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:	Meadowview
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Announced
Date of inspection:	26 September 2022
Centre ID:	OSV-0005508
Fieldwork ID:	MON-0029238

About the designated centre

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

Meadowview is a bungalow located in Co. Sligo. The service is provided by the Health Service Executive for four female residents with an intellectual disability. The care and support needs for each person is tailored to specifically meet their individual needs. Meadowview aims to support each person to meet their maximum potential in all areas of their lives. The service advocates a person-centre approach to care, and to provide people with the opportunities to participate in social activities, hobbies and community engagement. Services provided in the centre are suitable, meaningful and age appropriate and in lines with the resident's wants and desires. Support is provided by a team of nurses and social care staff, and there are three staff on duty during the day and there is one waking staff on duty at night.

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
Monday 26 September 2022	10:20hrs to 16:30hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This was an announced inspection. The provider was given four weeks' notice of the inspection. The inspection forms part of the routine monitoring activities completed during the registration cycle of a designated centre. From the inspector's observations and conversations with residents and staff, it was noted that there was a good quality service in this centre. Residents were routinely offered choices and these choices were respected. Residents engaged in activities that they enjoyed.

This centre consisted of a large bungalow in a rural location in Co. Sligo. The centre was clean, tidy and homely. Each resident had their own bedroom. Each bedroom was decorated in different styles. The person in charge reported that the interior of the house had been repainted at the beginning of the year and that residents had chosen the paint for their own rooms. They had also chosen their own furniture and décor. The bedrooms were personalised with the residents' photographs and with artwork that reflected their interests and style. The shared rooms in the house consisted of an open-plan kitchen-dining room and living room. There was also a separate sitting room, shared bathroom with wetroom shower, a WC and a shower room. The utility room was equipped with washing machine and dryer for use by the residents. All of the furniture in the centre was new, clean and in good condition. Outside, the grounds around the centre were well maintained. Outdoor seating was available. The person in charge reported that the windows in the centre were due to be replaced in the coming weeks and that the exterior of the house would be repainted once this had been completed. The centre had two buses for use by the residents.

The inspector met with three of the four residents in the centre. One resident was visiting family on the day of inspection. The residents were busy going about their daily routine. All residents left the centre in the morning to attend various activities or to go on outings. Later in the day, a resident asked to go for a walk and another left the centre to go grocery shopping. Residents were supported by staff to complete these activities. One resident showed the inspector their bedroom and talked about going to visit family. Another spoke to the inspector about attending the hair dresser and beauty treatments. Throughout these conversations, residents were supported by staff who were familiar with their communication style. Residents appeared comfortable in their home. There were limited interactions between residents and residents mainly spoke with staff members.

As part of an announced inspection, the Health Information and Quality Authority (HIQA) issue questionnaires in advance of the inspection to gather information from residents about their experiences living in the centre. These questionnaires were available for review on the day of inspection. Residents had completed the questionnaires with the support of staff. The responses indicated that residents were happy with their home and the service they received in the centre.

Staff were respectful when they spoke about residents. They spoke to the residents

in a caring way. Staff were quick to respond when residents asked for help. Staff offered choices to residents about their food and activities. These choices were respected. Staff were knowledgeable on the needs of residents and their preferences. Staff were observed using some of the strategies outlined in the residents' behaviour support plans during the day. This had a positive impact on the residents.

Overall, residents received a good quality service in this centre. They were supported to engage in activities that they enjoyed and that were meaningful to them. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident.

Capacity and capability

There was good governance and oversight in this service. The inspection was facilitated by the person in charge who was very knowledgeable of the needs of the residents and the requirements of the service to meet those needs. The person in charge had good oversight of the service and maintained a regular presence in the centre. They had the required qualifications and relevant experience as outlined in the regulations.

