Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Teach Geal
Name of provider:	St Hilda's Services Limited
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	16 January 2019
Centre ID:	OSV-0003261
Fieldwork ID:	MON-0025491

About the designated centre

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

Teach Geal offers residential services to adults whose primary disability is an intellectual disability. Teach Geal caters for those with an intellectual disability who have a level of independence such that waking night cover is not required. The service can accommodate those with a range of medical and physical issues. Residents generally attend day services outside of the house, except in the case of short - term illness when arrangements can be made to either recuperate in Teach Geal or go home to their families if residents wished. Needs are managed and accommodated by staff who have training in areas such as medication management, intimate care, first aid, manual handling, fire training, epilepsy awareness and management of behaviours that challenge. The service has fixed closures in line with day services and also closes one weekend a month. Teach Geal consists of two semi detached houses that can accommodate five residents. There are four double bedrooms and one single bedroom across the two houses. There is transport provided to travel to and from day services and taxis are availed of outside of these times which are paid for by the resident.

The following information outlines some additional data on this centre.

Current registration end date:	13/04/2020
Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
16 January 2019	10:00hrs to 18:00hrs	Erin Clarke	Lead

Views of people who use the service

The inspector met two service users on their return from day services, whom communicated using a mixture of verbal and non verbal communication. The inspectors observed residents and noted the positive interactions that took place between residents and staff.

In general, residents appeared content, well and comfortable with the support they were receiving from staff. They smiled and used body language to indicate their satisfaction. The inspector observed residents in their living environment after their evening meal and one resident lead a staff member by the hand to make their needs known.

The inspector viewed the complaints log and one recent complaint made by a resident which was responded to by staff. The resident replied that they were satisfied that their complaint was resolved fully. Compliments were evident from families regarding the care that their family members received, in the audit of services commissioned by the provider.

Capacity and capability

The purpose of this inspection was to assess the effectiveness of the actions taken by the provider to address the concerns raised by HIQA on the last inspection and to ensure that the centre was being appropriately monitored as required by the regulations. The previous inspection in August 2018 identified a number of significant repeated non compliance which raised concerns about the capability of the provider to appropriately govern the centre. In addition it was determined that the person in charge was unable to fulfill their regulatory responsibilities given the number of addition posts held within the broader organisation.

As a result of these concerns HIQA took escalated action and issued a warning letter outlining measures that may be taken should the centre not brought back into compliance within a defined time frame. The provider submitted a time bound plan in response to this letter outlining the actions that would be undertaken and implemented to strengthen the governance and management arrangements and to address the areas of non compliance.

This inspection found that the provider had made significant improvements under both the capacity and capability regulations and those pertaining to quality

and safety of the centre. A newly appointed person in charge was based in the centre on a full time basis. Whilst the person in charge was not available on the day of inspection, it was evident that the commencement of the person in charge had led to increased oversight and monitoring of the service through the improvement of regulatory compliance and through positive feedback expressed by families and staff.

Systems of governance had improved with the contracting of an independent contractor to conduct unannounced six monthly audits in order to produce action plans for the provider in areas of improvement. The inspector reviewed a comprehensive action plan developed by the independent contractor which addressed areas for improvement in the centre. The action plan highlighted 16 actions for completion with attached time lines and persons responsible for carrying out the actions. Some of these actions were found to be outstanding and the assigned completion dates had lapsed. The views of staff members and family representatives were sought and these were reported upon, the views indicated that there was satisfaction with the changes in management which had the result of improved communication. The inspector found that residential meetings had commenced with senior management and persons in charge since the previous inspection in order to facilitate shared learning across the service.

The inspector found that staffing arrangements at the centre ensured that residents' assessed needs were met in a timely and sensitive manner, with support being provided as described in personal plans and associated support interventions. From a review of the roster it was found that improvements identified from the previous inspection to ensure that it was centred around the needs of the residents was fully implemented and the requirement for a second staff member until 11pm was consistently in place. Supervision records were not available to the inspector for review due to the person in charge being absent for the inspection, however it was found that formal supervision for the person in charge by senior management had not yet commenced since being in post.

