Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Mullingar Centre 4
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	06 June 2019
Centre ID:	OSV-0004213
Fieldwork ID:	MON-0023381

About the designated centre

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

Mullingar Center 4 is a designated centre, providing support for a maximum of five adults with an intellectual disability and high dependency and support needs. The centre comprises of two bungalows situated in a quiet, historical village in North Co. Westmeath, surrounded by Lough Derravaragh. One bungalow has three medium sized bedrooms, one with an en-suite, shower room and a utility room, an open plan kitchen, dining and sitting room and a main bathroom. To the rear of the house is a large fenced enclosed garden and a lawn area to the front of the house. The second bungalow has three medium sized bedrooms, one with an en-suite, shower room and a utility room, an open plan kitchen, dining and sitting room and a main bathroom. There is a large fenced enclosed garden to the rear of the house and a lawn area to the front of the house. Both houses are wheelchair accessible. Services are provided from the designated centre to male adults (i.e. over 18 years old). 24 hour support is provided 7 days a week, with waking night and sleepover staff support. The centre is close to local amenities including shopping centres, numerous pubs/bars and restaurants, cinema, swimming pools and town park. The staff team consists of care assistants and nursing staff. A multi-disciplinary team are also available to provide support in areas including; Occupational Therapy, Physiotherapy, Speech and Language Therapy, Psychology and Behavioural Therapy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 6 June 2019	09:30hrs to 17:00hrs	Sinead Whitely	Lead

Views of people who use the service

The inspector had the opportunity to meet with three residents on the day of inspection. The residents met with used non verbal methods to communicate.

Residents were met with initially in the morning and were observed going about their normal morning routine. One resident liked to listen to music and put their feet up in the morning and this was facilitated by staff. This resident also appeared to have a favourite area to sit and they appeared content sitting in their space. Staff and residents then went out in the service vehicle for the day and went for a drive and for lunch. The inspector had the opportunity to meet residents again in the evening when they returned for dinner.

Warm and familiar interactions were observed by the inspector between staff and residents throughout the inspection day. Residents living in the centre appeared to be a compatible group of individuals who knew each other well and enjoyed living together. The inspector observed two residents smiling and laughing and using non verbal methods of communication. Staff appeared familiar with these communication cues. Families were consulted in the running of the centre, and visits and outings with relatives were facilitated and encouraged by staff.

The inspector had the opportunity to observe two meal times. Both appeared to be relaxed and comfortable experiences. Staff were respectful of residents individual preferences and support needs during these times and choice was offered. There were no complaints communicated with the inspector on the day of inspection.

Capacity and capability

The registered provider had systems in place to ensure that residents experienced a high quality service and that action was taken when improvements were needed. The person in charge had ensured that residents' needs were met and this was evident on the day of inspection from the care being provided.

There was a management system in place with clear lines of accountability. The person in charge in place had a full time post and met all the requirements of the regulation. An annual review of the care and support being provided had been completed and 6 monthly unannounced visits and audits had been carried out by a person nominated by the registered provider. These activities were set up to identify actions and were driving improvements in the designated centre. Residents and their families completed satisfaction questionnaires annually and these were used by the provider in their review of the service provided. Internal audits were also regularly completed by the person in charge in area's including finances,

medications management and care planning. A sample of the centres accident and incident log was reviewed and it was evident that adverse incidents were appropriately responded to.

A series of meetings were held including staff meetings, management meetings and multidisciplinary team meetings. These were used to discuss any issues in the centre and it was evident that these meetings gave the provider, the person in charge and management, clear oversight of the running of the designated centre.

There was a planned and actual staff rota in place that accurately reflected staff on duty. An appropriate level of staff was in place to ensure that the assessed needs of the residents were being met. Regular supervisions and performance management took place between the person in charge and staff working in the centre. These were used to review performance, discuss any ongoing issues and review any outstanding documentation that was part of a key working system in place. There was an on-call management system in place that supported staff outside of regular working hours. The inspector did not have the opportunity to review Schedule 2 staff files on the day of inspection as the location of these was off site.

Staff training records were reviewed and all staff had completed up-to-date mandatory training. This training appeared to be guiding the provision of a good standard of care. Training was being provided in areas including manual handling, safeguarding, medication management, behaviour management, epilepsy management, fire safety, complaints, hand hygiene, infection control and food safety. Staff spoken with appeared knowledgeable regarding the training they had received. There was human resources (HR) team in place that completed regular training needs analysis along with the person in charge to ensure that training was up-to-date and training opportunities were provided if needed.

