Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Meath Westmeath Centre 3
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	10 January 2020
Centre ID:	OSV-0004590
Fieldwork ID:	MON-0025346

About the designated centre

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

The designated centre comprises three locations, all within close proximity to the nearest small town. There is a 3 storey house in a housing estate which provides a full time residential service with a social care staff to five adults with medium support needs. The house consists of an open plan kitchen/dining room and sitting area, utility room, sitting room, five bedrooms (three are ensuite), two bathrooms. There is a garden to the rear of the house. There is also a detached bungalow in another housing estate which provides a full time residential service with a staff nurse, social care workers and support workers to five adults with medium to high dependency support needs. The house consists of five bedrooms (one with an en-suite), one main bathroom, sitting room, kitchen/dining area and utility room. There is garden to the rear of the house. Lastly there is a detached bungalow which provides a full time residential service with social care staff to one resident with medium to high support needs. The house consists of an open plan kitchen/dining/living area, a separate living area, utility room, two bedrooms and a bathroom. There is a garden to the rear of the property.

The organisation provides services to both male and females over the age of 18. All houses have 24 hour staff support with sleepover staff.
Residents are supported to access local amenities including bars, shops, leisure centre/swimming pool and restaurants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Friday 10 January 2020	11:30hrs to 17:00hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

There were ten residents at the time of the inspection, and the inspector met and spent time with five of them. Some of the residents were able to communicate verbally, and the inspector had a chat with them over a cup of tea, and some residents offered to show the inspector their rooms. Residents showed the inspector some of their treasured personal items which were in their own rooms.

Residents told the inspector that they liked everything about living in their house, and said that staff were always there to help them if they needed anything. They said that they felt safe and happy in the house, and some people described how they enjoyed the company of their housemates. They told the inspector about various activities they were engaged in, and explained that they enjoyed these. Some residents who did not communicate verbally were observed to be taking part in various activities, both in the house and in the community, with the support of staff.

Where residents could not communicate verbally, the inspector observed interactions between staff and residents, and saw that staff knew residents very well, and were familiar with their individual ways of communicating. Residents all appeared to be comfortable and at home, and to enjoy their relationships both with staff and each other.

Capacity and capability

The centre was effectively managed. There was a clearly defined management structure in place with clear lines of accountability and appropriate governance processes to ensure consistency of oversight.

The provider had ensured that key roles within the centre were appropriately filled. The person in charge at the time of the inspection, although not present on the occasion of this unannounced inspection, was appropriately skilled, experienced and qualified. Systems were in place to ensure continual quality improvement. Six monthly unannounced visits on behalf of the provider had taken place, and an annual review of the care and support offered to residents had been conducted. Any required actions identified during these processes had been monitored and completed. There was an annual schedule of auditing in place including fire safety and medication management, all of which were overseen by the person in charge. Regular staff meetings were held and again any agreed actions were monitored. These systems ensured continual oversight of the quality and safety of care and support in the designated centre.

The provider had arrangements in place to ensure a consistent and up to date staff team for the most part. The number and skills mix of staff was appropriate to meet the needs of residents. There was a core team of staff, and the occasional requirement for relief staff was managed from cover staff employed by the organisation who were known to residents, or by agency staff who were known to the residents.

Staff were in receipt of regular training and all were knowledgeable about the support needs of residents, and were observed to be implementing any guidance on the support requirements of residents. However one staff members had not received training required to meet particular support needs of residents. Staff supervision took place regularly and it was apparent that staff were supported to provide safe and quality care to residents in accordance with their needs and preferences.

There was a clear complaints procedure in place which was clearly available, and a log was maintained which included a record of both complaints and compliments received, including several recent compliments from relatives of residents.

Therefore the inspector found that oversight of the centre was robust, that issues were addressed in a timely manner, and that the quality of life for residents was upheld.

Regulation 15: Staffing

There were sufficient staff to meet the needs of residents, and consistency of care and continuity of staff was maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training, and regular supervision of staff took place.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and robust systems to monitor the

quality of care delivered to residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were contracts in place which clearly laid out the services offered to residents and any charges incurred.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications were made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure which was available in an accessible version, and residents knew who to approach if they had a complaint.

Judgment: 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, and that their rights were upheld and choices respected.

Each resident had a personal plan in place based on detailed assessments of needs and abilities, each of which were regularly reviewed. There was guidance in each of these plans to ensure that residents had a meaningful life, and access to various activities and interests in accordance with their preferences and abilities.

Healthcare needs were supported, and residents had access to allied healthcare professionals in accordance with their needs. The recommendations of any

consultations were recorded and adopted. Any changing healthcare needs were responded to appropriately and in a timely manner.

