# Office of the Chief Inspector

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

| Name of designated centre: | Mullaghmeen Centre 2 |
|---|---|
| Name of provider: | Muiríosa Foundation |
| Address of centre: | Westmeath |
| Type of inspection: | Announced |
| Date of inspection: | 28 May 2019 |
| Centre ID: | OSV-0005477 |
| Fieldwork ID: | MON-0022626 |

## About the designated centre

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

The designated centre is made up of a detached bungalow which can provide support to five adults with high support needs, and two self contained apartments which can provide supported living for two residents living independently. Both locations are in close proximity to the local town.
The provider describes the service as offering support for up to seven adults with an intellectual disability, and with specific support needs in relation to behaviours of concern, high dependency needs, mental health needs, sensory Impairment and autism.
The centre is staffed over 24 hours, with waking night staff in the bungalow, and sleepover staff in the apartments.

**The following information outlines some additional data on this centre.**

| Number of residents on the date of inspection: | 6 |
| --- | --- |

## 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 |
|---|---|---|---|
| 28 May 2019 | 10:00hrs to 19:00hrs | Julie Pryce | Lead |

## Views of people who use the service

There were six residents on the day of the inspection, and the inspectors spoke to and spent time with all six people. Some residents were happy to meet the inspector and readily engaged in conversation. Others indicated that they did not wish to interact, and were supported by staff to engage in activities of their choice.

Some residents showed the inspector round their home, in particular how their homes and gardens had been arranged to support their hobbies. Some residents told the inspector about their daily activities and preferences, which were supported by the service.

It was clear that residents were consistently consulted about the running of the centre, and that their voices were heard. Where residents had indicated a preference for independent but supported living had been facilitated and residents were seen to be settled and happy in their own homes.

## Capacity and capability

The centre was effectively managed to meet the needs of the residents The provider had ensured the centre was appropriately resourced. There was a clearly defined management structure in place with clear lines of accountability and appropriate governance processes to ensure consistency of oversight.

The provider had ensured that key roles within the centre were appropriately filled. The person in charge at the time of the inspection 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 had oversight of all aspects of care and support in the centre via an system of audits and communication with staff.

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

The provider had arrangements in place to ensure a consistent and up to date staff team for the most part. The number and skills mix of staff was appropriate to meet the needs of residents. There was a core team of staff, and the occasional requirement for relief staff was managed from cover staff employed by the organisation who were known to residents. Staff were in receipt of regular training, although there were some gaps in fire safety training and hand hygiene training. Staff engaged by the inspector were knowledgeable about the support needs of

residents, and were observed to be implementing any guidance on the support requirements of residents. Staff supervision took place regularly and it was apparent that staff were supported to provide safe and quality care to residents in accordance with their needs and preferences.

Systems were in place to ensure continual quality improvement. Six monthly unannounced visits on behalf of the provider had taken place, and an annual review of the care and support offered to residents had been conducted. Any required actions identified during these processes had been monitored and completed. There was a schedule of auditing in place including fire safety and medication management, all of which were overseen by the person in charge. Regular staff meetings were held and again any agreed actions were monitored. These systems resulted in various improvements including a reduction in restrictive practices and improved communication for residents.

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, and had clear oversight of the centre.

Judgment: Compliant

## Regulation 15: Staffing

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

Judgment: Compliant

## Regulation 16: Training and staff development

A suite of training courses were offered to staff, however some staff needed up to

date training in fire safety and hand hygiene.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

## Regulation 22: Insurance

The centre was appropriately insured.

Judgment: Compliant

## Regulation 23: Governance and management

There was a clear management structure in place and robust systems to monitor the quality of care delivered to residents

Judgment: Compliant

## Regulation 3: Statement of purpose

The statement of purpose contained all the information required by the regulations, and accurately described the service provided.

Judgment: Compliant

## Regulation 31: Notification of incidents

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

Judgment: Compliant

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

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

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

Judgment: Compliant

## **Quality and safety**

The provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, and that their rights were upheld and choices respected.

