



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

Issued by the Chief Inspector

Name of designated centre:	Mullaghmeen Centre 4
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	22 September 2021
Centre ID:	OSV-0005479
Fieldwork ID:	MON-0034309

About the designated centre

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

The designated centre is a detached bungalow in close proximity to the nearest small town which can accommodate up to three adult (male and female) residents, each with their own room, and with suitable communal and private areas. The provider describes the service as supporting individuals with modern to severe intellectual disabilities and additional specific support needs in relation to physical disability, behaviours of concern, autism and mental healthcare needs. The centre is staffed 24 hours a day, with sleepover staff at night. The staff team comprises social care workers and support staff. The residents are supported to access local amenities including leisure facilities, shops, bars and restaurants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2
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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
Wednesday 22 September 2021	10:30hrs to 18:00hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This was an unannounced inspection in order to monitor compliance with the regulations and standards. The inspector made observations, reviewed documentation, spoke to staff and the person in charge, and observed the daily life of the two residents who live in the centre. While residents appeared to be comfortable in their home, and content in the presence of familiar staff, they did not choose to interact with the inspector in any way. This choice was respected and the inspector observed unobtrusively.

On arrival at the centre, the inspector observed that residents appeared to be very comfortable in the designated centre, and were seen to be utilising all areas of their home. The home that had been developed for residents was individual to them. Each had their own bedroom which was personalised, nicely furnished and individual to each and suited to their needs. There were outside areas specific to the needs of individual residents. This was particularly important to one of the residents who was observed to enjoy their time outside and to have a preferred space in which to spend time. A gazebo area had been designed and maintained for this purpose together with family members and this was nicely furnished and decorated, including sensory items in accordance with the preferences of the resident.

Another resident preferred to spend time in one of the communal areas, and to have the freedom to wander about as they chose. There were several distinct areas in the house so that each resident could choose an area in which to spend time.

However, on the morning of the inspection, and throughout the day there were few activities available to residents. One resident accompanied a staff member undertaking errands in the morning, and another was facilitated in going for a walk to an area they enjoyed later in the day, but these were the only activities observed by the inspector.

While the activities of residents had been curtailed to some extent due to the current public health restrictions, efforts to ameliorate these restrictions appeared to have dwindled. During the public health crisis, one of the residents lost their regular day service, and this was replaced with an outreach service for three days each week. At the time of the inspection this had been reduced to one morning each week, and there was no evidence of activities to replace this.

While residents did not communicate verbally, the inspector observed staff using various strategies to ensure effective communication, including gestures and speech designed to meet the needs of residents. It was clear that staff were familiar to residents, and that residents were comfortable in their presence. The wishes of residents to have their own space and to be in their chosen areas of the home was evidently understood and respected by staff.

Contact with family and friends had been facilitated throughout the public health

crisis, and when visits had been curtailed, staff had supported residents with regular phone and video calls. Detailed protocols were in place, and all efforts had been put in place to ensure residents had continued involvement with their families. As restrictions lifted, it was clear that staff had an in depth knowledge of the preferences of residents in relation to visits, and that areas were available to support this, and that space to support their preferences was prioritised.

There was a vehicle for the sole use of residents to facilitate outings, which was maintained in accordance with safety standards. There was substantial parking space to accommodate the vehicles of the centre, and those of visitors.

There was a clear system to address potential complaints. There were no current complaints, but a complaint received earlier in the year had been addressed in accordance with the centre's comprehensive complaints policy, and was recorded to have been resolved to the satisfaction of the complainant.

In summary, the inspector found residents' safety was prioritised and maintained, but that some improvements were required to ensure the best quality of life for residents.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The provider had ensured that there was a management structure in place that was led by a person in charge. The person in charge was appropriately qualified and experienced and was a regular presence in the centre. The provider had completed the required reviews and reports focusing on the quality and safety of care provided in the centre in accordance with the regulations. An annual review of quality and safety of care and support in the centre had been completed, and six monthly unannounced visits had been conducted. A series of audits had been undertaken, and required actions identified by these processes had been implemented.

The person in charge had on-site methods for the monitoring and oversight of required actions. Some of the issues identified during the inspection, such as communication with residents, although not yet addressed, had been identified by the person in charge. However, issues in relation to fire safety had not been mitigated, and an urgent action issued to the provider was not addressed adequately in the first instance. A second response was required, and this response adequately mitigated the risk.

Staffing numbers and skills mix were appropriate to meet the needs of residents and there were sufficient staff on a daily basis. Any vacancies were covered by staff familiar to residents. The person in charge gave assurances that all staff training

was up to date, and investigation by the inspector supported this assertion. However the records were not easily available and, and there was insufficient evidence of oversight in this matter.

Staff supervision conversations were undertaken regularly, and annual appraisals were complete. These conversations covered various issues and were a meaningful reflection of issues within the centre.

There was a clear system to address complaints. While there were no current complaints, a complaint received earlier in the year had been addressed in accordance with the centre's comprehensive complaints policy, and was recorded to have been resolved to the satisfaction of the complainant.