There was an appropriate complaints policy and procedure in place that was guiding practice when a complaint or concern was raised. A form was in place for residents and their families to submit any complaints, comments or compliments regarding the service being provided. There was a designated person in place to ensure that complaints were then appropriately responded to. The inspector observed the complaints procedure was prominently displayed in the designated centre and this was in line with the service policy.

Regulation 14: Persons in charge

There was a person in charge in place that had a full time post and met all the requirements of the regulation.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual staff rota in place that accurately reflected staff on duty. Regular supervisions and performance management was completed with staff. There was an appropriate levels of staff in place to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed staff training records and found that all staff were up-to-date in mandatory training. This training appeared to be guiding the provision of a good standard of care.

Judgment: Compliant

Regulation 23: Governance and management

There was a robust management system in place with clear lines of accountability. An annual review of the care and support being provided had been completed and 6 monthly unannounced visits and audits had been carried out by a person nominated by the registered provider. These appeared to be driving improvements in the designated centre.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place that met all the requirements of Schedule 1 and accurately described the service being provided.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an appropriate complaints policy and procedure in place. There was a designated person in place to ensure that complaints were appropriately responded to.

Judgment: Compliant

Quality and safety

Overall, the registered provider was promoting a safe and quality service to the residents living in the designated centre. Any actions identified in the previous inspection had been adequately addressed. Management and staff were familiar with residents and their individual needs.

Residents were being supported to maintain their health. A range of multi-disciplinary supports were available including Occupational Therapy, Physiotherapy, Speech and Language Therapy, Psychology and Behavioural Therapy. Relevant referrals were being made by staff when appropriate. Nursing support was also available when needed. An appropriate pain assessment tool was being utilised to identify pain or distress cues for residents with limited or no verbal communication. Records of medical appointments were being maintained by staff and staff were supporting residents to attend any scheduled appointments when needed. Appointments were reviewed annually to ensure residents were being appropriately reviewed in areas including dentistry, phlebotomy, chiropody and ear and eye care. An appropriate assessment tool was utilised to assess the skin viability of residents who were at higher risk of developing pressure ulcers. Monthly checks of weight, blood pressure, temperature, pulse, and respiration were being completed by staff. Residents nutritional status was regularly screened and residents at risk of malnutrition were referred to dietitian services. Care plans were in place for any identified healthcare concerns or conditions and these were subject to regular review.

The inspector reviewed residents assessments and personal plans and found that they were all in place and guided staff to provide care to a good standard daily. There was a key working system in place that ensured all documentation was reviewed regularly by staff that knew the residents well and their individual needs. Social goals were in place for all residents. These were thematic and concentrated on skill building, independence, connecting with family, personal happiness and contributing to home and community. However, some improvements were needed to ensure that personal goals and plans in place were maximising the residents personal development in accordance with their individual needs and preferences. For example, the inspector noted that a holiday away from the centre had not been planned for any of the residents since 2015 and this was not part of any residents goal. Furthermore, some individualised goals and activities completed were repetitive at times and were not promoting residents independence. This was

discussed with the person in charge at length on the day of inspection.

There was appropriate behavioural support in place for residents living in the centre. Positive behavioural support plans were in place and these were subject to regular review. Some therapeutic interventions were used to alleviate causes of resident's challenging behaviour. Residents had access to psychology and behavioural therapy if required. Restrictive practices in place were to minimise an identified and assessed risk and these were subject to regular review with a restrictive practice committee. Any restriction in place had been notified to the Office of the Chief Inspector on the report submitted to the Authority at the end of each quarter of each calendar year. A de-sensitisation program was being introduced into the service, with a view to reduce the level of restrictive practices being utilised. All staff had received training in behaviour management and following any incident of challenging behaviours, the antecedent, behaviour and consequence (ABC) was recorded and reviewed.

In general, the inspector found that medication was being administered safely. A sample of administration records were reviewed and it was found that all medications administrations had been accurately recorded by staff. Self administration assessments had been completed for all residents living in the centre. All staff had received training in the safe administration of medication. Medication prescriptions were in place to guide medication administration. These were subject to regular review with the residents' general practitioner (GP). However, it was observed that an administration time was not detailed for one medication on a prescription. Furthermore, there were protocols in place to guide the administration of medication as required (PRN), however the maximum dose on one protocol was not in line with the dosage detailed on the residents prescription chart.
These increased the risk of medication errors occurring on administration. There was no separate facility in place for the storage of out-of-date or unused medication and some out-of-date topical creams were observed in place in the medication storage unit with current medications, posing a risk that these could be used should the need arise.

