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:	Delvin Centre 2
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	10 January 2023
Centre ID:	OSV-0003956
Fieldwork ID:	MON-0034291

About the designated centre

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

The designated centre provides a full time residential service to four adults, with a moderate intellectual disability, autism and behaviours that challenge. The centre comprises a large bungalow on its own grounds on the outskirts of a small town in Westmeath. Each resident has their own bedroom and there are suitable shower rooms, and bathrooms and communal facilities including sitting room, open plan kitchen and dining area. Wheelchair accessible vehicles are available to the designated centre to assist residents attend social activities and day services are provided from within the organisation. The centre is staffed by social care staff at all times when residents are present, with nursing oversight available as this is required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Tuesday 10 January 2023	10:40hrs to 19:20hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, residents were receiving a service that met their needs and they were supported by staff who knew them well. Improvement was required with regard to training and staff development. In addition, some improvements were required in relation to protection, governance and management, risk management, protection against infection, and fire precautions. These areas are discussed further in the next sections of the report.

The inspector had the opportunity to meet all four residents that lived in the centre. Three residents attended separate day service programmes outside of the centre and another worked on an allotment that had some animals. All four residents returned to the centre at the end of their respective day programmes. One resident communicated to the inspector that they had a good day.

Residents were observed to move freely around their home. They were supported at different times by the staff member on duty for the evening. Residents appeared relaxed in their home and contented in each others company. The inspector observed that the residents had alternative methods of communication other than verbal communication, the person in charge and the staff member on duty appeared familiar with these methods. The staff member on duty was also observed to communicate respectfully to the residents.

The inspector also had the opportunity to speak with a member of staff who was finishing their shift prior to them leaving the centre. The person in charge and the staff members spoken with demonstrated that they were familiar with the residents' support needs and preferences.

From a walkabout of the premises, the house appeared tidy and for the most part clean. There was adequate space for privacy and recreation for residents. Personal pictures, canvases and homemade artworks were displayed in different areas of the house.

Each resident had their own bedroom and there was sufficient storage facilities for their personal belongings. Residents' rooms had personal pictures, certificates and medals displayed. Each room was personally decorated to suit the personal preferences of each resident. For example, one resident showed the inspector their room which had their favourite football team stickers and posters displayed.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

Overall, the provider had ensured that there were effective systems in place to provide a good quality and safe service to residents. In addition, the centre was adequately resourced to meet their assessed needs. However, as previously stated, improvements were required in governance and management and training and staff development.

A statement of purpose (SOP) had been prepared for the centre and the inspector reviewed the areas of the SOP that were found to be non-compliant at the last Health Information and Quality Authority (HIQA) inspection. All previously omitted information was found to be included in the document.

There was a defined management structure in place which included, a newly appointed interim person in charge while the permanent person in charge was on a leave of absence. They were supported by the area director, who participated in the management of the centre.

The provider had completed an annual review of the quality and safety of the service and had carried out unannounced visits twice per year. There were other local audits and reviews conducted in areas such as finance, medication management, and health and safety. However, not all actions from audits were signed off as having been completed. In addition, a review of the fire risk register was not taking place in line with the time frame set by the provider.

A review of the rosters demonstrated that the number and skill-mix of staff was adequate to meet the assessed needs of the residents. Staff personnel files were not reviewed on this inspection.

Staff had access to necessary training and development opportunities, such as positive behaviour support training. However, it was difficult to ascertain if staff training was up to date from the training records. From documentation viewed, some staff required refresher training in some areas, such as fire safety training. In addition, there was no evidence to suggest that staff had completed some required infection prevention and control (IPC) training. For example, standard and transmission based precautions or that they received practical hand hygiene assessments from a competent person.

There was no evidence provided to the inspector that formal supervision was taking place for staff in 2022. In addition, a staff member that commenced work in February 2022 had not received any probationary meetings and staff meetings only took place once in 2022.

