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

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| Name of designated centre: | Mullingar 5 |
| Name of provider: | Muiríosa Foundation |
| Address of centre: | Westmeath |
| Type of inspection: | Unannounced |
| Date of inspection: | 08 October 2024 |
| Centre ID: | OSV-0002760 |
| Fieldwork ID: | MON-0044807 |

## About the designated centre

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

This designated centre offers a full time residential service to three residents over the age of 18 in a detached bungalow in close proximity to the nearest town. Each resident has their own bedroom which will be personalised in accordance with their preferences.
In addition to personal bedrooms, there are adequate communal areas, including a living room, kitchen and dining area. There is a large enclosed garden to the rear, and a lawned front garden.
The provider describes the support offered as being based on a social model of care for individuals with high support needs. Support is offered to people with an intellectual disability, autism, sensory needs and complex medical needs.
Staffing will be provided on a 24 hour basis, with waking night staff, and numbers and skill mix will be in accordance with the needs of residents.

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

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| Number of residents on the date of inspection: | 3 |

## 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 |
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| Tuesday 8 October 2024 | 10:45hrs to 18:50hrs | Karena Butler | Lead |
| Tuesday 8 October 2024 | 10:45hrs to 18:50hrs | Julie Pryce | Support |

## What residents told us and what inspectors observed

This was an unannounced inspection conducted with a specific focus on how residents are safeguarded. From what inspectors observed, it was evident that efforts were being made to promote a holistic safeguarding culture and to ensure residents were safeguarded in their home.

However, inspectors did find that improvements were required in the areas of governance and management, individual assessment and personal plan, positive behaviour support, staffing, training and staff development, and risk management. These areas will be discussed further, later in this report.

The inspectors had the opportunity to met all three residents living in the centre. While the residents had alternative communication methods and did not share their views verbally, the inspectors observed interactions between them and staff, spoke with the person in charge and three staff members and reviewed documentation over the course of the inspection.

Shortly after inspectors arrived to the centre, one resident left to attend a hair appointment and to get a massage. Upon arrival back to the centre, they appeared in good form and smiled when an inspector complimented them on their hair cut. They later went out for a walk with staff.

Another resident also attended an appointment for a hair cut and was observed during the inspection, to relax while listening to music in the living area of their home. All three residents received reflexology sessions in the afternoon.

Staff were observed to be responsive to residents' verbal or body language cues. For example, after a resident made a gesture, staff were observed to ask the resident were they okay. The resident responded with the hand sign for tea and staff made them a cup of tea.

It was clear from observations that residents were comfortable with staff members, and that they were being supported in accordance with their needs and preferences. Staff were observed on different occasions to offer residents choice. For example, if they were happy to have a cup of tea in the room with the inspectors or if they wished for the inspectors to leave. Staff assessed the resident's body language to judge their response and believed that the resident was happy to have their tea with the inspectors. Another example observed, was when a resident communicated through their actions that they wanted to have their lunch. A staff member was observed to offer two lunch options with the options shown to the resident for visual reference. They waited patiently for the resident to decide which option they wanted.

The provider had arranged for staff to have training in human rights. One staff member spoken with was asked about how they were putting this training into

everyday practice to promote the rights of the residents. They explained they were new to the area of social care and that the training instilled in them that, the residents have the same human rights as everyone. They explained that it was an extremely important part of their role that they upheld residents' rights. One way in which they felt they were supporting residents' rights was in their right to choose what they wanted to wear each day. They explained that it was important to do it in a manner which supported the resident to make the choice without feeling overwhelmed by the choice. For example, to leave out a couple of choices of clothes and wait for the resident to touch the ones they wanted to wear. They also explained, how the training made them more conscious as to how they spoke to residents. They said that it was vitally important to always include the resident in the conversation.

One of the inspectors conducted a walkabout of the centre and found the centre had adequate communal and personal space for residents use and the building was well maintained. There was a back garden with garden seating for residents use and a front garden which was mainly used for parking.

The complaints procedure was displayed in a prominent place in the centre. One of the inspectors reviewed the complaints log, and found that there were no complaints since the last inspection. The centre did receive three compliments which related to, the care and support of residents and staff interactions between residents and family representatives.