The registered provider had ensured there were appropriate safeguarding measures in place to safeguard residents from abuse.There was a designated officer in place to screen any safeguarding concerns. Any concerns raised, initiated an investigation in line with national policy. All staff had been trained in the safeguarding and protection of vulnerable adults and staff spoken with appeared knowledgeable regarding actions to take should a safeguarding concern arise. There were no safeguarding concerns observed on the day of inspection

Appropriate measures were in place for the assessment, management and ongoing review of risks and potential risks in the designated centre. Any identified risks in the designated centre were included on the centres risk register. Individualised risk assessments were also in place. Measures were in place to reduce the risk of injury to residents secondary to self injurious behaviours, falls, swallowing difficulties and behaviours that challenge. Emergency plans for the management of incidents including electrical failures, gas leaks, water failures and flooding were in place. The registered provider had ensured that the vehicle used to transport residents was

road worthy and appropriately insured.

In general, the inspector found that the registered provider had ensured there were effective fire safety management systems in place. Staff were completing daily, weekly and monthly checks on areas including fire detection systems, fire exits and routes, fire panels, internal doors, fire fighting equipment and emergency lighting. Residents needed full assistance to evacuate the centre in the event of a fire and each resident had a personal emergency evacuation procedure in place detailing this. These were subject to regular review by staff. Regular fire evacuation drills took place in the centre and these were reviewed by the person in charge. However, the inspector noted there were no fire doors in place in the designated centre. This meant there was not adequate containment measures in place in the event of a fire. The inspector acknowledges this was a small building and the provider had several measures in place to mitigate the risk as much as possible. The provider was aware of this issue and this had been discussed by management at a health and safety meeting earlier in the year.

Regulation 26: Risk management procedures

Appropriate measures were in place for the assessment, management and ongoing review of risks and potential risks in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

In general, the inspector found that the registered provider had ensured there were effective fire safety management systems in place. However, there was not adequate containment measures in place in the event of a fire

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

In general, medication was being administered as prescribed to whom it was prescribed. However, some improvements were needed with regard to documentation and the arrangements in place for PRN (as required) medications.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

All residents had an up-to-date comprehensive assessment and personal plan in place that was guiding care. These were subject to regular review.

Some improvements were needed to ensure that personal goals and plans in place were maximising the residents personal development in accordance with their individual needs and preferences. For example, the inspector noted that a holiday away from the centre had not been planned for any of the residents since the centre was registered. Furthermore, some individualised goals and activities completed were repetitive and were not promoting residents independence.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was appropriate positive behavioural support in place for resident living in the centre. Residents had access to psychology and behavioural therapy if required. Restrictive practices in place were in place to minimise an assessed risk and were subject to review. All staff had received training in behaviour management.

Judgment: Compliant

Regulation 8: Protection

There was a designated officer in place to screen any safeguarding concerns. There were no safeguarding concerns observed on the day of inspection. All staff had been trained in the safeguarding and protection of vulnerable adults.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to maintain their health. Nursing care was available when needed. An appropriate pain assessment tool was being utilised to identify pain or distress cues for residents with limited verbal communication.

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	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 6: Health care	Compliant

Compliance Plan for Mullingar Centre 4 OSV-0004213

Inspection ID: MON-0023381

Date of inspection: 06/06/2019

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 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The individuals are transferring to a new designated in the coming weeks. In the interim the PIC will continue to audit all fire preventative measures and ensure all fire checks are completed.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The PIC will review each prescription to ensure that the administration time of each medication is detailed. The PIC will ensure that the maximum dose stated on the PRN protocol is the same as stated on the prescription. A locked box is available for storage of unused or out of date medication until the medication is returned to the pharmacy. All topical cream will be labelled with an opening date and will now include an expiry date. All the above actions will be discussed at the monthly meeting	

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: The PIC will review each plan to ensure that the goals identified are in line with the individual's preference and offers opportunities for personal development. The staff team will support the individual with family involvement when possible in identifying the development needs of the individuals in areas such as skill building, community involvement and social 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 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2020
Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	02/09/2019
Regulation 29(4)(c)	The person in charge shall ensure that the	Not Compliant	Orange	02/09/2019

	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.			
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	02/09/2019