inspectors found that multiple cleaning and IPC issues needed to be addressed, and these are discussed later in the report. Each of the residents had their own room, and there was evidence of personalisation of rooms, and personal possessions throughout. However, while two of the locations were appropriate to meet the needs of residents, and to manage their care and support, even during an outbreak of infectious disease, one of the houses was smaller, and had much more limited facilities given the high support needs of the residents. For these residents, when they were being supported to self-isolate in their rooms, there were inadequate bathroom facilities to appropriately meet their needs.

Interactions observed between staff and residents in all three locations indicated that, staff were familiar with the support needs of residents, and that the residents were comfortable in their company.

It was clear that staff had made efforts to ensure that residents were made aware of the current public health situation, for example residents were observed to be accepting hand sanitiser from staff. Staff explained that they had encouraged residents to wear masks in accordance with public health guidance, and one of the residents explained to the inspectors how it felt to wear a mask, and how they found it difficult. Another person described how they had regularly had their temperature taken by staff.

Regular residents meetings were held, and COVID-19 was often discussed at these meetings. Easy read information had been developed to assist residents' understanding, including a detailed pictorial social story in relation to hand hygiene, vaccination and testing. There was easy read information about keeping in touch with family and friends throughout restrictions, and it was clear that staff had supported residents to keep in touch by various ways, for example, garden visits, video calls and home visits where appropriate.

For the most part, residents had been supported to have various on-going activities, both during community restrictions, and again following the lifting of restriction. However, there was insufficient evidence that the needs of those residents with higher support needs were met in relation to meaningful activities, and in particular during the period of self-isolation.

Inspectors reviewed feedback from residents relatives and found that various written complements from family members, and from members of their local community. This feedback was related to both the care and support staff had offered to residents throughout the pandemic, and residents involvement in local community activities.

Overall the inspectors found an inconsistency of practice throughout the centre, in activities for residents, the care and support of residents in relation to infection prevention and control, and in documentation such as, guidance for staff and monitoring of practices. Whilst the inspectors found some areas of good practice, the management and governance of the centre was not sufficiently robust to ensure a consistently high standard of care and support.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

There was a clearly defined management structure in place, including a person participating in management and a full time person in charge. However, the structures and process were ineffective in ensuring consistently high standard of care and support in relation to infection prevention and control throughout the centre.

Documentation and guidance for staff had not been maintained and made available in all locations. On arrival at the first house of the designated centre, inspectors asked staff for various policies and documentation to support effective IPC practices, but staff on duty were unable to locate them. Despite a recent outbreak of infection there was no evidence of a contingency plan to guide staff in the event of an outbreak of infectious disease, and staff were not aware of any plan. When policies were located later by the person in charge, they were not the current up-to-date policies, some of which were available in the other two houses.

Inspectors did note that policies and procedures were up to date in the single occupancy house and good practice was observed however, in the other two houses, these documents were out of date, some versions were from five years previous, and in one of the houses the guidance for staff in relation to the management of the current public health situation was out of date and incorrect.

Later in the afternoon of the inspection, the person in charge presented an 'outbreak emergency folder' with guidance documents for staff. This folder included a contingency plan which included the management of staffing in the event of an outbreak, the use of the isolation unit and the management supports. The document was comprehensive however, staff spoken with were unaware of it and therefore unaware of the information it contained which posed a risk to residents and themselves.

The person participating in management had commenced an Outbreak Review, and was in the process of gathering information from staff. The inspector discussed the outbreak with staff could describe the precautions taken and actions implemented during a recent outbreak of COVID-19.

There was a protocol in place for visitors to the centre, including a questionnaire, and a discussion around current precautions. However, the inspectors observed a visitor arriving to one of the houses, and this protocol was not implemented.

The annual review which is required by the regulations was requested by the inspectors, but was not presented. The two six monthly unannounced visits on behalf of the provider had not taken place. While there was a range of audits in one of the houses which had been undertaken by staff members on a regular basis, this was not the case throughout the centre.

Staff meetings had been held sporadically, but the minutes of these meetings were not held on site, and so were not available to staff. There was no evidence of staff supervision, and no records of supervision conversations over the previous two years.

Some staff training had taken place in relation to IPC and the current public health crisis, but the person in charge did not have oversight of this, and could not identify what training had been undertaken, or where there were any gaps.

The inspectors were concerned about the numbers of staff in one of the houses. Four of the five residents in this house had high support needs in relation to personal care, eating and drinking and mobility, and for much of the time there were only two staff on duty, including during the time that these residents were self-isolating. There was insufficient evidence that this level of staffing was sufficient to meet the personal care needs and the social needs of these residents.