For example, one family representative stated that they always felt welcome when they visited. Another family representative had thanked staff for the care their family member was receiving. A staff member from another house had commented once that the house was very clean and how well it looked.

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

## Capacity and capability

This inspection was an unannounced inspection with a focus to review the arrangements the provider had in place to ensure compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations) and the National Standards for Adult Safeguarding (2019). It followed a regulatory notice issued by the Chief Inspector of Social Services (The Chief Inspector) in June 2024 in which the safeguarding of residents was outlined as one of the most important responsibilities of a designated centre and fundamental to the provision of high quality care and support. Furthermore, that safeguarding was more than the prevention of abuse, but a holistic approach that promoted people's human

rights and empowered them to exercise choice and control over their lives.

One of the inspectors reviewed the provider's governance and management arrangements and noted that, there were some appropriate systems in place in order to ensure the quality and safety of the service. For example, there was a clearly defined management structure in place and staff were familiar with the reporting structure should they have a concern. However, certain areas for improvement were noted, for example timely action taken for high risks that were identified with regard to a fire containment door repeatedly not operating properly.

Overall, it was apparent that any concerns were taken seriously, appropriate actions and investigations were undertaken as required, and safeguarding was given high priority by the provider, the management team and the staff team.

In the months prior to this inspection, the office of the Chief Inspector received unsolicited information of concern relating to staff training and knowledge of policies and these matters were followed up on inspection. Following a review of documentation and speaking with staff members on duty and the person in charge, inspectors found that the concerns raised could not be substantiated other than not all up-to-date policies were available in the centre to appropriately guide staff.

There were sufficient staff available, with the required skills and experience to meet the assessed needs of residents. One of the inspectors observed that, staff were in receipt of appropriate training and for the most part refresher training. The inspector found that while formal supervision was occurring, not all annual appraisals were occurring as per the provider's guidance.

## Regulation 15: Staffing

The provider had for the most part appropriate staffing arrangements in place.

In order to assess if the provider had obtained all of the required information as per Schedule 2 of the regulations, one of the inspectors reviewed a sample of one staff member's personnel file. In addition, the inspector received emailed confirmation from the organisation's human relations (HR) department that all staff that were employed by the organisation that worked in the centre had received Garda vetting (GV) within the last three years.

Furthermore, the inspector reviewed the information available that related to, the employment of two agency staff that covered shifts within the centre. The purpose of those file reviews was to assess if the provider had safe recruitment practices in place to safeguard residents.

While the majority of information required was present, some minor areas for improvement were observed.These included:

- while the staff member's file reviewed did contain two references, it did not

contain a reference from their last employer as required by the regulations
- one agency staff member's GV had not been renewed since 13 September 2021 which was just outside of best practice of being renewed every three years.

From a review of a sample of rosters since August 2024, an inspector found that, there was a planned and actual staff roster in place maintained by the person in charge. The review demonstrated that, there were sufficient numbers of staff to meet the needs of residents over both day and night.

New staff to the centre received induction and completed some shadow shifts in order for the residents to get to know them prior to them working alone. This was found to be in line with the assessed needs of the residents who required familiar staffing in order to reduce the likelihood of incidents.

While there was not a full complement of staff for the centre, one new staff member was due to commence employment later in the month and on-going recruitment was taking place for the one remaining position. In the meantime, consistent relief and agency staff were used to fill gaps in the roster to ensure continuity of care was provided to all residents and to promote a safe environment.

The inspectors spoke with the person in charge and three staff members during the course of the inspection, and found them to be knowledgeable about the support needs and any safeguarding requirements for the residents. Interactions between staff and residents were observed to be gentle and professional.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

An inspector viewed the staff training matrix and a sample of certificates across eight trainings. This demonstrated that staff had received training in key areas of service provision in order to ensure staff knew how to safeguard and protect residents.

Training provided to staff included:

- safeguarding of vulnerable adults
- children first
- first aid or basic life support training
- feeding, eating, drinking and swallowing
- epilepsy awareness and emergency medication
- fire safety
- positive behaviour support.

In addition, staff were able to discuss the learning from various aspects of these trainings or were observed putting them into practice by the inspectors. For

example, an inspector observed a staff member sign a resident's emergency epilepsy medication back into the centre after returning from an outing. They informed the inspector that the medication always travelled with the resident and that the medication was always signed in and out to ensure its whereabouts if required in an emergency.

