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:	Mullaghmeen Centre 2
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	06 June 2024
Centre ID:	OSV-0005477
Fieldwork ID:	MON-0038330

About the designated centre

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

The designated centre provides support to two adults (male or female) with intellectual disabilities in two self contained apartments located in close proximity to the local town. The provider describes the service as offering support for up to two adults (male and female) 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 sleepover staff overnight. Residents have access to local amenities including restaurants, shops, leisure facilities and library. The staff team comprises social care staff and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Thursday 6 June 2024	11:00hrs to 15:30hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection conducted in order to monitor on-going compliance with regulations and standards.

The two residents living in this designated centre each had their own self-contained apartment and lived independently of each other. Each resident had their own living area/kitchen, bedroom and bathroom, and each was furnished and decorated in accordance with their preferences.

On arrival at the centre the inspector was greeted by one of the residents and invited into their apartment. The resident was smiling and appeared to be comfortable with the visit. They were preparing for an outing and talked about the walk they were going on, and the treats they would like to get whilst they were out.

The inspector observed the preparations for the outing, and saw that the resident went to get the key to a locked drawer and collected some of their money from the money box in the drawer. They identified the amount that they wanted and took it out of the money box.

The preparations also included taking required medications, and the resident approached the staff member with their glass of water ready to take their tablets. They then said that they were going out to the car, indicating the close of the visit, and 'high-fived' the inspector as a goodbye.

The inspector also visited the second apartment, and the resident greeted them and said 'welcome to my house'. They were having coffee with the staff member, and having a chat about their shopping list and a purchase they wished to make. The resident asked the inspector if they were from HIQA, and was aware of the purpose of the visit. They also chatted about ringing their mother.

The resident was also getting ready to go out, and the inspector saw them put their shopping list in their purse, and get their 'thick and easy' drink thickener ready to take out with them. The inspector asked about this and the resident explained the purpose in their own words. The staff later explained that this was in accordance with the recommendations of the Speech and Language Therapist (SALT) and showed the inspector a social story which had been developed to assist the resident to understand the requirement.

The inspector reviewed the records in relation to activities and events for residents, and it was evident that they had full lives and were involved in various activities and community groups, and that they were making daily decisions and choices for themselves. Staff and the person in charge discussed with the inspector the ways in which they supported residents to maintain their independence, including supporting them to have time alone in their apartments.

Overall residents were supported to have a comfortable and meaningful life, with an emphasis on supporting choice and preferences and there was a good standard of care and support in this designated centre.

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

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective both in relation to monitoring practices, and in quality improvement in various areas of care and support.

There was an appropriately qualified and experienced person in charge who was knowledgeable about the support needs of the residents and showed clear oversight of the centre.

There was a competent staff team who were in receipt of relevant training, and they demonstrated good knowledge of the support needs of residents. Staff were appropriately supervised both formally and informally.

There was good oversight of any accidents and incidents, and all required notifications were submitted to HIQA within the required timeframe.

There was a clear and appropriate complaints procedure in place, and a good response to complaints was recorded.

Regulation 14: Persons in charge

The person in charge was appropriately skilled and experienced, and was involved in the oversight of the centre, and in quality improvement of care and support offered to residents.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and

night, with each resident having a one-to-one staff member each day. There was a consistent staff team who were known to the residents, and a review of the last year's rosters indicated that staff unknown to residents had never been on duty in the designated centre. There was a new staff member in the process of joining the staff team, and this person had completed three 'shadow shifts' with established staff until the resident had become comfortable with them.

The inspector spoke to both staff members on duty on the day of the inspection, and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

Judgment: Compliant

Regulation 16: Training and staff development

All staff training was up-to-date and included training in fire safety, safeguarding, and infection prevention and control. Additional training in relation to the specific support needs of residents had been undertaken including training in the management of dysphagia and autism.

Regular supervision conversations were held with staff, again, there was a clear system of recording of completion of these conversations and ensuring that the schedule of supervision was overseen.

A review of the records of two of these discussions showed that they were meaningful two way conversations. All aspects of the care and support of residents were discussed, and staff had the opportunity to identify their personal and professional development needs.

Staff were facilitated to identify areas of self-development, and the person in charge identified any areas requiring improvement.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents included all the required information.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships. All required actions identified in the previous inspection of the designated centre had been completed.

Various monitoring and oversight systems were in place. An annual review of the care and support of residents had been prepared in accordance with the regulations, and this report provided a detailed review of the care nd support offered to residents. Questionnaires had been offered to residents and their families, and their views were included in the report. The final report had been made available in an easy-read version.