The inspector reviewed the transition plan for the most recent admission to the centre. There was evidence of the resident being supported to visit the house before their admission. In addition, the plan had also been adapted into a largely picture

based plan in order to support the resident's understanding.

A sample of contracts of care were reviewed and they were found to be signed by the residents' representatives and included fees to be charged.

Regulation 14: Persons in charge

The interim person in charge was suitably qualified and experienced. The person in charge worked on a full-time basis and demonstrated a good understanding of residents and their needs.

Judgment: Compliant

Regulation 15: Staffing

A review of the rosters demonstrated that the number and skill-mix of staff was adequate in order to meet the assessed needs of the residents. Staff personnel files were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a suite of training and development opportunities. For example, staff had access to training related to safe administration of medication and positive behaviour supports. However, it was difficult to ascertain if staff training was up to date from the training records as it was not always reflective of all staff members' actual training or dates.

From documentation viewed some staff required refresher training in some areas, such as fire safety training and IPC training, for example, personal protective equipment (PPE) and hand hygiene. One staff required refresher training in safeguarding and another in manual handling. In addition, there was no evidence to suggest that staff had completed some required IPC training. For example, in standard and transmission based precautions or respiratory hygiene and cough etiquette. Additionally, staff had not received practical hand hygiene assessments from a competent person.

Furthermore, there was no documentary evidence of formal supervision in place for staff as per the organisation's policy for 2022. In addition, a staff member that

commenced work in February 2022 had not received any probationary meetings.

Judgment: Not compliant

Regulation 23: Governance and management

There was a defined management structure in place which included the person in charge and the area manager, who was the person participating in management for the centre.

The provider had completed an annual review of the quality and safety of the service and had carried out unannounced visits every six months. There were other local audits and reviews conducted in areas such as vehicle checks, medication management, and health and safety. However, not all actions from all audits were signed off as having been completed.

In addition, a review of the fire risk register was not taking place in line with the time frame set by the provider. For example, the inspector observed it was reviewed once in 2021 and 2022, however, it was due for review twice per year. Additionally, staff team meetings were found not to be happening regularly. For example, there was evidence to suggest that only one meeting took place in April 2022.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There was evidence of the most recent admission to the centre being supported to visit the house before their admission. In addition, their transition plan had also been adapted into a largely picture based plan in order to support the resident's understanding.

A sample of contracts of care were reviewed and they were found to be signed by the residents' representatives and laid out and fees to be charged to them.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose (SOP) had been prepared and made available to residents. The inspector reviewed the aspects of the statement of purpose that were found to be non-compliant at the last HIQA inspection. All previously omitted information was

found to be included within the SOP.

Judgment: Compliant

Quality and safety

The governance and management arrangements in the centre were found to facilitate good quality, person centred care and support to residents. However, as previously stated improvements were required in relation to protection, risk management, and protection against infection.

The provider had ensured that assessments of residents' health and social care needs had been completed and care plans developed for any identified needs. Staff spoken with were familiar with residents' care and support needs.

The person in charge was promoting a restraint-free environment and there were no restraints used within the centre. Where necessary, residents were referred for specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk.

The inspector reviewed the safeguarding arrangements in place and found that for the most part residents were protected from the risk of abuse. For example, there were clear lines of reporting for any potential safeguarding risks. However, there was a safeguarding incident earlier in the year that wasn't responded to appropriately at the time. While it was addressed after it was brought to the provider's attention, at the time of the incident the system in place was not effective in ensuring appropriate measures were put in place. In addition, residents' finances were not subject to all of the necessary finance audits as per the provider's policy.

The centre was being operated in a manner that promoted the rights of residents. For example, there were weekly residents' meetings and residents were supported to make decisions about their week.

Visits were facilitated with no visiting restrictions in place in the centre. Furthermore, a private area for entertaining visitors was available.