There were clear management structures in this centre. Staff in the centre reported to the person in charge. Staff were knowledgeable on who to contact if any incidents or concerns arose. A review of incidents showed that issues were escalated to the person in charge and onwards to senior management, as required. Staff received supervision on an annual basis. Staff meetings occurred monthly and minutes were available for all staff to read. The meetings were used to share information with staff about issues relevant to the residents and the running of the centre. For example, open safeguarding plans and learning from incidents were discussed at the meeting. There was a meeting once every two weeks between all of the persons in charge who worked in the region. Minutes from these meetings were available for all staff in the centre.

The provider maintained oversight of the service through the use of a suite of audits. A new audit schedule and new audit tools had been introduced in the centre at the beginning of August 2022. There was evidence that audits were completed regularly and that the new schedule had been commenced. As the audit schedule was newly introduced, it required additional time for its effectiveness to be established. The person in charge reported that the findings from audits were recorded in a communication diary that was accessible by all staff. Findings were also communicated to staff nurses. There was evidence on some audit tools that issues identified had been signed-off as 'completed'.

The centre had a quality improvement plan that was updated monthly. The plan

listed the service improvement actions that had been identified and gave target dates for their completion. The service improvements were identified in a number of ways. This included the provider's six-monthly unannounced audits and the annual report into the quality and safety of care and support in the centre. Findings from previous HIQA inspections, senior management evaluations, and assessments completed by the person in charge also identified specific goals for service improvements.

The staffing arrangements in the centre were reviewed and it was noted that there had been considerable changes in recent months. This was in response to negative interactions that occurred between residents and formed part of the centre's safeguarding plan. This will be discussed later in the report. The number and skill-mix of staff were appropriate to meet the assessed needs of residents. Nursing support was available throughout the day and there were on-call arrangements to access nursing support at night, if required. Agency staff were required in the centre to cover existing vacancies and unplanned leave. However, a review of the rosters found that the same staff worked in the centre routinely, ensuring that there was a continuity of familiar staff in the centre. The person in charge reported that the relevant forms had been submitted and approved to fill the vacant posts in the centre. A sample of staff files were reviewed. It was noted that all files had the required documentation as outlined in the regulations.

The provider had identified a number of mandatory staff training modules. A review of training records found that all staff were fully up to date in most modules. Where staff had been identified as requiring refresher training, dates for the completion of this training had been identified and booked by the person in charge. Two new training modules had recently been added and staff training in these areas had commenced. Training in Sexuality Awareness in Supported Settings (SASS) had also commenced. Two staff in the centre had completed training in this module and the person in charge reported that a 'train the trainers' programme was underway so that this training could be rolled out to all staff in the locality. All staff had completed training in human rights-based approach in health and social care.

The provider submitted the required documentation to the Chief Inspector to apply for a renewal of registration of this centre. The necessary documentation had been submitted in time and contained the required information to process the application. This included a copy of the centre's statement of purpose which outlined the services and facilities in the centre and contained the necessary information as outlined in the regulations. The resident's guide, that provides information to residents on the services they will receive in the centre, was also submitted. It was reviewed and found to be in line with the information set out in the regulations.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted the required documentation to process an application to renew the registration of this centre. The documentation was

submitted in time and the appropriate fee had been paid.

Judgment: Compliant

Regulation 15: Staffing

The number and skill-mix of staff were appropriate to meet the needs of residents. The staffing arrangements in the centre had been reviewed and amended recently to address issues identified in the service. Nursing support was available on-site during the day and there were on-call arrangements for nursing support at night. A review of staff files found that the provider had obtained the required information and documents specified in the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified a number of training modules that were mandatory for all staff. Staff had up to date training in these modules, including training in human rights-based approach to health and social care. Where staff required refresher training, this had been identified by the person in charge and dates were booked to complete this training.

Judgment: Compliant

Regulation 23: Governance and management

The provider maintained good oversight of the service through a suite of audits and a quality improvement plan. The provider had completed an annual review into the quality and safety of care and support in the centre. Six-monthly unannounced audits were also completed in the service. There were clearly defined lines of management and accountability. Issues identified were escalated to more senior management, as appropriate.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had submitted a copy of the centre's statement of purpose as part of their application to renew the registration of the centre. The statement of purpose contained the information set out in the regulations and had been reviewed within the previous 12 months.

