Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed)

Name of designated centre:	Mulcahy House (Respite)
Name of provider:	St Aidan's Day Care Centre Limited by Guarantee
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	14 January 2019
Centre ID:	OSV-0001854
Fieldwork ID:	MON-0024668

About the designated centre

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

The statement of purpose for the centre states that it will provide respite care for up to seven residents, adults and children both male and female with high and low support needs. The seventh bed is allocated for emergency respite only. Staffing and support arrangements are flexible to the needs of the residents and respites are planned so as to provide two weeks of high support, one of low support and one children's respite week per month. The service is open 51 weeks per year. Residents can choose to come for a full week or a number of days per week. Admissions' are agreed via the Health Service Executive (HSE) admission and referral panel and up to 108 persons could avail of the service annually. The centre is located in a rural town with easy access to a lot of amenities and transport was available for the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
14 January 2019	10:00hrs to 19:00hrs	Noelene Dowling	Lead

Views of people who use the service

The inspector met with four residents and spoke with three who were starting their respite break.

The residents communicated in their own preferred manner and told the inspector that they always looked forward to their respite break and really enjoyed the various activities they took part in.

Residents stated that they had a rest or lie in at morning times as they wished and said it was good place to come to for respite. The staff supported respite users to cook the food they liked, made sure appropriate activities were available, provided and facilitated. Residents told the inspector that they felt safe there.

Capacity and capability

This inspection was undertaken in order to ascertain the providers' ongoing compliance with regulations.

The centre was last inspected in October 2016.There were two actions required following that inspection in 2018, One of these was addressed and the second non compliance was in the process of being addressed. Two of the providers centres had been the subject of enforcement proceedings in 2018. As result of this the provider had made changes to the management structures in the organisation to provide better oversight and monitoring of practice.

These changes included the recruitment of a suitably qualified person as the quality and compliance manager with defined responsibility for oversight and quality improvements systems in the organisation. These revised systems were not as yet embedded in practice and complete. However, there was evidence of changes which would result in better monitoring of quality and safety for the residents.

To this end, a number of unannounced quality and safety inspections had taken place and further were scheduled. Matters reviewed included a health and safety walk through, reviews of resident personal plans, medicines administration procedures, staffing levels. A number of parents and relatives had also been contacted for their views on the service and these were found to be very positive. These reviews would form part of the annual review of the service for 2017 which was in process at the time of the inspection. In addition, more effective systems for

reporting and responding to accidents/ incidents were being developed.

The findings of this inspection in regard to risk management, safeguarding and personal planning indicate that further improvements is required in a number of substantial areas to ensure a positive and safe experience for the residents. Some of these findings relate to the capacity of the person in charge to manage this complex and fluid service with a limited amount of protected time to do so. They can also be attributed to the lack of direct oversight, robust auditing, communication and planning for this type of service.

The inspector found that the skill mix and numbers of staff identified was suitable to meet the needs of the residents with nursing care provided at all times. Rostering arrangements were found to be flexible and based on the needs of the residents. A number of residents including children were assessed as requiring two to one staffing which was provided. This ensured they had the supports needed and could have additional activities during the time.

A review of a sample of personal files indicated that recruitment practices were satisfactory. However there were some deficits in mandatory training with six staff overdue for refresher fire training, two for safe lifting and patient handling and one for the safeguarding and protection of residents. However dates were scheduled for this training. All staff had the required Children First training completed. The staff had nursing, social care or associated relevant qualifications. This ensured staff had the skills and knowledge to meet the needs of the residents.

The inspector found that staff supervision systems had not been implemented sufficiently. Records of team meetings showed that they were held frequently in order to ensure good communication and consistency of care for residents. From a review of the complaints records the inspector found that any concerns raised were addressed transparently by the provider.

The statement of purpose was satisfactory and the service was operated in accordance with this statement which supported residents well-being and welfare.

Regulation 14: Persons in charge

The person in charge was not engaged full-time in the management of the service.