Six-monthly unannounced visits on behalf of the provider had been conducted as required. Both of these processes had identified required actions for improvement, and all those actions reviewed by the inspector had been completed. Fr example a missing document from a person centred plan had been located, hospital passports had been updated and the template for recording any absences from the centre had been updated.

Any accidents and incidents were reported and recorded appropriately and the record of each included any learning outcomes from the incident. These were then discussed at team meetings.

Regular staff meetings were held, and a record was kept of the discussions which included accidents and incidents, safeguarding and the care and support of residents. A record of attendance at these meetings was maintained, and any staff unable to attend were required to sign the record to say that they had reviewed the minutes. Any required actions identified during the team meetings were recorded, and again these were monitored until complete. The inspector reviewed the minutes of the previous two meetings and found all the actions to have been completed, for example one of the residents had been supported with a major purchase.

The inspector was assured that there was clear oversight of the centre, and a continuous review of the care and support offered to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

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

Judgment: Compliant

Regulation 31: Notification of incidents

The required notifications were submitted to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure available to residents and their friends and families, and displayed in the designated centre as required by the regulations. Any complaints were recorded and remained open until resolved. The records were clear and included the steps taken to resolve the issue, and the satisfaction of the complainant.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met.

There was an effective personal planning system in place, and residents were supported to have a meaningful day and to make their own decisions about their daily lives. Communication with resident was prioritised and well supported.

Healthcare was effectively monitored and managed and there were appropriate practices in relation to the management of medication.

There were very few restrictive practices in place, and those that were in place were found to be the least restrictive necessary to manage the risk, although not all restrictions were recorded appropriately.

Fire safety equipment and practices were in place to ensure the protection of residents from the risks associated with fire, and it was evident that the residents could be evacuated in a timely manner in the event of an emergency.

There were risk management strategies in place, and all identified risks had effective management plans in place, although the risk ratings of identified risks were not appropriate to the level of risk posed.

The rights of the residents were well supported, and given high priority in the

designated centre.

Regulation 10: Communication

There was easy-read information readily available to residents, for example in relation to safeguarding, human rights and restrictions. Where a new staff member had joined the staff team, there was a social story including photographs to ensure that residents understood that someone new was joining the team.

A 'communication passport' had been developed for each resident which outlined the way they communicate, including the ways in which they indicate their choices. There was also a detailed assessment of the ways in which residents communicate discomfort or pain.

Throughout the inspection the inspector observed staff to be communicating effectively with residents, and to understand the ways in which residents indicated their choices.

Judgment: Compliant

Regulation 13: General welfare and development

It was clear that residents were supported to have a meaningful day and to be supported to maintain their independence. Both residents had occupations outside of their home, one in the organisation's nearby offices doing administration work, and the other doing local deliveries.

They also had a variety of leisure activities including outings for meals and snacks, shopping and attending church. They were members of some local community groups which they attended regularly. It was evident that residents were a regular presence in the community, and that they were making their own decisions about their daily lives.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk management policy which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to residents. Risks were appropriately risk

rated, and there was a detailed risk management plan in place for each.

There was a risk management plan in relation to staff lone-working, whereby they were required to contact another designated centre operated by the organisation at set times twice during the shift.

One of the residents did not have staff support overnight, and there was a detailed risk management plan in relation to maintaining their independence safely. The resident knew how to contact staff, who were based in the next door apartment, if they needed any support and contacted them at the start of their shift just to check in. The staff member again checked in with the resident around their bedtime.

Where a recent incident had alerted staff to a risk in relation to access to medication, a risk assessment had immediately been conducted, and a management plan developed to mitigate the identified risk. It was evident that the person in charge had clear oversight of risk management in the centre, and that risks were responded to appropriately and in a timely manner.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place structures and processes to ensure fire safety. All equipment had been maintained and regular fire drills had been undertaken. The inspector reviewed the records of the last two fire drills and saw that the record described the response of each resident and that residents could be evacuated quickly.

There was an up-to-date personal evacuation plan in place for each resident, giving clear guidance as to how they would react in the event of an emergency and how staff should respond to ensure their safety.

Staff were all in receipt of fire safety training and could describe the actions they would take in the event of an emergency. Members of the local firefighting service had attended the designated centre and undertaken training with both the staff and the residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were safe practices in medication management in relation to the prescriptions, ordering and storage of medications. Staff had all received training in the safe administration of medication. The inspector observed the administration of

medication for one of the residents and the staff member demonstrated good practice. They had a clear knowledge of the medications prescribed for residents, including and 'as required' (PRN) medications.

