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 (Mixed)

Name of designated centre:	Meath Westmeath Centre 1
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	30 April 2019
Centre ID:	OSV-0003957
Fieldwork ID:	MON-0022111

About the designated centre

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

The centre comprises two detached bungalows in close proximity to the nearest town. A full time residential service is offered to six residents, each of whom has their own bedroom, and access to communal space and gardens in the houses. The provider describes the centre as offering support to individuals with medium support needs, including behaviours of concern and autism.
The centre is staffed over 24 hours including sleepover staff at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
30 April 2019	10:00hrs to 17:30hrs	Julie Pryce	Lead
30 April 2019	10:00hrs to 17:30hrs	Eoin O'Byrne	Support

Views of people who use the service

There were six residents living in the centre on the day of the inspection, and inspectors met and interacted with four people as they arrived home from their daily activities in one of the two houses that made up the centre.

Some residents made clear their choice as to the level of interaction they would like with inspectors and this was respected. Where residents chose to engage with the inspectors they were supported by staff who were familiar with their preferred methods of communication.

Residents greeted staff fondly and were keen to tell the story of their day. Some involved the inspectors in this and used their communication aids to explain the things that they had done that day, what they would prefer to do in the evening and to ask questions such as who was on the sleepover shift that evening.

The views of residents were also established by residents meetings, by the well established use of communication aids and by the involvement of family members. There was no meaningful advocacy service available to residents, and it was clear that not all choices had been facilitated, in particular where residents did not all like living together, and that some of them felt unsafe because of the incompatibility of residents in the house.

Capacity and capability

The inspectors found that governance arrangements were in place with a clearly defined management structure, clear lines of accountability and some governance processes in place. However, staffing levels, appropriate deployment of staff, and an inappropriate mix of residents did not ensure positive outcomes for residents.

The provider had made arrangements to ensure that key management and leadership roles were appropriately filled. There was a person in charge in position at the time of the inspection who was appropriately skilled, experienced and qualified. She had only been in post for three weeks at the time of the inspection, and had already developed a list of practice development points and quality improvements which she planned to address.

The provider had put some systems in place to enable the staff team to meet the needs of most residents, however staffing numbers required review to ensure that

the mix of residents was safely managed throughout the day. There was an extra member of staff on duty each late afternoon into early evening to provide one-to-one staffing to each resident in order to facilitate activities. However, where particular residents had been identified as benefiting from one-to-one support from staff in order to ensure that behaviours of concern did not have a negative impact on other residents, this was not regularly in place. Whilst behaviours of concern were recorded and monitored, the trending of behaviours did not include consideration of the staffing levels at the times of incidents. A series of notifications provided to HIQA, in accordance with requirements, together with unsolicited submitted concern information, indicated that overall the staffing arrangements were not effective in ensuring that all residents were safeguarded against the possible negative outcomes resulting from behaviours of concern in the centre.

The provider had put measures in place to ensure that staff were appropriately supervised in the centre. There was regular structured supervision of staff, and the person in charge was a regular presence. Staff were in receipt of regular training which was found to be up to date. Therefore staff were supported in good practice and staff engaged by the inspectors during the course of the inspection demonstrated knowledge of the support needs of residents.

The provider had systems in place to identify and address areas for improvement, although improvements were required in the monitoring of required actions to sustain quality improvements. There was a schedule of auditing from which any required actions were clearly identified and overseen. Unannounced visits had been conducted on behalf of the provider every six months as required, however the required actions identified during this process were not monitored, so that some were complete and some were not. This did not demonstrate effective quality improvement.

While there were systems in place to record and oversee feedback in the centre, the systems were not always effective. There was information available to residents as to how to make a complaint through easy read documentation and social stories that were clearly displayed in the centre. It was also clear that families of residents knew how to make a complaint. However current and previous complaints were not clearly documented and logged so that it was unclear as to the progress of actions taken. Therefore it was unclear that the system of managing and responding to complaints was effectual.

Overall the oversight of the centre was not always effective, and that this had resulted in negative outcomes for residents.

Regulation 14: Persons in charge

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

of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

Staff were knowledgeable about the support needs of residents, however the numbers and deployment of staff required review in order to meet the needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were appropriately supervised, and were in receipt of up to date training.

Judgment: Compliant

Regulation 23: Governance and management

Governance and management arrangements required review in order to ensure they were response to meeting the needs of the residents. Oversight of the centre was not always effective, and that this had resulted in negative outcomes for residents. The procedures for responding to audit findings were not effective.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All required notifications had been submitted to HIQA

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints policy in place and available in a format accessible to residents. However the complaints log did not include all the required information.

