Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Mulhussey
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	07 August 2019
Centre ID:	OSV-0002967
Fieldwork ID:	MON-0021739

About the designated centre

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

Mulhussey designated centre, operated by St. John of God services is located in the countryside in Co. Meath. It is a six bedroom house, with a capacity for four male and female residents with a moderate/ severe intellectual disability. The property, a two-storey house has two sitting rooms, a dining room, two bathrooms, a large kitchen area and two offices. There is a large garden and grounds for residents to enjoy. There is a purpose built activity building located adjacent to the house. This building is used as a base for the residents to access their community activities and to complete their independent living skills training. Residents are supported on a 24 / 7 basis by a team of social care workers and health care assistants. Access to the community is facilitated by two accessible vehicles.

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
07 August 2019	09:30hrs to 17:30hrs	Erin Clarke	Lead

Views of people who use the service

In response to the needs of residents, the inspector of social services did not engage verbally with residents. The inspectors judgements in relation to the views of the people who use the service, relied upon observation of residents, documentation, brief interactions with some residents, and discussions with staff.

Although a number of residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits.

The inspector found that residents were enabled and assisted to communicate their needs, wishes and choices which supported and promoted residents to make decisions about their care. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits.

Staff spoken with outlined how they advocated on behalf of the residents and how they felt that each of the residents enjoyed living in the centre.

Capacity and capability

There were governance and management arrangements in place to monitor the quality and safety of the service, however there was improvement required to ensure effective oversight of key areas and that required actions were implemented. The provider conducted a six monthly unannounced visit and subsequent report, and a review of this report found that a number of issues had been identified and included in an improvement plan, and for a number of these issues action had been taken. The provider also carried out an annual review of the quality and safety of the care and support delivered to residents. This report required review, to ensure that the views of the resident and their representative were captured and a time bound plan developed arising from any identified actions.

A schedule of audits was devised for the year which included the following; residents' personal plans, hygiene and environmental, medication, fire safety and finances. The responsibility for completion of these audits were listed at the supervisor and coordinator level. The schedule also included peer review audits for best practice and the use of local pharmacy for medication audits. It was identified that improvement was required to ensure that audits were completed as set out by the provider with oversight from management.

In May 2019 a new person in charge had been appointed for a fixed term contract, having worked in the centre previously as a social care worker. The person in charge had the relevant professional qualifications and a number of years' experience of supporting people with an intellectual disability. They spoke to the inspector of their plans regarding the implementation of audits and review of work practices. As an example of good practice, the person in charge had reviewed the centres environmental cleaning checklists and protocols in line with a revised infection control policy implemented by the provider.

The inspector reviewed staff rosters and found that there were enough staff with the right skills, qualifications and experience to meet the assessed need of the residents at all times. While there was one vacancy at the time of the inspection the inspector found that there were arrangements in place for continuity of staffing so that support and maintenance of relationships were promoted. There was a comprehensive handover from night staff to day staff on a daily basis. It was evident that it was an effective system that ensured that all of the key information relating to service provision and residents' needs was communicated clearly, available resources were allocated, and appropriate actions and responsibilities were delegated among staff members on duty.

Staff were facilitated with training that was in keeping with the resident's individual profile, however, some improvement was required to ensure that the resident's needs were seamlessly supported. Members of the management team discussed the organisational review of the training requirements, that was taking place to address restrictions to accessing training refreshers in a timely manner. The inspector viewed supervision records for the previous 12 months, it was observed that the maintenance of these records required review for ease of retrieval and to ensure they aligned with organisational policy. This is addressed under regulation 21, records. The person in charge had implemented a new supervision meeting recording system since commencing post that accurately recorded details of meetings that had occurred.

The inspector saw from the accident and incident log that there was timely follow-up of incidents by the person in charge; corrective actions were identified and followed through on based on other records seen; for example minutes of meetings with staff. Improvement was required regarding the timeliness of quarterly notifications to the Chief Inspector of Social Services and the notification of all restrictive practices in the centre.

Regulation 14: Persons in charge

The person in charge was found to be suitably skilled, experienced and professionally knowledgeable in their role.