Judgment: Not compliant

Regulation 15: Staffing

The numbers and skill mix of staff was suitable to meet the residents needs.

Judgment: Compliant

Regulation 16: Training and staff development

Mandatory and refresher training had not been provided for a number of staff . Staff were not formally supervised pertinent to their role.

Judgment: Not compliant

Regulation 23: Governance and management

Management systems were not sufficiently robust and devised to adequately monitor and ensure the safety and quality of the service.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was satisfactory and the service reflected this in practice.

Judgment: Compliant

Regulation 31: Notification of incidents

A number of notifications required to be submitted to the Chief Inspector had not been submitted in relation to peer to peer abusive interactions.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were managed in a timely and transparent manner.

Judgment: Compliant

Quality and safety

Inspectors found that the emphasis during the respite was on social and relaxing activities of the residents choosing. The time was planned to be a holiday experience. Staff were found to be very familiar with residents preferences and need for support and on the first day of admission they planned activities with the residents. It was apparent to the inspector that the residents and staff were very familiar with each other and the residents settled in very quickly.

There was a weekly schedule of activities for each resident and they could choose to take a break from their day services or not during the time. Children availing of respite breaks were supported to continue their education and attend schooling as normal. The evenings and weekends were for activities and outings of their choice.These activities included visits to local cafes and restaurants, cinema trips and shopping trips, playgrounds. There were televisions and DVD players and stereos in residents' rooms, with toys and a safe playground areas for the children.

Medicines management systems were appropriate to the respite service and staff recorded both intake and return along with the administration of medicines.

In accordance with this type of service resident's parents/ guardians maintained primary responsibility for their care and managed appointments and reviews of care needs. There were systems for communicating with parents/relatives prior to the resident's admission. However, the inspector found that these systems could be improved to ensure that residents overall and changing needs including health and psychological care were clearly known. This would ensure that support and personal plans could be implemented based on this information. In some instances there was little information available as to any assessment outcomes to guide the development of personal support plans. There was a lack of clarity as to ongoing health needs and outcomes of some interventions undertaken which could impact on the residents while in the service. There were no overall health assessments or information available for a number of residents.

A speech and language assessment for swallow care had not been reviewed since 2010. A resident with a very specific and potentially acute health condition did not have a support plan detailed to guide staff and ensure the symptoms were managed. A number of residents had behaviour support plans in place which staff implemented but access to pertinent reviews and updates on these were

not always available to the staff. These factors were however somewhat mitigated by the consistency of the staff group and their obvious knowledge of the residents. It is acknowledged that due to the type of service provided and the number of other services involved accessing this information can be more difficult.
Nonetheless, some revision of the process is necessary to ensure the residents most important needs are known and can be met by the provider during the respite period.

Systems for safeguarding residents were in place and included admissions decisions based on compatibility. Additional staff were provided where necessary.The inspector found that the person in charge was robust in managing the admission process to this end. All of the required policies and systems including a child safety statement was in place. Despite this the inspector found a number of incidents of peer to peer assault which had not been promptly responded to or reported as safeguarding concerns. While the residents in question did not attend the centre together for some time following this, no safeguarding plan to support this situation was devised. It was of some concern to the inspector that there was a lack of clarity regarding the threshold for abuse in these type of incidents and the potential impact on other residents. The inspector also found that a significant piece of information pertaining to a formal safeguarding intervention had not been made available to the person in charge by the provider.These matters posed a potential risk to resident's safety and well-being.

A number of restrictive practices were used in the centre. In most instances it was apparent that these were assessed as necessary by the appropriate clinician. There was however a lack of adequate assessment or review of need or safety of use of these restrictions in some instances. In particular, a sleeping structure was in place which entirely encompassed a resident's bed and was fastened from the outside so as to prevent the egress of the resident from the bed. The actual rational for the use of this could not be ascertained by the inspector. No assessment had been conducted regarding the safety of this intervention or consideration of any alternatives to the restriction were evident.