Overall, the provider and person in charge had ensured that some of the systems in place to provide good quality and safe service to residents were effective, but that improvements were required to ensure the safety of residents.

Regulation 14: Persons in charge

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

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents. Both planned and actual rosters were available, and all staff were familiar to 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 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were various monitoring systems in place, however these had failed to identify or address several issues including maintenance requirements, difficulty in retrieving information and in particular fire safety, indicating insufficient oversight overall.

An urgent action required following the inspection was not adequately addressed in the first instance, although the subsequent submission addressed the issue and mitigated the identified risk.

Judgment: Not compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. A complaints log was maintained, and complaints were recorded and acted on appropriately.

Judgment: Compliant

Quality and safety

The centre was being operated in a manner that promoted and respected the rights of residents to a large extent, although improvements were required to ensure that the quality and safety of care and support was meeting all the needs of residents.

While the premises were suitable to meet the needs of residents, significant maintenance requirements had not been addressed. On arrival at the house the inspector immediately noticed that the external aspect of the house was not

maintained. The fascia boards were unclean and covered in debris and insect nests. Internally there was scuffed paintwork down to the wood or metal in the case of radiators in several areas and there was mould on the ceilings of a bathroom and one of the resident's bedrooms.

Infection control systems and processes were in place for the most part. Significant work had taken place to ensure that residents' choices in relation to vaccination were supported, including detailed programmes to allay anxiety around inoculation processes. However, some of the checks relating to staff adherence to infection control policies had not been monitored, and oversight of these processes was insufficient. The centre's contingency plan developed to manage any potential outbreak of an infectious disease did not include plans to replace staff in the event of a serious outbreak.

Restrictive practices in the centre were monitored, and there was a clear strategy to reduce any restrictions. Records showed that restrictive practices had been systematically reduced, and that any in place were the least restrictive to ensure the safety of residents. This included the management of medications, and there was evidence of medications being reduced in liaison with the relevant healthcare professionals.

Communication with residents was effective on a daily basis. Interactions observed by the inspector indicated that staff were familiar with residents and that their communication with them was adequate on a day to day basis. Some of this information was documented in personal plans, but not in sufficient detail. In addition, a review of residents meetings did not demonstrate that these were inclusive for residents, and indicated that they were actually meetings between staff in the presence of residents. There was no record of their involvement and no evidence that these meetings were in any way meaningful for residents.

Personal plans were in place for each resident, and these were regularly updated, Most of the care plans were detailed and gave clear guidance to staff, although the information was not easily retrievable. However, evidence of assessments of needs was not available for all residents, and there was insufficient evidence that all areas of personal planning were meaningful.

Healthcare was well managed, all healthcare needs had been addressed, and appropriate referrals to members of the multi-disciplinary team had been made as required. Additional supports had been put in place to enable residents to avail of appointments in accordance with their abilities and needs. Medications were overseen, and it was clear that the person in charge sought regular reviews of medications, and that there was effective oversight which had resulted in a reduction of medications in some instances.

Fire safety had not been addressed appropriately. While fire safety equipment was in place, fire drills did not demonstrate that all residents could be evacuated in a timely manner. The inspector reviewed documentation of fire drills and found that where residents refused to comply, there was no contingency plan in place. Records of fire drills showed that where a resident refused to evacuate, the drill was

discontinued without an evacuation, and without any plan to resolve the risk. An urgent action requirement was issued to the provider. The initial response did not demonstrate that the risk was mitigated, and further action was required immediately. The provider then submitted assurances that the risk was mitigated.

A detailed risk register was in place which identified both environmental and individual risks. Risk assessments and management plans were in place for each, and there was a system of oversight by senior management. There was a clear system in place for the oversight of any accidents and incidents. Any accidents or incidents were appropriately reported and recorded, and risk assessments developed in liaison with and established safeguarding team..

There were no current safeguarding issues. There was, however, a detailed policy relating to the prevention, detection and response to allegations of abuse, and this was an item discussed at team meetings. All staff were in receipt of up to date training in this area. The provider had ensured that there were systems in place to respond to safeguarding concerns.

Regulation 10: Communication

Communication between staff and residents was meaningful, however, residents meetings took the form of staff discussions in the presence of residents without their involvement, and there was no evidence of effective systems to elicit the views of residents.

While there was some information in personal plans as to residents' means of communication, there was insufficient information to provide guidance to staff in effective communication.

Judgment: Substantially compliant

Regulation 11: Visits

Visits were facilitated and welcomed, and additional strategies had been put in place to ensure contact with families was maintained.

Judgment: Compliant

Regulation 17: Premises

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

residents and significant adaptations were in place to support the needs of residents. Some maintenance issues had been addressed, and there was new flooring in place. However, there were various areas of maintenance outstanding, including cleaning of external areas, badly scuffed paintwork and visible mould in two rooms in the house.