The provider had implemented a schedule of training to address training gaps as identified in the previous inspection; all staff had attended training in the use of a hoist. Whilst some training needs were outstanding, dates had been booked within the coming weeks for completion. The inspector was satisfied that the training requirements were met in relation to the assessed needs of residents.

The inspector reviewed the complaints log and one compliant had been logged since the previous inspection which was found to have been appropriately responded to and satisfaction levels recorded.

Registration Regulation 7: Changes to information supplied for registration purposes

The provider failed to supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the

matters set out in Schedule 3.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was found to be actively involved in the governance and operational management of the centre and they were found to have the capacity to fulfil their role as person in charge for this centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that appropriate staff numbers were in place to meet the assessed needs of residents and continuity of care was provided in the centre. Staffing arrangements were found to centre around the needs of the resident. Staff files (Schedule 2) were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Overall the provider had implemented a good training programme which addressed many of the training deficits raised from the previous inspection. At the time of inspection there was still some outstanding training. Supervision records were not reviewed as part of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the inspector were satisfied with the overall arrangements in place for the governance and management of the designated centre and the oversight of delivery of care and support and care to residents, some areas of improvement were identified. These related to the frequency and effectiveness of the audits tool used.

The inspector found that audits not were carried out as per organisational policy and where audits were carried out they did not identify areas of non compliance or areas for improvement as found by the inspector due to the frequency in which they were being carried out and the detail contained within the audit. Supervision of the person in charge had not yet commenced.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints procedures, protocols were evident and appropriately displayed and available to residents and families. The complaints log was reviewed on inspection.

Judgment: Compliant

Quality and safety

The provider had made assurances to HIQA as to address regulatory breaches in safeguarding, healthcare and individualised assessment of need and personal plan. It is acknowledged that works had commenced in relation to all actions, with safeguarding of residents and healthcare found to be compliant by the inspector. However some improvements were still required to strengthen the systems in place to ensure that the assessment of need contained all information relating to the residents' health and well-being, personal development and that goal planning was consistent and regularly reviewed for progress. Additionally the inspector found improvements were enquired in risk management, fire prevention and medication management.

Since the previous inspection a new system in relation to the personal plans of the residents was implemented to better capture the assessed needs and supports required to assist with all aspects of the residents' daily lives. The healthcare needs of the residents had been responded to and annual reviews had commenced with clear follow up from staff in relation to blood tests and national screening programmes. From a review of a sample of the personal plans the inspector identified that comprehensive support plans had been developed to provide clear and concise guidance to staff to direct care relating to residents' assessed needs with evidence of medical and health allied health professionals such as Occupational Therapy and Speech and Language Therapy. The assessment of need required further development to ensure that it captured all aspects of the residents' health, personal and social care needs. Audits of personal

goal planning had commenced by the person in charge, however improvement was required in the goal planning process as the majority of goals were one off events such as shopping for clothes and there was a lack of evidence that identified goals were being progressed.

The inspector found that the management of safeguarding concerns was appropriate and in line with policy and best practice. All staff had received safeguarding and protection of vulnerable adults training and demonstrated a clear understanding of their role in responding to any allegation.

An up to date version of the risk policy was not available on site at the time of the inspection, this was reviewed by the inspector post inspection. This policy had been reviewed in November 2018 as a result of non-compliance in a previous inspection. There still remained some gaps in the policy and information relating to risk assessment was contained in a separate policy. The inspector found that all individual risk assessments for the residents had been reviewed since the last inspection and discussed at a recent team meeting these included transport, road safety, mobility and travelling independently. Risk assessments identified all known risks and staff were aware of same. Improvement was needed in the system that underpinned the risk assessment processes, for example the risk assessment policy referred to five by five risk matrix that combined impact and likelihood when determining risk, however the risk assessment used following a three by three matrix. Staff were responsible in the centre for devising risk assessments for new identified risks which differed from organisational policy, staff were found not to have risk assessment training.