The inspectors spoke to several staff members during the course of the inspection, and found them to be knowledgeable about the care needs of residents, and to support them in a caring and respectful manner. One of the residents had a localised infection, and staff were able to describe the steps they were taking to manage this infection, however there was no guidance available to them in the centre, so they had asked the general practitioner (GP) for advice as to the management of the condition.

Quality and safety

There was a person centred plan in place for each resident, and for some residents these had taken account of the need to reconsider daily activities during community restrictions, and again when these restrictions were lifted. There was a care plan for each resident in two of the houses in the event that they should contract COVID-19, and although these had not been regularly reviewed or updated, contained guidance as to the management of each resident. The plans had not been updated following the outbreak, and were not in place at all in one of the houses.

There was a 'hospital passport' in place for each resident, which contained pertinent information to guide staff of acute services should they require admission to hospital.

During a recent outbreak of COVID-19 in two of the houses, staff explained the practices they had implemented, and the support they had given to residents. They had encouraged the use of masks, although some of the residents did not comply with this request. However, they had managed to support residents to self-isolate, by the use of the organisation's isolation unit for one of the houses, and by helping residents to self-isolate in their rooms in another house.

In another of the houses however, four residents with high support needs shared one bathroom. Each of their rooms were small, with limited space for storage. This meant that one of the residents is transported from their room to the bathroom in a hoist. During the outbreak, each of the four residents were self-isolating in their own rooms, and as the bathroom was shared, all personal care was delivered in their bedrooms. This meant that their personal care plans could not be implemented. In addition, given the high dependency of the residents, the additional supports required during the outbreak of the infection to maintain isolation no additional staffing supports has been put in place to ensure residents care needs were met and their isolation did not impact negatively on them.

In one of the houses a large office space had been allocated as a 'donning and doffing' area for staff. However, while there was a good stock of personal protective equipment (PPE) evident on the day of the inspection, there was no stock control system, other that sporadic phone calls and emails. There were pedal bins that were not functioning, and the bin for the disposal of PPE had a touch top lid. However, first aid boxes were available, and all the contents were in date and checked every two weeks, including antigen tests and thermometers.

Various issues relating to cleanliness and maintenance were found in two of the houses. Multiple examples of unclean areas and items, including cobwebs in some areas of one of the houses, debris in fixtures and fittings, unclean mobility equipment and stained or ill-fitting flooring. There were unsuitable bins which were either broken, or not foot operated, and inappropriate storage of cleaning equipment.

While bathrooms throughout the centre were visibly clean, in one of the houses there were only cloth towels available for use, and despite there being sufficient bathrooms that residents did not need to share in this house, there was nothing preventing residents, staff and visitors all using the same towels. In addition in this house the staff room also had a cloth towel for all staff to use. This had the potential to spread infection from person to person in an environment where vulnerable people lived.

Cleaning checklists were in place of the environment and of equipment, and these had been completed by staff regularly. However, it was clear from the findings of the inspectors that these were not an effective strategy in maintaining the cleanliness of all areas of the centre. In addition, while cleaning of vehicles following each use was in place in one of the locations, staff reported that it had been discontinued in another.

Infection control audits had been undertaken, and a monthly health and safety audit had taken place. However, required actions from these audits were not completed in a timely manner, for example the need for a flat mop system had been identified four months prior to this inspection, but was still not in place.

While it was evident that there were areas of good practice throughout all three locations of the centre, however, these was inconsistent, and reliant on the local staff members with no consistent management oversight.

Regulation 27: Protection against infection

There were areas of the centre that were not clean or well maintained and were not being routinely detected by management in the centre and corrected, in particular:

- some of the flooring did not meet the walls, leaving a gap in which debris had gathered
- the foot rest on one of the resident's wheel chairs had a build-up of dirt and debris
- mops were stored upside down in the used water outside on of the houses
- an expelair had not been cleaned of build-up of debris
- a freezer which was not clean was stored in an unclean outside shed below falling debris
- incontinence protective pads on one of the beds had not been changed from the previous night
- a cracked and stained ceiling in one of the living rooms
- velux windows unclean externally, including debris.