Judgment: Substantially 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 of the regulations.

Judgment: Compliant

Regulation 27: Protection against infection

Significant infection control measures were in place to ensure the safety of residents, including a completed self assessment, and individual 'self preparedness plan' for each resident and a contingency plan. However, some of the checks relating to staff adherence to infection control policies had not been monitored, and oversight of these processes was insufficient. The centre's contingency plan developed to manage any potential outbreak of an infectious disease did not include plans to replace staff in the event of a serious outbreak.

There was mould on the ceilings of one of the bathrooms and one of the resident's bedrooms and no evidence of plans to mitigate any infection control risk that this might indicate.

Judgment: Not compliant

Regulation 28: Fire precautions

There was appropriate fire equipment including fire doors throughout the centre, and all equipment had been maintained and certified. However the records of fire drills showed that where a resident did not comply with evacuation, the attempt was aborted, and there was no indication that the resident could be evacuated in a timely manner in the event of an emergency.

There had been no fire drills undertaken under night time circumstances where only

one staff member is on duty, and therefore no evidence that a successful evacuation could take place at night.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

While personal plans were in place, not all residents had a detailed assessment of needs in place on which to base a plan of care. Information about residents was stored in multiple files, and was not easily retrievable.

There was insufficient evidence that goals for residents, which were documented in their personal plans, were designed to meet the needs of residents. Information relating to the activities of residents was not easily available, and there was no evidence that this issue was monitored.

While communication with residents presented challenges, there was insufficient evidence of personal plans being made accessible to them.

Judgment: Substantially compliant

Regulation 6: Health care

There was a high standard of healthcare, and there was a prompt and appropriate response to any changing conditions. Additional supports had been put in place to ensure residents had access to healthcare appointments.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was good oversight of restrictive practices which had resulted in the discontinuation of some restrictive measures in accordance with the needs and rights of residents.

Judgment: Compliant

Regulation 8: Protection

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

Judgment: Compliant

Regulation 13: General welfare and development

Some of the activities lost to residents during the public health crisis had been replaced in the short term, but there was insufficient evidence that this had been maintained in a meaningful way. Some of the strategies put in place had now been discontinued or reduced and had not been replaced.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 13: General welfare and development	Substantially compliant

Compliance Plan for Mullaghmeen Centre 4 OSV-0005479

Inspection ID: MON-0034309

Date of inspection: 22/09/2021

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Monthly audits have been amended to capture the relevant information required to ensure good governance of the Centre. The audits have been implemented with immediate effect.	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: Both residents now have a communication passport in place which details the most effective communication methods to be used. These are going to be treated as ‘live’ documents and reviewed and updated on a regular basis. Lamh training has been sought for the staff team. Documentation is being reviewed with a view to being user friendly and informative and given in such a way that both residents can fully understand. Positive Behaviour Support input has been sought and recommendations from a previous SLT report are being implemented.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
 The mould in the bathroom and one of the resident's bedroom has been rectified. Internal painting of all rooms has taken place since the inspection. Externally the house has been cleaned. Painting of the outside of the house is due for completion by 31st March 2022.

Regulation 27: Protection against infection	Not Compliant
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Outline how you are going to come into compliance with Regulation 27: Protection against infection:
 The mould in the bathroom and resident bedroom has been rectified. It has been treated To ensure that the mould does not reappear.
 A local area contingency plan is being developed and is in the draft stages. The contingency plan will be completed by 30th November 2021, upon completion it will be placed in the Centre.
 Checks are taking place on a daily basis and any non-compliance by staff is noted and addressed immediately.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
 A night time drill has taken place under the observation of the PIC with one staff member. This drill was successful. Weekly simulated drills take place in addition to the monthly drills. An urgent response was given by the management team in regards to this matter immediately after the inspection. Both residents PEEPS have been reviewed and updated to reflect new learning.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
 An easy read version of the care plan will be introduced. This will reflect the details noted

in the resident's main care plan, but will be in an accessible version for the resident. The number of files for each resident has been reduced and information is now easily accessible.

A complete review of the goals has taken place, which has brought about a change in goals and goal setting. A new key working report has been introduced which allows for the goals to be reviewed on a monthly basis and tracks the progress.

Regulation 13: General welfare and development

Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

A complete review of the schedules for each resident has taken place. A schedule will be put in place to replicate that of the outreach received for one resident. The day shift time has changed to utilise to the fullest the second staff on duty and allow for meaningful activities to take 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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/11/2021
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/11/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests,	Substantially Compliant	Yellow	30/11/2021

	capacities and developmental needs.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	08/11/2021
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.	Not Compliant	Orange	08/11/2021
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	Not Compliant	Orange	30/11/2021

	control of healthcare associated infections published by the Authority.			
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	Red	24/09/2021
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 reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	08/11/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but	Substantially Compliant	Yellow	30/11/2021

	no less frequently than on an annual basis.			
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	30/11/2021
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	30/11/2021
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	30/11/2021