Judgment: Compliant

Regulation 15: Staffing

Each staff member played a key role in delivering person-centred, effective, safe care and support to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with training in a wide range of areas but some staff were overdue refresher training in areas such as manual handling, medicines management and de-escalation and intervention from training records reviewed on the day of inspection. These outstanding training requirements had dates scheduled for completion. Infection control training which was identified as a requirement in this centre had no identified date scheduled and seven staff had not completed this training.

Judgment: Not compliant

Regulation 21: Records

Improvement was required in the streamlining of residents' records and staff records to ensure they are easily retrievable and accurate. For example, staff supervision records, restrictive practices recording sheets and health appointment records.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clear governance structure in place with identified lines of accountability and authority. Staff reported to the person in charge who in turn was supported by other persons participating in management. Annual reviews were being carried but while the 2018 annual review did refer to some of the pertinent issues related to residents' quality of life and safety, it did not include consultation with residents and their representatives. The auditing system in place

also required review.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the centre's statement of purpose and found that it contained the information as outlined in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Overall, notification of incidents were reported to the Chief Inspector in an appropriate and timely manner however, the most recent quarterly notification had not been submitted at the time of the inspection. It was also identified that one restrictive practice had not been notified as required. The inspector found that this did not have a negative impact on the care provided as the person in charge had sufficient oversight of this practices.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the quality and safety of the care which was provided in the centre was maintained to a good standard and actions from the previous inspection had been adequately implemented.

There were some restrictive practices in place which had been assessed in terms of risk and also had a clear rationale for their use. These restrictive practices had been reviewed on a regular basis by the staff team and by the provider's rights review committee to ensure that the least restrictive practice possible was implemented.

The focus of the positive behaviour support plan was on proactive strategies and all alternative measure were exhausted prior to considering a restrictive practice. The staff members with whom the inspector spoke had a good understanding of supporting residents with behaviours of concern. Where behaviours of concern were identified these were supported by a plan of care to ensure that consistency of care was provided to the resident. The inspector noted that every effort was made to identify and alleviate the cause of one resident's behaviour of concern which

resulted in the reduction in the behaviours and the use of restrictive practices.

There was a good understanding of each resident, their needs, choices and required supports. This was based on staff knowledge, formal assessments of resident's needs and regular review by the multi-disciplinary team of the effectiveness of the support provided to each resident. However, a review of some documentation by the inspector did not provide assurance that the personal plan adequately addressed all resident's needs so as to provide sufficient guidance for staff particularly from a healthcare perspective. The inspector did find that staff supported residents in times of illness and sought medical review and advice.

There were no current safeguarding concerns in the centre and the provider had systems in place which promoted the safety of residents, this included ensuring that staff had received appropriate training. The inspector carried out a review of safeguarding notifications that had been notified to the Chief Inspector since the previous inspection. It was identified that for one incident, national policy was not adhered to in the management of or follow up to this incident. However the provider had since shared a communication memo to ensure that all notifiable events were correctly investigated in line with the national policy.

Fire safety systems in place in the designated centre including a fire alarm system, emergency lighting and fire extinguishers. Such equipment was being serviced at the required time frames while internal staff checks were also being carried out. The provider had implemented an emergency response plan with protocols in place for a range of scenarios including power outages, loss of water and heating an adverse weather. Residents had detailed personal evacuation plans in place which outlined the supports to be provided to residents to assist them in evacuating the centre. It was identified by the provider that there was a risk that some residents may not evacuate as demonstrated in fire drills. The provider had sought the advice of external fire consultants and the local fire bridage to create a robust contingency plan in the event of refusal. Staff spoken to were aware of the contents of these plans and the rationale.

The centre had a policy in place in relation to medication and there was established medication practices in place. The inspector found that staff demonstrated good knowledge of the medication systems. Staff were appropriately trained in the administration of medication within the centre. Some residents were prescribed PRN (medicines to be taken when required) and the inspector found that the guidance provided to staff on the administration of these medicines supported safe and consistent practice. It was noted that improvement was required to the labelling of liquid and topical medication to ensure that they were disposed of before expiring.