Judgment: Substantially compliant

Quality and safety

The provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, however residents were not safeguarded from the identified risk in relation to the behaviours of concern of other residents.

The designated centre comprised two detached bungalows in close proximity to the local town, each with spacious outside areas. While some aspects of the centre were homely and personalised, there were unresolved maintenance and space concerns. Some of the bathroom attachments were rusting and causing staining, which were both unsightly and indicated an infection control risk. There was also insufficient space to ensure that the needs of residents were met. In one of the houses there was nowhere to store wheelchairs and occupational therapy equipment, both of which were kept in the living room which meant that the communal living area was cluttered and therefore not conducive to a homely living environment. While some of the bedrooms were of a reasonable size, some were very small. There was no evidence of the restricted living space of some residents having been taken into consideration when reviewing behaviours of concern. There was therefore insufficient evidence that the premises were meeting the needs of residents.

There was a system of personal planning in place. Each resident had a personal plan which was based on assessments of both healthcare and social care needs. The personal plans outlined the supports required to maximise the residents' personal development in accordance with their needs, abilities and choices. Personal goals had been identified for residents based on identified needs, and involvement with families. However personal plans had not been made available to residents in a format which was accessible to them, so that they did not have access to the information.

There were detailed assessments relating to the communication needs of residents, and the inspectors observed the implementation of these plans. It was clear that residents had significant support in learning to use augmentative forms of communication such as a picture exchange system and the use of signing and social stories. Systems for assisted communication were well established and effective, so that it was clear that the voices of residents were heard.

Any identified healthcare needs were well managed and monitored. There were detailed healthcare plans in place which provided guidance to staff as to how to manage any healthcare issues. Staff were knowledgeable about the healthcare needs of residents, and the interventions required. Practice was observed to be in accordance with these plans. It was clear that residents were supported to have the best possible health.

Improvements were required in the area of behavioural support. Where residents needed support with behaviours of concern, behaviour support plans had been developed by the multi-disciplinary team, some reviews were undertaken and staff had received appropriate training in the response to behaviours of concern. However, while both proactive and reactive strategies relating to behaviour support were available, the documentation did not indicate review dates so that it was unclear as to when plans were updated. A number of therapeutic interventions were identified in relation to support for residents in this area but not all of these interventions were implemented. Some aids identified to support residents were not available to them and not all required actions following reviews had been implemented. Therefore not all measures were being taken to ameliorate the causes of behaviours of concern.

Residents had access to facilities for occupation and recreation. Some residents were in employment within their local community. Residents were supported to engage in educational activities such as computer courses. Some residents were attending day services and were enthusiastic about their activities. It was apparent that residents were supported to have meaningful activities.

Consultation with residents took place in the form of weekly residents' meetings which facilitated residents to voice their views, and by involving residents and their families in personal planning meetings. There were easy-read documents available to residents in relation to making complaints.

However the rights of residents were not upheld regarding their right to choose their living companions, or to have a home in which they feel safe. There had been a series of incidents whereby residents were not safeguarded from the behaviours of concern of others. All of the incidents had been reported to HIQA as required, however there was insufficient evidence that residents were safeguarded against further incidents. The identified risk had been mitigated to some extent by the implementation of restrictive practices for some residents in order to safeguard them from the behaviours of concern of others, resulting in rights restrictions for them. Recording of restrictive interventions was not adequate, as not all interventions were included in the recording, and records maintained did not include times. There was therefore insufficient data to ensure effective oversight of restrictions.

There were systems in place in relation to the identification and oversight of risks throughout the centre. The risk register listed all identified risks, all of which were risk rated. However the most significant risk at the time of the inspection, which was the risk to residents from living together, was inappropriately assessed and risk rated. The document was a generic organisational risk assessment regarding

residents sharing accommodation, and was rated as a low risk. It did not include any of the information specific to the designated centre. However, it had been clearly identified by the provider that the optimal living environment for one of the residents was to have individual accommodation and support both for the purpose of meeting the needs of the individual, and in order to safeguard others, but this had not been facilitated.

Safeguarding plans had been developed and were available for some residents in relation to this issue, but not for all residents who were at risk. Overall insufficient control measures were in place to ensure the safeguarding of residents in the centre.