However, some training related to infection prevention and control (IPC) was found to be outside of the provider's time frames for refresher of every two years. For example, fresher training was required for:

- two staff for personal protective equipment (PPE) and it was not evident if a third staff was trained in this area as they were on the matrix as not having completed it
- three staff required hand hygiene
- four staff required respiratory hygiene and cough etiquette

Those trainings would ensure that staff had the necessary skills and up-to-date knowledge in key areas of IPC. This was in order to safeguard residents from the risk of developing healthcare associated infections and manage infection control risks should they occur.

Staff had received additional training to support residents, for example staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

Judgment: Substantially compliant

## Regulation 23: Governance and management

There were management systems in place for oversight of the safety of the residents in the centre. For example, there was a clearly defined management structure in place and a staff spoken with was able to confirm the reporting structure to an inspector. They explained they would be comfortable reporting any concern to management if one arose.

There were various monitoring and oversight processes in place in relation to the safeguarding of residents. It was evident that, any safeguarding concerns or allegations were responded to appropriately and in a transparent manner.

However, an inspector observed that a resident's fire containment door would not close in order to prevent the spread of fire and smoke in the event of an emergency. This was observed to be a repeated issue ongoing since at least 25 August 2024. While there was evidence that the maintenance department had called to the centre on two occasions to fix the door however, the door remained an ongoing issue on the day of the inspection. The person in charge arranged for the maintenance department to call on the day of the inspection and fix the door. However, from speaking with the maintenance person and the person in charge, inspectors were

not assured that the fix would resolve the issue permanently.

While reviewing documents inspectors found that, there was repeated delays in the inspectors being provided with required information to facilitate the inspection and not all information was being held in the centre to ensure staff had access to it if required.

From a review of the audits it was not always evident if actions were complete, as often sections of the audit documents were left blank. For example, this was observed from a review of the six monthly provider led visits. The person in charge confirmed that it was a documentation issue and that the actions were completed. However, while it was evident that, there were organisation led and local audits occurring, it was not evident to the inspector if all were being completed as prescribed. For example, the daily residents' finance checks for September 2024 and the July audits for the vehicle checks, health and safety audit, and the medication audit were not present in the folders.

One of the inspectors reviewed the organisation's policy folder for the Schedule 5 policy that was present in the centre. The regulatory requirement is that Schedule 5 policies were required to be in place, were made available to staff and were reviewed every three years or sooner if needed.

The inspector found that some policies on file were either past their required review period or not the most up-to-date version of the policy. For example:

- the policy on file for intimate and personal care was last reviewed March 2021
- the policy on 'management of risk and the individual' that was on file was the previous now out-of-date version last reviewed in May 2021. The organisation had since reviewed it in June 2024; however, the recently revised version was not on file
- the policy on communication with residents was found to be recently overdue its review period. It was due for review by no later than the 17 September 2024.

Up-to-date polices were required to ensure they appropriately guided staff in line with best practice on how to support and keep residents safe. Therefore, safeguarding them from inappropriate practices.

Monthly staff meetings were held, and safeguarding was a standing item at each of these meetings.

Discussions included the following:

- what was safeguarding
- what were the different forms of abuse
- discussion of any safeguarding plans in place
- who the designated safeguarding officer was
- restrictive practices in place

- residents' finances.

In addition, communication was discussed and included topics, such as psychological safety and respectful language. Incidents were also reviewed, and any shared learning was discussed with the staff team as well as discussion around the on-going safety of residents in all areas of daily life, for example residents' healthcare, and their activities.

Judgment: Not compliant

## Quality and safety

This inspection found that residents received a good quality service which respected and promoted their rights.

The provider assessed the residents' needs and support plans guidance documents were developed as applicable, to help staff support the residents in the best possible way. However, some personal plans were found to be limited in the guidance they provided at times. This will be discussed in more detail under Regulation 5: assessment of need and personal plans.

The provider was actively working on promoting positive behaviour supports in the centre in order to safeguard residents, as far as possible, from any negative consequences of their behaviour towards themselves or others. However, some behaviour support plans required review, for example; they did not elaborate fully on guidance provided to staff to manage certain behaviours that maybe displayed.