The premises was tidy and for the most part found to be clean and in a good state of repair. There were some outstanding maintenance works and some areas required a more thorough clean, for example the extractor fan. Any identified issues are being dealt with under Regulation: 27.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a policy on risk management available. However, some control measures in some of the centre's risk assessments were found to be not applicable or not being used in practice. In addition, all residents' individual risk assessments were found to be outside of the provider's review time frame.

Furthermore, equipment used to support residents was not serviced in 2022.

The inspector reviewed matters in relation to infection control management in the centre. The provider had systems in place to control the risk of infection both on an ongoing basis and in relation to COVID-19. However, gaps were identified on the centre's cleaning schedule and some areas required a more thorough clean, such as the toilet chair used to support a resident. In addition, some areas required repair or replacement to ensure they could be cleaned effectively.

There were systems in place for fire safety management and the centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place including scenarios used. Residents had up-to-date personal emergency evacuation plans (PEEPs) in place which outlined how to support residents to safely evacuate in the event of a fire.

However, some fire containment doors had a larger than recommended threshold gap and some doors did not have cold smoke seals fitted. In addition, the frequency of fire drills conducted within the centre was not in line with the centre's statement of purpose which stated that monthly drills occur.

Regulation 11: Visits

Visits were facilitated with no visiting restrictions in place in the centre. Residents were supported to maintain contact with their family and friends. Furthermore, a private area for entertaining visitors was available.

Judgment: Compliant

Regulation 17: Premises

The premises was tidy and for the most part found to be clean and in a good state of repair. There were some outstanding maintenance works and some areas required a more thorough clean, for example the extractor fan. Any identified issues are being dealt with under Regulation: 27.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk and keep residents safe in the centre. There was a policy on risk management available and each resident had

a number of individual risk assessments on file so as to support their overall safety and wellbeing. However, some control measures in some of the centre's risk assessments were found to be not applicable or not being used in practice. For example, with regard to the risk assessment in place for ensuring privacy to residents, one of the control measures in place was to use accessible privacy signage but this was found not to be in place. In addition, all residents' individual risk assessments were found to be outside of the provider's review time frame.

Furthermore, equipment used to support residents was not serviced in 2022 and while the person in charge had requested the servicing of the items, there was no set date provided for when this would take place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspector reviewed matters in relation to infection control management in the centre. The provider had systems in place to control the risk of infection both on an ongoing basis and in relation to COVID-19. For example, there was colour-coded cleaning equipment used in the centre in order to minimise cross contamination. However, gaps were identified on the centre's cleaning schedule. In addition, some areas required a more thorough clean, such as the toilet chair used to support a resident and some kitchen presses.

Some of the maintenance issues identified on this inspection had already been highlighted by the person in charge or staff members and reported to maintenance. However, at the time of this inspection there was no arranged date for repairs. For example, a lot of windowsills and walls had peeling or chipped paintwork and some areas had chips in the wall plaster. Repair of these areas was required to maintain a finish that enabled effective cleaning. Furthermore, some mildew was observed in the washing machine and around some windows and windowsills.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management and the centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place including scenarios used. Residents had up-to-date PEEPs in place which outlined how to support residents to safely evacuate in the event of a fire. However, some fire containment doors had a larger than recommended threshold gap and some doors did not have cold smoke seals

fitted.

In addition, the frequency of fire drills conducted within the centre was not in line with the centre's statement of purpose which stated that monthly fire evacuation drills occur. The inspector saw evidence of six drills that took place in 2022. Additionally, two fire containment doors did not close fully by themselves, however, this was rectified by the provider on the day of the inspection with evidence shown to the inspector.

Subsequent to the inspection, the provider submitted information to the inspector on works they intended to complete in order to address all identified areas that were identified on this inspection. However, at the time of this report the works had a proposed date and they were yet to commence.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that assessments of residents' health and social care needs had been completed and care plans developed for any identified needs. These assessments, along with residents' support plans, were under regular review and demonstrated that multidisciplinary professionals were involved in the development of care being provided. Care and support was provided in line with their care needs and any emerging needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge was promoting a restraint-free environment and there were no restraints in operation within the centre at the time of this inspection. Previous environmental restrictions were removed once deemed no longer necessary. Where required, residents were referred for specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk.