It was not evident that the design and layout of all the houses were appropriate to meet the needs of residents. In one of the houses four residents with high support needs shared one bathroom. Each of their rooms were small so that there was inadequate storage for mobility equipment

There was insufficient monitoring of equipment:

- while there was a sufficient stock of PPE evident on the day of the inspection, there was no stock control system
- there were pedal bins that were not functioning, and the bin for the disposal of PPE had a touch top lid
- there were only cloth towels and no paper towels in some of the bathrooms in one house along with a cloth towel in the staff room

The protocol to be implemented by staff with any visitors to the house was not implemented.

The provider did not show that staff were being appropriately supported:

- staff were not appropriately supervised in relation to IPC practices
- staffing numbers were not always adequate to meet the needs of residents
- there was no oversight of staff training
- there was insufficient guidance to support staff, either in relation to infection prevention, or in the management of an outbreak of an infectious disease, and where up-to date- policies had been developed, these had not been made available to all staff.

The provider was unable to demonstrate adequate oversight of the centre to ensure they had implemented the national standards for infection prevention and control in accordance with regulation 27.

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	
Quality and safety	
Regulation 27: Protection against infection	Not compliant

Compliance Plan for Meath Westmeath Centre 3 OSV-0004590

Inspection ID: MON-0035852

Date of inspection: 04/05/2022

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 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Walkabout of properties conducted by PIC and PPIM on 12th & 16th May 2022 to review outstanding works required which presented IPC risk in designated centre
• The flooring in hallway that did not meet the walls has been sealed to ensure that no gaps are present that could contribute to build up of debris.
• Resident's mobility equipment has been cleaned and added to location specific cleaning schedule
• Colour Coded flat mopping system implemented in designated centre
• Expelair has been cleaned and added to quarterly cleaning schedule
• Freezer has been removed from outside storage
• All resident's beds are checked each morning to ensure all incontinence protective pads are removed from night before.
• Cracked and stained ceiling in living room has been repaired
• Velux window has been cleaned externally and debris removed
• To enhance governance and management oversight,PIC completes monthly Quality & Safety Audit (with Action Plan)in the designated centre with sign off from PPIM
• Quarterly comprehensive IPC Audit (with Action Plan) conducted in designated centre-sign off from PPIM
Design and layout of houses:
• Comprehensive Business Case developed by Registered Provder in April 2022 and submitted to funder for funding to complete major reconfiguration of house outlined in this report. Reconfiguration funding would allow for extention to property allowing for additional bathroom and storage facilities for residents and their equipment
Monitoring of Equipment
• Weekly PPE Inventory and Order System implemeted in all locations.
• New fully functioning pedal bins have been installed in all locations as required
• Paper towel dispenser system installed in all locations as required.
• Local Protocol on Guidance for Visitors implemeted in the designated centre

Staff Support:
• IPC Practices:
- IPC is a standing agenda item on all staff team meetings
- Hand Hygeine Practice Spot Checks conducted by PIC with staff in designated centre- May 2022
- Staff Team meeting and Staff Supervision & Support Schedule developed for 2022
- All have have received training in IPC practice and guidance
Staffing:
- Current recruitment campaign to recruit additional staffing supports within the designated centre. Additional Staffing implemeted on roster for day supports as required in location with high support needs
- Location home to residents with high support needs - Weekly log of activities and supports provided to residents is forwarded to Area
- Staffing Training records have been comprehensively reviewed and annual training plan implemeted for designated centre
- Staff training records are revewed every quarter and training plan developed as required
- IPC Guidance folder reviewed and updated. IPC Contingency plan reviewed and implemented
- IPC Outbreak Review completed by PPIM and learning shared with staff teams and registered provided

• The organization has established an IPC Control Committee for this region, chaired by the Regional Director (Registered Provider) with all Area Directors (PPIM) as members. The IPC Control Committee meets every quarter.
• IPC Governance Framework updated for all locations in May 2022
• Regional Director meets with Area Director on monthly basis following submission of Area Director's report to review issues arising (including IPC risks) and plan for next month.
• Regional Director meets with all Area Directors monthly through Senior Managers Team (SMT) meeting. Matters arising re: IPC Practices and Risks are discussed as required.
• Muiriosa Foundation Training Department is currently developing IPC Training modules (QQI Level 5) which will be delivered to all Persons in Charge. This training is planned to be completed by 30/09/2022.
• There will be a nominated IPC Lead (with qualification) in each designated centre.
• All identified IPC risks in the designated centre are assessed and added to Location Risk Register and control measures implemented to reduce risk.
• PIC and PPIM meet weekly to review performance in the governance and management of IPC in the designated centre, IPC compliance plan and update with any issues arising.
• Schedule of six monthly audits for 2022 completed
• Annual Review Report completed for designated centre.

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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	30/09/2022