While there were restrictive practices in place, for example a lap belt used while a resident used their wheelchair, they were observed to be in place for the safety of the residents.

It was found that concerns or allegations of potential abuse were investigated and reported to relevant agencies.

The inspectors observed that, the individual choices and preferences of the residents were promoted and supported by staff. Communication was promoted in relation to safeguarding as well as all aspects of daily life. Staff were found to be very familiar with the ways in which the residents communicated, for example what way they presented if they were uncomfortable.

Risk management arrangements, for the most part, ensured that risks were identified and monitored. However, some improvements were required to the risk assessment arrangements in the centre. For example, not all risk assessments were reviewed in light of recent safeguarding risks.

## Regulation 10: Communication

On the day of the inspection, inspectors saw that the residents' communication was respected and responded to in a timely manner. Inspectors saw kind and caring interactions between residents and staff. Staff were able to use their knowledge of the residents and their routines to gather responses.

The residents had received speech and language therapy (SALT) assessments and recommendations were provided, so as to maximise understanding. There were communication care plans in place and an inspector reviewed all three. They outlined some strategies and guidance for staff to use to promote effective communication with residents. For example, to use objects of reference to support a resident to understand what is being discussed or proposed. However, the plans did not contain all information known by staff and this had the potential for information to be lost if the staff team were to change. This is being actioned under Regulation 5: Individual assessment and personal plan.

Staff were knowledgeable as to how residents communicated and how staff would communicate with them. They provided many examples to the inspectors, such as when a resident was heard making a particular vocalisation staff explained it meant the resident was happy. They could also explained what verbal sounds and body language signs that they might look out for that could mean that a resident was distressed or not happy. They also explained some examples of environments that the residents liked and some they were not comfortable in. They explained to the inspectors that they were led by the residents' preferences and comfort levels.

Judgment: Compliant

## Regulation 17: Premises

The safeguarding of residents included providing a safe living environment. The inspectors observed that the person in charge was reviewing the environment in order to optimise the living spaces and encourage residents to use different areas.

There were separate communal spaces for residents to use although residents in the past had a tendency to only use the open plan living room and dining room area and the sitting room was never used. The person in charge was in the process of ensuring the premises was laid out in accordance with the current support needs of residents and minimise the chances of safeguarding incidents. This resulted in the aesthetics of the two rooms not being fully finished while the new rearranged spaces were being trialled. It meant that one space felt cluttered and one space felt bare.

The new arrangement appeared to be working for the residents and the sitting room space was now being used as observed on the day of the inspection when one

resident had a cup of tea and later had their lunch in that room. The person in charge communicated to the inspectors that they were aware further improvements were required and that a review of how the space looked was under review with the staff team.

The inspectors viewed the new arrangement of the rooms as a benefit for the residents and afforded them the use of a once unused space and gave them additional space. This had the potential to minimise negative peer-to-peer interactions if residents had more personal space.

The centre was observed to be clean and tidy and each resident had their own bedroom. One resident had sensory lighting displayed in their room. Residents had personal items displayed in their rooms, for example favourite soft toys.

Judgment: Compliant

## Regulation 26: Risk management procedures

For the most part, there were appropriate processes and procedures in place to identify, assess and ensure ongoing review of risk. This included, ensuring that effective control measures were in place to mange centre specific risks.

One of the inspectors reviewed accidents and incidents which had occurred in the centre in the months prior to the inspection. Incidents and accidents were reviewed by the person in charge and learning from adverse incidents was shared with the staff at team meetings.

The provider had ensured a risk management policy was in place and subject to regular review. The current policy had been reviewed in June 2024; however, as previously stated, it was not the up-to-date version available in the centre for staff.

There was a risk register and associated risk assessments in place for identified risks. The inspectors found, there were escalated risks in the designated centre at the time of this inspection. While the person in charge had ensured that there were control measures in place to maintain the safeguarding of residents, the associated risk assessments were not found to be up to date and the risk rating was no longer applicable. In one instance, a risk assessment had identified a certain risk of a resident reaching out to grab people in order to possibly get a reaction; however, there was no evidence provided of detailed guidance to guide staff to support the residents during those incidents.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

While the provider had systems in place for the assessment of residents' needs and ensured that personal plans were in place as required, the inspectors observed some areas that required improvement.