Some improvements were also required in risk management procedures to take account of the transient nature of the service and some of the risks presented. The risk register was generic and not specific to the centre and its statement of purpose. Individual residents had a number of risks identified and management plans implemented. However this process was not a consistent finding. For example, a child had absconded via the front door in the presence of staff. While additional staff were then allocated to support the resident there was no effective review of the exit door undertaken.

Fire drills were held frequently with the various residents. Following one such drill when a resident had declined to leave the building no review or additional measures were identified should this occur again during a real emergency. The sample of residents personal evacuation plans viewed by the inspector were also generic and not specific to their needs. A range of fire safety management systems were in place and there was evidence of the servicing of the fire alarm, emergency lighting and

extinguishers on an annual and quarterly basis. Self closing fire doors were installed.

The premises is very suitable for purpose, spacious and well laid out to meet the needs of the residents. It was equipped with assistive equipment and easily accessible. The communal areas and residents bedrooms were comfortable and nicely decorated. Residents brought their own personal possessions which were documented and returned and the monies were carefully managed by staff.

Regulation 12: Personal possessions

Residents personal possessions were carefully stored and recorded.

Judgment: Compliant

Regulation 17: Premises

The premises was suitable to meet the varied needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Process for assessing and responding to known risks were not satisfactory.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable arrangements for the evacuation of all residents were not devised.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Practices for the management of medicines were satisfactory and pertinent to the service provided.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Pertinent assessments of residents health and psychosocial needs were not consistently available and personal plans were not devised based on the residents assessed needs on an ongoing basis.

Judgment: Not compliant

Regulation 6: Health care

Residents health care needs were not clearly identified in some cases and pertinent support plans could not always be implemented as a result.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where necessary there were positive behaviour support guidelines for residents and staff had training in providing this support.

Judgment: Compliant

Regulation 8: Protection

Incidents of direct or threatened harm to residents were not adequately reviewed or responded to which did not protect the residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Mulcahy House (Respite) OSV-0001854

Inspection ID: MON-0024668

Date of inspection: 14/01/2019

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 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
The Person in Charge works a four week roster of 130 hrs per month i.e. an average of 32.5 hrs per week (86.67% of nursing full time hrs @ 37.5 per week)

Week 1 40 hrs
Week 2 33 hrs
Week 3 31 hrs
Week 4 26 hrs
Total 130 hrs per month

The PIC has a total of 61 protected hours per month i.e. 47% of total working hours.

Additional nursing hours were introduced into the service to enhance communication and oversight within this service. The Day Registered Nurse overlaps with the Night Nurse. This affords the PIC protected time to supervise and oversee the work practices of the staff and the quality of care being delivered.

Also the Night Nurses hours have been increased on discharge dates to afford the PIC time with the staff to observe the admission/discharge procedures and transport. The PIC has advised that this affords her and the staff time to review and evaluate procedures and the quality, safety and effectiveness of the systems in place. The PIC has advised that this has resulted in a seamless transition for discharge and admissions within this respite service.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The HR Manager has completed a training analysis of the service and a training schedule/planner is now in place for all compulsory training required for 2019. The training gaps identified during the inspection has been planned and scheduled.

The PIC is carrying out super-visions with all members of the staff team. A record of supervisions will be held on staff personal files and the Time Management System for ease of reference. This will ensure that staff have the skills and knowledge to meet the needs of the service users.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC and PPIM are currently liaising with other external providers in relation to devising an overall health assessment. This assessment will be in collaboration with the families also and will support the service with the changing needs of the resident and the development of their personal support plan.

The HSE in collaboration with our service are currently reviewing the overall database of service users availing of respite in Mulcahy House. This is with a view to reducing the number of service users availing of respite.

This process commenced in the last quarter and a number of service users have been discharged from our service due to the opening of a new respite service in County Wexford.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Following inspection, the following actions were implemented: -

An education session was delivered by the PIC to the staff team in relation to notifications and importance of communication to ensure that the chief inspector receives notice in writing within 3 working days of adverse incidents occurring in this designated centre in line with regulation.