The premises were suitable to meet the needs of residents. Some residents who had expressed a wish to live independently were supported in their own apartments. Each resident had their own room, which was furnished and decorated in accordance with their needs, including residents being supported to choose the colour of the paintwork in their rooms. Therefore the rights of residents to have control over their living environment was respected and supported.

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. Residents were supported towards the achievement of these gals, and the quality of life for residents had steadily improved under this system.

Healthcare needs were supported, including health promotion such as smoking cessation support. Residents had access to allied healthcare professionals in a accordance with their needs, and the recommendations of any consultation s were adopted. However the system of recording personal plans, particularly healthcare plans was not organised in a way the guidance for staff was readily available. Information relating to specific healthcare needs was not all located in the same place in the personal plans, the structure of the plans being such that it was unclear where information should be stored, and therefore located when required. Therefore guidance to staff around significant issues could easily be overlooked and consistency and safety of care delivery was not ensured.

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. However there was an identified risk in relation to the external lighting to the emergency assembly area which had not been mitigated. With this exception, overall the processes in place indicated that risk management was robust, and that the safety of residents was prioritised.

Where residents required support with communication there were detailed communication passports in place which included information about how residents communicated, and also how to ensure their understanding. Staff had undertaken additional training in augmentative communication in response to the specific needs of some residents. The inspector observed interactions between residents and staff, and it was clear that staff both understood and were understood by residents.

Regular discussions were held with residents to ensure that residents were involved in the day to day running of the house, and a record of these discussions was maintained. Residents choices and preferences were a priority, and various improvements and changes had been made in response to expressed preferences. Some residents were learning new skills and were being introduced to new experiences. Rights were upheld for residents in both choice, and in the support to have a meaningful day. 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 including employment and small business ventures, which they had been supported to develop based on their preferred activities and hobbies.

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 has a restrictive practice committee who has oversight of all restrictive practices, and any restrictions are 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 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.

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

## Regulation 10: Communication

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

Judgment: Compliant

## Regulation 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 26: Risk management procedures

Appropriate processes were in place to assess and mitigate identified risks for the most part, although an identified risk relating to external lighting required in an emergency situation had not been mitigated.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Adequate precautions had been taken against the risk of fire.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

There was a personal plan in place for each resident based on an assessment of needs, however the structure of the plans meant that information was not clear or easily retrievable

Judgment: Substantially compliant

## Regulation 6: Health care

Provision was made for appropriate healthcare.

Judgment: 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 | Substantially 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 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | 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 9: Residents' rights | Compliant |

# Compliance Plan for Mullaghmeen Centre 2 OSV-0005477

## Inspection ID: MON-0022626

## Date of inspection: 28/05/2019

**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:**

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• The Person In Charge will ensure all staff receive fire training and hand hygiene training and records are updated.</td></tr>
<tr><td>Regulation 26: Risk management procedures</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>• The Person In Charge will liaise with HSE maintenance department to complete works to outdoor lighting.<br>• The Person In Charge will update current risk in place and review accordingly.</td></tr>
<tr><td>Regulation 5: Individual assessment and personal plan</td><td>Substantially Compliant</td></tr>
</table>

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 carry out a review of personal plans to include all relevant detail and assessment of health and social care needs.
• The Person In Charge and staff team will ensure that all indexes are updated to ensure information is easily retrievable.

## 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. | Substantially Compliant | Yellow | 30/09/2019 |
| Regulation 26(2) | The registered 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. | Substantially Compliant | Yellow | 30/09/2019 |
| Regulation 05(4)(a) | The person in charge shall, no later than 28 days after the resident is admitted to the | Substantially Compliant | Yellow | 30/09/2019 |

| | designated centre, prepare a personal plan for the resident which reflects the resident’s needs, as assessed in accordance with paragraph (1). | | | |
|---|---|---|---|---|