Judgment: Compliant

Quality and safety

Residents in this centre were in receipt of a good quality service. Their needs had been appropriately assessed and the necessary supports required were in place. Their rights and safety were promoted. Residents had access to a wide variety of healthcare professionals.

As mentioned previously, the centre itself was suited to the residents' needs. The house was fully accessible to all residents and equipped with the necessary facilities and equipment to meet the residents' needs. There was adequate communal space so that residents could spend time together. There was also adequate private space so that residents could spend time alone or receive visitors. The centre was homely and in good structural and decorative repair. The interior had recently been repainted and there were further plans to enhance the building through the replacement of windows and exterior painting.

The building was equipped with fire doors throughout the centre. On the day of inspection, the person in charge activated the fire alarm and it was noted that all magnetic locks released, allowing all fire doors to close completely. Fire checks were routinely completed by staff in the centre and there was evidence that issues identified were promptly reported and addressed. For example, a faulty fire door had been recently replaced. The fire alarm, emergency lighting and fire extinguishers were checked and maintained by an external company. Residents had personal evacuation plans that gave clear guidance to staff on how to support residents to evacuate the building in case of a fire. All staff were trained in fire safety.

A sample of the residents' personal plans was reviewed. An assessment of the needs of residents had been completed within the previous 12 months. Where a particular need was identified, a corresponding care plan had been developed that gave guidance to staff on how to support the resident. The care plans were regularly reviewed and updated. The plans also contained personal and social goals for the residents. An annual review of residents' personal plans were completed. There was evidence of input from the resident or their families in these review meetings. The effectiveness of the previous year's plan was reviewed and new goals set for the coming 12 months. There was evidence within the plans that residents' healthcare needs were well managed. Residents' detailed medical histories were recorded. Residents had a named general practitioner (GP) and access to a wide variety of

healthcare professionals. Reports, correspondence and guidance from these professionals were available in the plans. The plans also indicated that residents had access to a variety of activities that were in line with their interests. Residents could access activities within the centre that they enjoyed; for example, baking and beauty treatments. Residents also engaged in activities in the wider community; for example, swimming, horse riding, tennis, attending the cinema and going shopping. Residents were supported to maintain links with family and friends through regular visits.

Residents' personal plans also contained risk assessments for each resident. These assessments identified risks that were specific to the resident and control measures that should be implemented to reduce the risks. The risk assessments were regularly reviewed and updated. In addition, the person in charge maintained a risk register for the centre. This risk register identified risks to the service as a whole. The risk assessments were relevant and specific to the centre. Control measures to reduce the risks were identified and the risk assessments were regularly reviewed and updated.

The rights of residents were respected in this centre. The inspector noted that residents were routinely offered choices throughout the day. Their choices were respected by staff. Residents met with a member of staff on a one-to-one basis every week to discuss their choices and preferences in relation to planned activities, meals, outings and visits. Records of these meetings were maintained in the centre. Where required, referrals had been made to independent advocacy services to support residents make choices and to promote their rights.

Where required, residents had behaviour support plans that were devised by appropriate healthcare professionals. It was noted that input and recommendations were sought from a wide variety of relevant professionals to support residents manage their behaviour. This included the support of psychiatry, psychology, speech and language therapy and behaviour support therapists. Further, there was evidence that multidisciplinary team meetings had been held so that the relevant professionals could collaborate on identifying the supports needed by residents to manage their behaviour. Staff were knowledgeable on the strategies that should be implemented to support residents with their behaviour. The inspector observed the effective use of some of these strategies on the day of inspection. In some cases, medication was prescribed to support residents with their behaviour. The inspector reviewed the protocol that was in place to guide staff on when to administer this medication. Guidance was given on the type of medication to use and the appropriate dose. However, the protocol did not give sufficient detail on the behaviours or criteria that would warrant the administration of the medication.