Regulation 28: Fire precautions

Fire safety was taken seriously by the provider and external competent persons were sourced to conduct regular servicing of fire equipment and to review fire evacuation plans where required. Staff within the centre were conducting regular reviews of fire precautions such as emergency lighting, alarm system, extinguishers and fire doors to ensure that these were in good working order.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

A sample of prescription and administration records were reviewed by the inspector. It was found that the required information such as the medicines' names, the medicines' dose and the residents' date of birth were contained in these records. Records indicated that medicines were administered at the time indicated in the prescription sheets. Appropriate storage facilities for medicines were also provided for. Improvements were required for the processes in place for expired or out of date medication and auditing systems to identity that the system complied with policy and best practice.

Judgment: Substantially compliant

Regulation 6: Health care

There was evidence that the provider was providing appropriate healthcare for each resident with evidence of regular and timely access to general practitioners, other medical specialists and allied health professionals. The inspector identified some gaps in healthcare documentation, for example the health assessment did not accurately detail the health concerns for one resident. As a result staff did not have clear guidance provided to direct care relating to this residents healthcare needs

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The staff members with whom the inspector spoke had a good understanding of supporting residents with behaviours of concern. Where behaviours of concern were identified these were supported by a plan of care to ensure that consistency of care was provided to the resident. The inspector noted that every effort was made to identify and alleviate the cause of one resident's behaviour of concern which

resulted in the a reduction in the behaviours.

Judgment: Compliant

Regulation 8: Protection

There are policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Staff spoken with had a good understanding of safeguarding and of the providers reporting procedures.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Mulhussey OSV-0002967

Inspection ID: MON-0021739

Date of inspection: 07/08/2019

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff team members have be upskilled and trained in Infection control. The organisation is currently reviewing how all mandatory training and refresher training is going to be delivered going forward. All mandatory refresher training, Positive Behaviour Support & Autism training for staff in this Designated Centre has been scheduled for completion by end of January 2020.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • An accessible form of the Annual Review for the Designated Centre has been completed to ensure and evidence residents' inclusion and consultation. Family inclusion in this process will be obtained via phone calls by the PIC to family members and face to face conversations when families visit the house. • Internal Audits have been reviewed and commenced by the PIC in consultation with their peers in the service. • All four MPPs have been reviewed by PIC. Health Assessments have been reviewed and audited by PIC and outcomes from audits have been actioned by keyworkers. Care Interventions have been developed to reflect assesses needs of the residents. All Restrictive Practices has been reviewed by the Positive Behavioural Support Committee and documented in relevant folder in the Designated Centre. All risk assessments that	

involve a physical intervention highlight clearly the staff to service user ratio have been reviewed to ensure accuracy of information. • All quarterly notifications for the Designated Centre will be forwarded to HIQA in a timely manner. • Documentation checklist for liquid medication/s has been developed by the Pic to ensure oversight and governance of when medication is due to expire or has expired. This will also be added to the Designated Centres medication auditing tool.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: • An accessible form of the Annual Review for the Designated Centre has been completed to ensure and evidence residents' inclusion and consultation. Family inclusion in this process will be obtained via phone calls by the PIC to family members and face to face conversations when families visit the house. • Internal Audits have been reviewed and commenced by the PIC in consultation with their peers in the service. • A Staff Supervision scheduled has been developed up until the end of 2019. Formal supervision meetings between the PIC and team members are ongoing and minuted as required. PIC will develop a further 12 month supervision schedule for the team for 2020 in December 2019 to ensure continuity of support to the team.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC has registered on the HIQA online portal. The PIC will notify HIQA of all incidents in the Designated Centre Within three days as is required by the Regulation.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Documentation checklist for liquid medication/s has been developed by the Pic to ensure oversight and governance of when medication is due to expire or has expired. This will also be added to the Designated Centres medication monthly auditing tool.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • All four MPPs have been reviewed by PIC. Health Assessments have been reviewed and audited by PIC and outcomes from audits have been actioned by keyworkers. Care Interventions have been developed to reflect assesses needs of the residents. If any changes in a residents health care support needs this must be immediately reflected in the residents current health assessment in their MPP.	

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	18/10/2019
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	10/09/2019
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	10/09/2019
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	10/09/2019

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/12/2019
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	10/09/2019
Regulation	The person in	Not Compliant	Orange	09/10/2019

31(3)(a)	charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	10/09/2019
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	10/09/2019