One of the inspectors reviewed the personal plans of the three residents and observed that, there was a section called 'about me' which provided an overview of the person for the reader. There was a personal plan in place for each resident based on their identified needs. For example, the inspector observed that, there were swallow care plans and a care plan to help manage a specific identified risk of aspiration in the shower for an individual. All plans reviewed by the inspector had received a review date within the last year to ensure information provided to staff was accurate.

For the most part, guidance provided for staff in order to support the residents was clear and staff spoken with could explain their role in ensuring the safety of residents in these areas.

However, some plans did not guide staff fully with regard to residents' epilepsy management. For example, in two plans, there was no information with regard to the type of seizure the resident may have or what it would look like when they were in recovery. Therefore, staff may not have all relevant information in order to safeguard a resident during a seizure. Additionally, one resident's respiratory plan did not guide staff as to steps to take if any for prevention of chest infections.

Furthermore, communication care plans did not contain all applicable information in order to appropriately guide staff to be effective communicators with the residents. For example, the person in charge discussed objects of reference in order to support one resident's communication. However, these recommendations were not clearly documented and not fully implemented in practice.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

For the most part, residents were provided with the necessary support to manage behaviours that may cause distress to themselves or others and in turn provide appropriate safeguards. For example, residents had access to a behaviour support specialist.

However, a lot of out-of-date information was still stored in the residents' behaviour support folders which made it difficult to find and ensure the information you were reading was still applicable. While there were behaviour support plans in place conducted by a behaviour therapist, the plans were limited at times in the guidance they provided and sometimes applicable information was recorded in meetings that took place regarding behaviour support instead of in the plan itself. For example, the reactive strategies to guide staff to ensure a safe outcome for all when a

resident was displaying behaviours of concern was brief. Another resident's plan did not guide staff to ensure they had a consistent bedtime routine as per the guidance in a safeguarding plan.

One resident's plan stated 'consider providing an oral stimulation program in consultation with an occupational therapist (O.T)'. However, this same statement was observed in their 2024, 2023 and 2017 plan. Therefore, it was not evident what steps the provider had taken to acquire the recommended support for the resident.

Notwithstanding that, the staff members spoken with, were knowledgeable as to how a resident may present when distressed and what responses were appropriate under the circumstances.

While there were some restrictive practices in place, such as restricting access to water in the taps on occasions to prevent aspiration, these were used as a measure of last resort and for the shortest duration of time. Any restrictive intervention had been assessed to ensure its use was in line with best practice and they were subject to periodic review. They were found to be last reviewed in July 2024.

Judgment: Substantially compliant

## Regulation 8: Protection

The inspectors reviewed the safeguarding arrangements in place and found that the provider had appropriate arrangements in place to protect residents from the risk of abuse. There were clear lines of reporting and any potential safeguarding risk was escalated and investigated in accordance with the provider's safeguarding policy. Potential safeguarding risks were reported to the relevant statutory agency.

While one investigation outcome did not identify any cause for concern, the provider had identified areas for improvement in care practices as overseen by an occupational therapist (OT).

Staff had received specific training in order to support and safeguard residents in their home. Training included:

- safeguarding vulnerable adults
- communicating effectively through open disclosures
- national standards for adult safeguarding: putting the standards into practice.

A workshop in May 2024 was held to discuss all three residents and complete staff support exercises. This workshop provided staff with a more in-depth guidance as to examples of behaviours that they may observe that they should be reporting. The purpose of the workshop was to increase staff awareness and attempt to decrease the possibility of institutional abuse whereby staff become used to observing certain behaviours and see them as acceptable not requiring reporting.

Staff confidently spoke about their role in ensuring the safety of residents. They were aware of the various types of abuse, the signs of abuse that might be of concern, and their role in responding to any concerns.

Residents' finances were safeguarded through the various checks and audits completed. For example, staff completed daily balance checks and every time money was spent it was recorded and signed off by staff. An inspector reviewed the money balance for two residents and found that they matched the money balance sheets in place.

An inspector reviewed three intimate care plans and found they guided staff appropriately as to supports residents required in that area.