The provider had ensured systems were in place to ensure the prevention of fire, and the safe management of any emergency. There was appropriate fire safety equipment available, and fire doors throughout the centre. Each resident had a personal evacuation plan which outlined the support needs in case of an evacuation. The appropriate servicing and maintenance of equipment had taken place, and regular fire safety checks were undertaken and documented. While fire drills had been conducted in the centre these had not included al the residents at one time, therefore the provider could not be assured that all residents could be evacuated in a timely manner in the event of an emergency.

The support and care in relation to residents' health and social care needs was in accordance with their needs and preference in a number of areas. However, a range of improvements were required and this included the systems in place to safeguard residents form the impact of the behaviours of concern of others were not effective.

Regulation 10: Communication

The registered provider had ensured that residents were assisted and supported to communicate in accordance with their needs and preferences.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to have meaningful activities.

Judgment: Compliant

Regulation 17: Premises

The centre required maintenance in some areas. There was insufficient storage for some of the equipment required by residents, and there was no evidence that very small bedrooms for some residents were appropriate to meet their needs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While some risk management procedures were in place, not all risks in the centre were mitigated.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety equipment and fire doors were present throughout the centre, however the provider had not demonstrated that they could effectively evacuate the centre in the event of a fire if all residents were present.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs. However, these plans had not been made available in an accessible format to the residents.

Judgment: Substantially compliant

Regulation 6: Health care

It was found that the residents' healthcare needs were being supported in a proactive manner with evidence or regular check-ups and the provider supporting the residents' to access appropriate services.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were behaviour support plans in place for residents which had been developed with multi-disciplinary input. However, the plans were not always followed as not all prescribed interventions were implemented.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were not safeguarded from the impact of the behaviours of concern of other residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The rights of residents to live in a home in which they felt safe was not sufficiently supported.

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 - 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Meath Westmeath Centre 1 OSV-0003957

Inspection ID: MON-0022111

Date of inspection: 30/04/2019

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing hours have been increased by 19 hours per fortnight to ensure that all individuals are safely supported throughout the day and that 1:1 support where identified as required for certain individuals to pursue specific interests is in place. A review was undertaken by the Area Director and PIC. Staff were redeployed within the Designated Centre to ensure individuals enjoyed opportunities for social and recreational activities that were identified as important. On completion of the review 19 hours of additional support per fortnight were put in place.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC will provide monthly updates to the Area Director in relation to the monitoring of actions arising from 6 monthly audits to ensure identified actions are successfully completed.	

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints log was reviewed by the PIC to ensure clear documentation and progress of actions.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
PIC will ensure identified bathroom attachments are replaced.

Occupational therapy equipment will be stored in the staff room when not in use.
Individual's wheelchair will be stored in individual's bedroom.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register has been reviewed by The Area Director and PIC to ensure appropriate risk rating and location specific risk assessments.
The risk rating was increased and is also specific to the individuals residing within the designated centre.
Use of restrictive practices were reviewed by Area Director, PIC and Behaviour Support to ensure that all restrictive practices were listed and use of same recorded accurately.
This was discussed at the staff meeting of the 08/05/2019.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A night time fire evacuation has been undertaken and all individuals were safely evacuated within three minutes.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Easy read care plans devised and in place and are easily accessible for each Individual. The individuals' key workers will provide support to ensure that people have the opportunity to familiarize themselves with the easy read. This was discussed at the staff meeting of 08/05/19.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Proactive and reactive strategies have been reviewed by behavior support and complied into an easily accessible document.

Recommended therapeutic interventions have been implemented. This was discussed with the staff team on 08/05/19.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding plans have been put in place for the individuals residing within the designated centre.

Staffing hours have been increased by 19 hours per fortnight to ensure that all individuals are safely supported throughout the day.

A review was undertaken by the Area Director and PIC. Subsequently staff have been redeployed within the Designated Centre to ensure regular opportunities for social and recreational activities for the individuals residing within the designated centre.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Staffing hours have been increased by 19 hours per fortnight to ensure that individuals are safely supported throughout the day.

A review was undertaken by the Area Director and PIC. Subsequently staff have been redeployment within the Designated Centre to ensure regular opportunities for social and recreational activities.

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	26/05/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	01/06/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	30/07/2019

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
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.	Substantially Compliant	Yellow	30/07/2019
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	30/07/2019
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.	Substantially Compliant	Yellow	01/05/2019
Regulation 34(2)(f)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/06/2019

	nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/06/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	10/06/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	27/05/2019
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Not Compliant	Orange	27/05/2019

	of his or her disability has the freedom to exercise choice and control in his or her daily life.			