As outlined previously, there were a number of open safeguarding plans in the centre. These plans related to negative interactions between residents. There was evidence that these plans were reviewed and progressed. Meetings had occurred between the person in charge, senior management, members of the multidisciplinary team and residents' families to address some of the identified issues in the centre. The provider had taken proactive steps to protect residents' safety. These included the revision of staffing arrangements so that residents could

be supported in ways that minimised negative interactions. A second vehicle had been obtained for the centre to allow residents to travel alone, if required. The provider was in the process of identifying possible alternative accommodation for some residents. This was noted in the centre's annual review and report into the most recent six-monthly unannounced audit. Family meetings were held to keep families informed of these plans and to seek their input.

Overall, the service provided in this centre was of a good quality. Residents were supported to express their preferences, make choices and engage in activities that they enjoyed. The provider had taken proactive steps to protect residents' safety with input from relevant healthcare professionals, residents and their families.

Regulation 13: General welfare and development

Residents were supported to engage in activities that were in line with their interests and preferences. These activities occurred within the centre and in the wider community. Residents were supported to maintain contact with family and friends.

Judgment: Compliant

Regulation 17: Premises

The centre was suited to the needs of residents. The centre was accessible to all residents and equipped with the facilities that they required. There was adequate communal and private space in the centre. The house was in good structural and decorative repair.

Judgment: Compliant

Regulation 20: Information for residents

The residents' guide gave information in relation to the services and facilities provided in the centre. The terms and conditions of residency were outlined. The guide also contained information in relation to the complaints procedure, the arrangements for visitors to the centre, and how residents were involved in the running of the centre. Information about accessing inspection reports was also provided.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk register for the centre and individualised risk assessments for residents. There were control measures to reduce the risk and all risks were routinely reviewed.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had implemented fire safety management systems. Fire alarms, emergency lighting and fire extinguishers were maintained and checked by an external fire company regularly throughout the year. The centre was equipped with fire doors. Staff completed regular checks of fire safety equipment. Fire drills were completed on a regular basis and residents had emergency evacuation plans.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' health, social and personal needs were assessed. Goals and plans were devised to meet these needs. The needs and plans were routinely reviewed and updated. The residents' personal plans were subject to an annual review and residents' families participated in this review meeting.

Judgment: Compliant

Regulation 6: Health care

The health needs of the residents were well managed. Health assessments were conducted. Care plans were devised for any health need identified on the assessment. There was evidence of input from a variety of health professionals as required by residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

When required, residents had behaviour support plans. These had been devised with input from relevant healthcare professionals. Staff were trained in supporting residents manage their behaviour and knowledgeable of the strategies set out in residents' individual plans. However, further clarity was required in relation to the protocol for the administration of medication to support residents manage their behaviour.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had taken measures to protect residents from abuse. Staffing arrangements had been reviewed to reduce negative interactions between residents. Incidents were reported and escalated to senior management as required. There were safeguarding plans in the centre that outlined how to protect residents' safety. Staff were trained in safeguarding and knowledgeable of steps that should be taken if they had any concerns regarding a resident.

Judgment: Compliant

Regulation 9: Residents' rights

The rights of residents were protected in this centre. Residents were routinely offered choices in relation to their daily life and these choices were respected. Residents were supported to be active participants in the running of the centre through regular meetings with staff.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	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 Meadowview OSV-0005508

Inspection ID: MON-0029238

Date of inspection: 26/09/2022

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:
• The Person in Charge in collaboration with the relevant members of the Multidisciplinary Team have reviewed the PRN protocol for the administration of medication to residents. The Protocol now ensures clarity for staff in relation to the least restrictive procedure, for the shortest duration necessary in relation to the management of Residents behaviours. Completed 20/10/2022.

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(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	20/10/2022