A risk register was maintained in which all identified risks, both local and individual, were recorded. The information included a brief description and a risk rating and was reviewed every six months. Each entry referred to a full risk assessment and risk management plan which detailed guidance for staff in the management of the risk. The processes in place indicated that risk management was robust, and that the safety of residents was prioritised.

There was a detailed section in the personal plans in relation to communication for those residents who needed support in this area, based on detailed assessments of need including speech and language therapy assessments. Staff were observed to be implementing these communication plans.

Regular discussions were held with residents to ensure that residents were involved in the day to day running of the house, and a record of these discussions was maintained. Residents' choices and preferences were respected. Rights were upheld for residents in both choice, and in the support to have a meaningful day. Residents were supported to maintain privacy of their personal living areas, and some residents had possession of the key to their rooms. Residents were supported to engage in activities which were meaningful to them, in accordance with their abilities and preferences. There were many and varied activities available to residents.

Where restrictive practices were required to support residents, these were recorded appropriately, and oversight was in place to ensure that they were the least restrictive possible to mitigate the risk. There was an ethos of minimising the use of restrictive practices in the centre, and some restrictions had been discontinued. Where restrictions were found to be necessary, consent had been obtained from either residents or their representatives.

There were systems and processes in place in relation to fire safety, although there was insufficient evidence that fire containment measures were appropriate, or that residents could be evacuated in the event of an emergency at night time. There was emergency lighting and firefighting equipment available. There were self closing fire doors throughout the centre, however one of these was broken, and was observed to be propped open. Whilst fire drills had been undertaken regularly, and residents were evacuated in a timely manner during the day, there was insufficient evidence that this could be replicated in the event of an emergency during the night.

There were robust systems in place in relation to the safeguarding of residents. All staff had had appropriate training and there was a policy in place to guide staff. Staff and the person in charge were aware of their roles in relation to safeguarding of residents. There were no current safeguarding issues.

Overall the provider had systems in place to ensure that residents had a safe and meaningful life, that their choices were respected and that their rights were upheld.

Regulation 10: Communication

Residents were supported in communication so that their voices were heard, and that information was available to them.

Judgment: Compliant

Regulation 11: Visits

Visits were facilitated and welcomed in accordance with residents' preferences.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were provided with appropriate care and support in accordance with their assessed needs and preferences.

Judgment: Compliant

Regulation 18: Food and nutrition

There was adequate food and nutrition in accordance with the needs and preferences of residents.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk register in place including risk ratings, and a detailed risk assessment for each risk identified. There was a risk management policy in place which included all the requirements or the regulations.

Judgment: Compliant

Regulation 28: Fire precautions

While precautions had been taken in relation to fire safety, night time fire drills did not demonstrate that residents could be evacuated in a timely manner, and fire containment was not ensured at all times.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was a personal plan in place for each resident in sufficient detail as to guide practice, including detailed healthcare plans, which had been regularly reviewed with the involvement of the residents and their families.

Judgment: Compliant

Regulation 6: Health care

There was a high standard of healthcare, and there was a prompt and appropriate response to any changing conditions.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were very few restrictive interventions in the centre, and those in place had been assessed appropriately, and residents or their representatives had consented to their use.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to ensure that residents were protected from all forms

of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights were upheld, and no rights restrictions were identified.

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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Meath Westmeath Centre 3 OSV-0004590

Inspection ID: MON-0025346

Date of inspection: 10/01/2020

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: Detecting, containing and extinguishing fires:

Actions completed:

A new door closure was fitted on 17/01/2020 to replace the broken closure.

Night Time Evacuations:

Actions completed:
All individual evacuation plans were reviewed. Night time evacuation drill took place on the 03.02.2020 which took 6 minutes 38 seconds.

Day and night time evacuation drills will continue to take place on an alternative monthly basis. The findings of which are discussed at the monthly staff meeting.

Measures in place to support evacuation;

- Zoned fire detection alarm panel in operation.
- Monitored smoke and fire alarms in every room.
- All doors are 30-minute fire doors.
- All doors closures are operational.
- The fire exits are checked and recorded daily by staff.
- There are 3 evacuation exits.
- Fire extinguishers are in place, serviced and certified annually.
- Staff are all trained in fire safety.
- Fire protection equipment are checked and certified quarterly.

A home safety check sheet to be followed nightly has been devised.

Actions to be completed:

A site visit by the Trim Fire Officer has been requested to familiarize them with the house layout and any recommendations they have to be incorporated into the evacuation plan.

The key system on two fire doors are to be replaced with thumb locks. 13.02.2020

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	Yellow	17/01/2020
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	Yellow	31/03/2020