There were detailed protocols in place in relation to PRN medications, which gave clear direction as to the circumstances under which they should be administered. The protocol included reference to non-verbal communication that might be an indication of discomfort for a resident. The stock of these medications was monitored, and one the stock of one of the medications was checked by the inspector and found to be correct.

Judgment: Compliant

Regulation 6: Health care

Healthcare was well managed and monitored, and there were detailed healthcare plans for any identified healthcare needs. The inspector reviewed the plans for both residents and found them to give detailed and appropriate guidance to staff. There was a plan in place in relation to dysphagia for one of the residents, and they had attended the training with the staff in relation to the condition.

Residents had ready access to members of the multi-disciplinary team including the General Practitioner (GP) and Speech and Language Therapist (SALT). All relevant health screening had been offered and undertaken by residents, including bowel screening and women's health checks.

Residents were being supported in health promotion, and were being supported to give up smoking for example, and to lose weight by joining a community weight loss group.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on an assessment of needs which were regularly reviewed. Proactive strategies were clearly identified, and all staff were aware of these strategies, and were able to describe the actions that might increase or reduce the likelihood of behaviours of concern.

Reactive strategies were clearly documented, and included a description of the potential presentation of residents and how staff should respond. Any incidents were recorded in detail and the records submitted to the behaviour support team. The behaviour support specialist attended some of the staff meetings in relation to the

positive behaviour support needs of residents.

However, staff had not been in receipt of training in the management of behaviour that is challenging including de-escalation and intervention techniques as required by the regulations.

Where there were some restrictions in place to ensure the safety of one of the residents, they were kept under constant review, and were the least restrictive available to manage the risk. There was evidence of restrictions being reduced or discontinued when it was safe to do so. There was easy-read information available to the resident on each of the restrictions, the resident attended all the review meetings for their restrictions, and gave their signed consent.

However, not all restrictive practices were recorded and reported. There was an alarm on the door of the apartment of the resident who does not have staff support in the evenings and overnight. This alarm alerts the staff in the adjacent apartment if the resident opens the front door so that the staff can check that they are safe. The alarm is set by the staff team each evening and remains set until the following morning. The resident does not have the facility to deactivate the alarm. It had been decided by the restrictive practices review committee that this no longer constituted a restriction because the resident had not attempted to open the door for several months, and since January 2024 was no longer recorded or reported as a restriction, even though it was in place every night. Since January, the resident has opened the door and activated the alarm on five occasions.

All other restrictions were recorded appropriately. A log of all restrictions was maintained and each was reviewed every six months. There was daily recording of the application of each restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were in receipt of up-to-date training in safeguarding, and could discuss the learning from this training including their responsibilities in relation to safeguarding residents.

Where safeguarding issues had been queried, appropriate reporting and recording had taken place, and the issue had been followed up in detail. The inspector reviewed the documentation, and saw that all appropriate actions had been taken, and that the preliminary screening that had been undertaken by the provider had found no grounds for concern.

Judgment: Compliant

Regulation 9: Residents' rights

Staff had all received training in human rights, and could discuss their role in supporting residents in making their own decisions. They were aware of the importance of supporting the rights of residents to make their own decisions and choices.

For example, one of residents was making their own decision about their healthcare. The SALT had recommended thickened drinks, however the resident had chosen to thicken some types of drinks but not others. The resident had attended training in relation to the management of dysphagia along with the staff team and understood why the recommendation had been made, and has still decided not to thicken one of their drinks. They had recently made other choices to support optimal health, for example they had given up smoking, and it was clear that they were making informed decisions.

Residents were choosing their own activities and schedules, and were being supported to maintain their independence. Throughout the inspection it was clear that the respect and privacy were acknowledged rights.

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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullaghmeen Centre 2 OSV-0005477

Inspection ID: MON-0038330

Date of inspection: 06/06/2024

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 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Regulation 07(2)

The Person in Charge will continue to ensure that staff have access to training, including refresher training – ensuring staff are appropriately trained to manage behaviour that is challenging, including de-escalation and intervention techniques.

Since the inspection, staff have been scheduled to attend Safety Intervention Training.

Regulation 07(4)

The registered provider shall ensure that, where restrictive procedures – including physical, chemical or environmental restraints are used, such procedures are identified and included in the Restrictive Practice Register.

The Person in Charge will ensure a written report is provided to the Chief Inspector at the end of each quarter in relation to any occasion where a Restrictive Practice procedure is used – to include physical, chemical or environmental restraints.

Since the inspection, the Person in Charge liaised with the Restrictive Practice Committee – to ensure all restrictive practices in the Centre are appropriately documented.

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 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	04/09/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	17/07/2024