Judgment: Compliant

## Regulation 9: Residents' rights

Overall, the inspectors found that there were suitable arrangements in order to uphold the rights of residents. They were supported to make their own decisions and choices about their daily lives, for example what they wanted to eat and what they wanted to wear each day.

Residents were provided with opportunities for a meaningful day in line with their preferences. For example, some residents were trialling going swimming. The person in charge confirmed that there was never an occasion that an activity could not be facilitated, as there were additional staff supports available from the provider's on-call nurses in order to support residents should the need arise.

In addition. to the examples provided by staff earlier in this report on how residents' rights were upheld, the person in charge also described some ways in which residents' rights were supported and facilitated. For example, one resident preferred on occasion to mobilise in a manner that had the potential to hurt their knees. The person in charge had arranged for an appropriate review by an occupational therapist (OT) and guidance to staff on how to support the resident with regard to this. Special knee pads were purchased that could be slotted into the resident's trousers when they chose to mobilise like that. This ensured that the resident had the choice to mobilise how they choose while at the same time protecting their knees.

Due to an increase in some negative peer-to-peer interactions, the person in charge confirmed to the inspectors that compatibility assessments were in the process of being completed. This was to ensure the residents were still suitably matched for living with one another and to review the impact that living with one another may have on each other.

In addition to receiving training on human rights, staff had received training around the assisted decision making act and also dignity at work in order to promote an

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| open culture and promote residents' 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 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Mullingar 5 OSV-0002760

## Inspection ID: MON-0044807

## Date of inspection: 08/10/2024

**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 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br><br>• There are files on record for all staff containing a reference from their last employer.<br><br>• One staff members Garda vetting is currently in process. All other staff currently working in the designated centre have up to date Garda Vetting on file. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br><br>• All staff have completed training in Personal Protective Equipment.<br>• All staff have completed training in Hand Hygiene.<br>• All staff have completed training in Respiratory Hygiene and Cough Etiquette.<br><br>• The Person in Charge has scheduled annual appraisal dates alongside supervision date in a new schedule. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br><br>• New fire door scheduled to be installed in one of the individual's bedrooms which will meet Fire Regulation. Installation is scheduled for 27th November 2024.<br><br>• There is a new audit schedule in place identifying staff members to complete each audit, thus resulting in Audits not being missed. | |

• All schedule 5 policies have been updated and are available on site in the designated centre:

• The policy for Intimate and Personal Care-last review date Sept 2023.
• The policy on Management of Risk and the Individual - last review date June 2024.
• The Policy on Communication with Residents was reviewed in October 2024.

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| Regulation 26: Risk management procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• There is a new audit schedule now in place identifying staff members to complete each audit, thus resulting in audits being missed.

• Review of risk assessments relating to Safeguarding – risk rating increased to reflect ongoing Safeguarding issues.

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| Regulation 5: Individual assessment and personal plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• Epilepsy care plans updated to reflect the type of seizure the resident may have and details of the presentation of recovery for the resident.

• Health Care Plan has been updated to support an individual in preventing chest infections, detailing how to maintain good respiratory health.

• Communication care plans are updated for all residents, with information to appropriately guide staff to communicate with residents.

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| Regulation 7: Positive behavioural support | Substantially Compliant |

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

• The Behavior Support Team and the Designated Officer facilitated a workshop with the staff team on 21st October 2024 – review of Safeguarding and Positive Behavior Supports.

• There was a review of the safety and support plans which now incorporate safeguarding plans.

• A review of the safety and support folders was carried out by the Behavior Support

Team – plans clearly defines current supports with all items that are no longer relevant have been removed.

• Oral stimulation training was carried out with the staff team in July 2024 by an occupational therapist – behavior support plans revised to reflect this.

## 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 15(5) | The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2. | Substantially Compliant | Yellow | 31/12/2024 |
| 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 | 18/11/2024 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 18/11/2024 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in | Not Compliant | Orange | 27/11/2024 |

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| | place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| 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 | 18/11/2024 |
| 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 | 18/11/2024 |
| Regulation 07(3) | The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed | Substantially Compliant | Yellow | 18/11/2024 |

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| | as part of the personal planning process. | | | |