Judgment: Compliant

Regulation 8: Protection

Safeguarding arrangements in place which for the most part protected residents from the risk of abuse. For example, there were clear lines of reporting for any

potential safeguarding risks.There was one open safeguarding that was being investigated by the provider. There had been unforeseen events that caused delay in the timely completion of the investigation, however, the inspector was informed that the investigation was due to be completed within the coming weeks.

However, there was another safeguarding incident earlier in the year that wasn't responded to appropriately at the time. While it was addressed after it was brought to the provider's attention, at the time of the incident the systems in place were not effective in ensuring appropriate measures were put in place. In addition, residents' finances were not subject to all of the necessary finance audits as per the provider's policy. For example, from a sample of three residents' finances they had received four out of six financial audits due in 2022.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control in different area from activities they participated in, food they ate and promoting their independence skills. For example, one resident was developing their independence skills by learning to withdraw their disability allowance themselves without staff support.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Delvin Centre 2 OSV-0003956

Inspection ID: MON-0034291

Date of inspection: 10/01/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • PIC has undertaken a full review of all staff training records and in consultation with training department is scheduling dates for all outstanding staff training required. • PIC has contacted all staff with outstanding HSELanD training requirements (IPC and SPVA) and this outstanding training completed as of 07/02/2023 • PIC has arranged date – 22/02/2023 for Hand Hygiene Assessment to be completed by organisation's IPC Lead with all staff in designated centre. • PIC has developed staff supervision schedule for 2023 which has been distributed to all staff on 7/02/2023 • All outstanding probationary meetings with staff have been completed as of 03/02/2023	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC is completing an in-depth review of all audits from 2022- inc. Six Monthly Audits, Annual Review and has workplan to complete all outstanding actions. • Review of Fire Register completed by Fire Officer on 09/02/23. Schedule of Fire register Biannual Review in place for 2023 • Schedule of staff team meetings in place for 2023.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • All induvial risk registers are being reviewed and updated by keyworkers with support of PIC, ensuring all control measures applicable are in place. • Equipment to be reviewed by OT on 15/02/23	
Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: • PIC has reviewed annual cleaning records, discussed same at January 2023 staff team meeting to ensure all staff are aware of cleaning schedule to be completed on a daily, weekly, and quarterly basis. • Staff have completed thorough cleaning of all kitchen presses and maintain same through weekly cleaning schedule. • Cleaning of resident's equipment including toilet and shower chairs and cleaning of washing machine, and management of mildew on windows/windowsills now included in daily cleaning schedule- 01/02/2023. • Work Request forwarded to maintenance team to repair peeling and chippings on walls and windowsills

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire doors- all outstanding work on fire doors has been completed on 30/01/2023. All threshold gaps have been fitted with additional wood strips and painted with intumescent fire paint coating. • Cold smoke seals fitted to all fire doors requiring same – 26/01/2023 • Schedule of fire drills completed for 2023, importance of adherence to same discussed at January 2023 staff team meeting.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • All staff have completed Safeguarding of Vulnerable Adults training. PIC and staff team are aware of responsibility to recognize and respond to allegations of abuse within guidance set by National Safeguarding Office and reporting structure internally in Muiriosa Foundation. All safeguarding concerns are notified to the designated officer and Area Director on the same day. This was discussed with all staff members at the January 2023 staff team meeting. • All resident's financial audits completed and up to date by PIC- 31/01/2023 • Safeguarding Designated Officer will facilitate staff training and information session in March 2023	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2023
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	30/04/2023
Regulation 26(2)	The registered	Substantially	Yellow	25/02/2023

	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.	Compliant		
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	28/02/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is	Substantially Compliant	Yellow	31/01/2023

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/01/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	31/01/2023