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:	Mullaghmeen Centre 3
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Announced
Date of inspection:	14 May 2019
Centre ID:	OSV-0005478
Fieldwork ID:	MON-0022627

About the designated centre

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

The designated centre was a detached house in a rural location near to the local town. The house can accommodate four residents, each with their own room, and had suitable communal and private areas. The provider describes the service as offering a high level of support to individuals with an intellectual disability, and additional specific support needs in relation to physical disability, behaviours of concern and healthcare needs. The centre provides 24 hour support with waking night staff.

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
14 May 2019	10:30hrs to 18:30hrs	Julie Pryce	Lead

Views of people who use the service

Three people were living in the centre on the day of the inspection, and the inspector met and spent some time with them. Not all residents communicated verbally, and some were assisted by staff, using various strategies, to communicate with the inspector.

Residents indicated that they were happy with their current living arrangements, and enjoyed the company of staff. Some residents showed the inspector their hobbies, and appeared to enjoy this. All residents appeared to be comfortable and at home.

The inspector also reviewed notes taken of meetings and consultations with residents, and their opinions and preferences were clearly documented, and responded to.

Capacity and capability

Overall 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.

There was a detailed Statement of Purpose in place, which accurately described the service offered to residents.

The provider had ensured that key roles within the centre were appropriately filled. The person in charge at the time of the inspection was appropriately skilled, experienced and qualified. She was a regular presence in the centre and was knowledgeable about the care and support needs of residents. She conducted regular structured supervision of staff, and had clear methods of ensuring effective communication with staff.

The provider had arrangements in place to ensure a consistent and well informed staff team. 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 who were known to residents. Staff were in receipt of regular training and staff engaged by the inspector were knowledgeable about the support needs of residents. Staff supervision took place regularly, both in a structured and unstructured manner. It was therefore evident that staff were supported to provide safe and quality care to residents in accordance with their

needs and preferences.

There were effective systems in place for driving 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. There was a schedule of auditing in place including fire safety and medication management. Regular staff meetings were held at which quality improvements were discussed. These processes identified required actions and the persons responsible for implementing them, and agreed actions were monitored. These systems resulted in various improvements including choices for residents being implemented.

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, and included a record of actions taken to address any issues raised.

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 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

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 22: Insurance

The centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were effective monitoring systems in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider was aware of the requirement to notify HIQA of periods of absence of the person in charge. No absences were anticipated.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

Appropriate arrangements were available in the event of an absence of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place which was available in an accessible version and a complaints log was maintained.

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.

The premises were suitable to meet the needs of residents, and was located in an area which suited the needs of residents. Each resident had their own room, which was furnished and decorated in accordance with their needs. A risk relating to access to the premises under extreme winter weather circumstances had been identified and assesses by the provider. A detailed emergency plan was in place.

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 person in charge had oversight of all risks in the centre, and escalation, if required was to the area director. Accidents and incidents were recorded and reported appropriately, and records maintained included learning outcomes and actions taken to mitigate any risk. These processes indicated that risk management was robust, and that the safety of residents was prioritised.

Each resident had a personal plan in place based on an assessment of needs and abilities, each of which were regularly reviewed. Meaningful goals had been set for each person in accordance with their needs and preferences These goals were reviewed with residents on a monthly basis, and the comments and opinions of residents were recorded on these occasions. This information was made available to residents in a format which was accessible to them, for example wall charts.

Healthcare needs were prioritised, and residents had access to members of the multi-disciplinary team in accordance with their needs. The recommendations of these professionals had informed the healthcare plans and staff had detailed knowledge of the needs of residents.

However, some improvements were required in the system of documenting the personal plans, which did not support clear and consistent maintenance of current information. Not all important information relating to individual issues was located in the same section of the personal plans, so that key pieces of information could be missed. This also led to inconsistency in some of the guidance for staff in relation to healthcare interventions which therefore did not ensure consistent and safe delivery of care.

Where residents could not communicate verbally, or had limited expressive verbal communication, there were detailed communication passports and dictionaries in place which included information about how residents communicated, and also how to ensure their understanding. The inspector observed interactions between residents and staff, and it was clear that staff both understood and were understood by residents.

These systems of communication were also implemented in residents' meetings, or one-to-one discussions where residents preferred not to attend a meeting, which were held regularly to ensure that residents were involved in the day to day running of the house. These meetings and conversations were recorded, and each resident's opinion was included.

Information was made available to residents in a format accessible to them, including information about fire drills, healthcare and risk management plans. This meant that the voices of residents were heard, and that information was made available to them.

Where residents required positive behaviour support, staff were knowledgeable in relation to supports needed. There was guidance in the personal pans in relation to management behaviours of concern, and this was observed in practice to be effective. 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 clear evidence of a reduction

in the use of restrictive practices in the centre. In addition the organisation is in the process of implementing a restrictive practice committee who will have oversight of all restrictive practices, and any restrictions will be referred to this committee. It was apparent by these processes and initiatives that there was an ethos of reducing and minimising the use of restrictive interventions.

There were safe practices in relation to the ordering, storage and administration of medications. All staff involved in the administration of medication had received training. Self administration assessments had been conducted, although all residents required assistance with medication, which was provided safely.

There were systems and processes in place in relation to fire safety. All required fire safety equipment was in place and appropriately maintained. There was a personal evacuation plan in place for each resident, which included the level of assistance required in the event of an evacuation, and strategies to encourage the resident to evacuate if required. Fire drills had been undertaken, including under night time circumstances, and the provider had demonstrated that residents could be evacuated safely in the event of an emergency.

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. Where safeguarding plans were in place these were fully implemented, and were effective in ensuring residents were protected.

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. Some were supported to have pets, and to engage in their hobbies in the grounds of the house. Others were supported to use technology and to avail of local community facilities. Overall the provider had systems in place to ensure that residents had a meaningful life, that their choices were respected and that their rights were upheld.

Regulation 10: Communication

There was clear guidance relating to communication, and this was observed in practice.

Judgment: Compliant

Regulation 11: Visits

Visits were facilitated and welcomed.

Judgment: Compliant

Regulation 12: Personal possessions

A record was maintained of each resident's personal possessions.

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 17: Premises

The design and layout to the premises was appropriate to meet the needs of the residents.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were supported to have a nutritional diet, and to have choice of meals and snacks.

Judgment: Compliant

Regulation 20: Information for residents

Information was available to residents, and important information was made available in a format accessible to residents .

Judgment: Compliant

Regulation 26: Risk management procedures

Appropriate processes were in place to assess and mitigate identified risks.

Judgment: Compliant

Regulation 27: Protection against infection

Effective measures were in place to ensure protection against infection.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Structures and procedures were in place to ensure the safe management of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs. Plans had been reviewed regularly, however the format did not ensure that information was readily retrievable.

Judgment: Substantially compliant

Regulation 6: Health care

Provision was made for appropriate healthcare, although guidance for significant interventions was unclear.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Appropriate systems were in place to respond to behaviours of concern.

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

The rights of residents were upheld, and the privacy and dignity of residents was respected.

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 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullaghmeen Centre 3 OSV-0005478

Inspection ID: MON-0022627

Date of inspection: 14/05/2019

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 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 Person in Charge and staff team will review the individual personal plans with a change of format to ensure all relevant information is readily available. The proposed change will be discussed at staff team meetings	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The Person in Charge will review all healthcare plans and ensure an update of all documents required. The change of protocols will be discussed at the next staff team meeting to ensure all staff are aware of the specific detail and guidance in place.	

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 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/08/2019
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	30/08/2019