There is now a system in place in the absence of the PIC. The PPIM will be notified during her rostered hours. The on-call manager will be notified outside of PPIM's rostered hours.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC has 61 hours protected time to support her in planning, managing and overseeing service delivery. There is an additional 22 nursing hours implemented into this service to enhance oversight, communication, and the delivery of a quality and safe service to the individuals availing of a respite service.

The risk register is under review to be centre specific taking into account compatibility in relation to admissions and changing needs.

In relation to the child absconding through the front door. There has been a review of the exit door and it will be captured in the risk register.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
On admission to Respite, service users are re-orientated to the fire evacuation procedure, the assembly point and the sound of the fire alarm. This is carried out as part of their admission group meeting and is recorded in the group meeting book.

On admission the PEEP's are being reviewed to ensure that they are specific to the service user's needs.

In relation to a particular service user who declined to leave the building during a fire evacuation. This has been discussed with the fire officer and on his next admission a training session will be arranged with the individual.

This service user will be supported by staff prior, during and post fire evacuation.

This individual's fire evacuation PEEP has been reviewed and updated and will be tested on next admission.

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:
Currently the system in place to ensure relevant information is obtained is as follows:-
· *Four weeks prior to admission personal plans are reviewed
· *Medication needs, kardex, changes are made via verbal liaise,
· *Mailing process and followed up prior to admission.
· *Families are contacted via phone one week prior to admission to most up to date information in health needs.

The PIC and PPIM are liaising with other external providers in relation to devising an overall health assessment. This assessment will be in collaboration with the families also and will support the service with the changing needs of the resident and the development of their personal support plan. This will further improve systems to ensure that residents overall and changing needs including health and psychological care are clearly known.

The Health Assessment Form, will go directly to families via post and requested to be completed and returned with the relevant information to the service two weeks prior to the admission date. The information returned will be reviewed an updated into the personal care plan. Families will continue to be liaised with one week prior to admission in the event that there are any further recent changes.

The PIC is liaising with the DON, St. Johns Hospital in relation to a profiling bed that can reach the floor as an alternative to using the cosy fit bed.

The cosy fit bed will be available to Service Users prescribed by an OT.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure that appropriate health care is provided for each resident and their needs are

identified in their personal plan. The PIC and PPIM are currently liaising with other external providers e.g. day service providers in relation to devising an overall health assessment.

This assessment will be in collaboration with the families also and will support the service with the changing needs of the resident and the development of their personal support plan. This will further improve systems to ensure that residents overall and changing needs including health and psychological care are clearly known.

The Health Assessment Form, will go directly to families via post and requested to be completed and returned with the relevant information to the service two weeks prior to the admission date. The information returned will be reviewed an updated into the personal care plan. Families will continue to be liaised with one week prior to admission in the event that there are any further recent changes.

This will further support the service in collating information in relation to the service users health & wellbeing including outcome of assessments since their last admission for respite service. This will also support the PIC in ensuring that the admissions are compatible within the group.

Currently the system in place to ensure relevant information is obtained is as follows:-
- *Four weeks prior to admission personal plans are reviewed
- *Medication needs, kardex, changes are made via verbal liaise,
- *Mailing process and followed up prior to admission.
- *Families are contacted via phone one week prior to admission to most up to date information in health needs.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The HR Manager has scheduled training with an external provider for Abuse training.

The PIC will ensure that all peer on peer abuse will be promptly responded to and reported as a safeguarding concern.

A safeguarding plan is in place to ensure that due to non-compatibility the two service users identified will not avail of respite together.

The PIC will ensure that the chief inspector will be notified in line with regulation.

The service provider nominee will ensure that there is effective communication between internal services and sharing of information in relation to service users who attend St. Aidan's Day Service and avail of Mulcahy Respite.

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	21/01/2019
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	31/03/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff	Not Compliant	Orange	28/02/2019

	are appropriately supervised.			
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	31/05/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/03/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	21/01/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring	Not Compliant	Orange	21/01/2019

	in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	31/05/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/05/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/05/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	18/01/2019