Fire precaution measures had increased with the installation of new magnet releases for fire doors. Personal evacuation plans for the residents had been updated to contain detailed and concise information which clearly guided staff about individual residents' support needs in an emergency. The provider had ensured that the centre was also equipped with a range of fire safety equipment which was regularly checked and serviced to ensure its reliability in an emergency. Regular fire drills were occurring in the centre, both day time and simulated night drills, which indicated that the residents could be evacuated in a prompt manner. Improvements were required in the recording of fire checks to ensure any faults or defects were identified in a timely manner as a monthly fire safety inspection had not been completed since August 2018.

There were policies and procedures in place for the management of medication in this centre. A review of prescriptions and medication administration records for residents found that medication had been recorded as having been administered to residents as prescribed. Staff administering medications had completed specific training in the area and the inspector observed a staff member administrating medication respectfully, seeking consent of the resident and provided information on what they were doing. Staff spoken with were very familiar with, and could demonstrate, the systems in place for the ordering, receipt, prescribing, storage, disposal and administration of medications. Staff were also aware of the procedures in place to take if a resident refused medication. A stock check was conducted every week by staff to ensure medication that was used matched the remaining

balance. Some creams and liquid medication did not have an open date on them to ensure that it had not passed its expiry dates and one medication had conflicting information for administration. Medication audits occurred quarterly in the centre but some improvements were required with reviewing the effectiveness and timeliness of the audit template, as errors identified by the inspector were not areas for audit as listed by the tool utilised.

Regulation 26: Risk management procedures

The centre had reviewed its individual risk assessment since the previous inspector and staff demonstrated a good knowledge of these risks.Some changes were required in the systems for addressing risks specific to the centre and monitoring the action taken. The risk management policy did not provide adequate guidance to staff in this regard and did not include all required elements as outlined in the regulations.

- The measures and actions in place to control the risks identified.

- Arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

- Arrangements to ensure that risk control measures are proportional to the risk identified , and that any adverse impact such measures might have on the resident's quality of life have been considered.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, suitable fire precautions were in place to keep the residents safe in the event of fire. The centre had an established fire management system as required and fire equipment was serviced annually and quarterly. Improvements were required in the auditing and checks of fire documentation to ensure an effective system and any deficits are identified in a timely manner.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Overall, the centre had a comprehensive medicines management system to support the residents' needs. The centre had appropriate medication storage and administration practices in place. Staff that administered medicines to residents were trained in its safe administration. Improvements were required for the processes in place for expired or out of date medication and auditing systems to identity that the system complied with policy and best practice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Since the previous inspection the provider had introduced a new system to streamline the personal planning process and ensure that the personal plan reflected the needs of the residents as assessed by appropriate healthcare professionals, from which quality support plans were developed. Improvements were required to ensure that all needs of the residents were reflected in their personal plan; for example

1) Medical investigations that had been carried out were not reflected in the residents file and instead contained in the house diary.

2) The template for the assessment of need was limited and did not allow for all identified needs to be captured.

3) An Occupational Therapist recommendation in relation to the use of a mattress was not implemented.

4) Progress of goals were not always captured.

Judgment: Substantially compliant

Regulation 6: Health care

There was evidence that the provider was providing appropriate healthcare for each resident with evidence of regular and timely access to general practitioners, other

medical specialists and allied health professionals.

Judgment: Compliant

Regulation 8: Protection

Appropriate systems were in place relating to the investigation of and response to, any safeguarding concerns if they arose. Information relating to residents' intimate care was contained within the residents' personal plans. Staff spoken with had a good understanding of safeguarding and of the providers reporting procedures.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Teach Geal OSV-0003261

Inspection ID: MON-0025491

Date of inspection: 16/01/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: Documentation in relation to PIC sent to HIQA 1/2/19.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: PIC Training was completed on 14/11/19. Supervision Meeting completed on 17/1/19.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Supervisory completed 17/1/19	

Annual Audit completed 5/3/19 All actions highlighted in the 6 monthly report 28/11/18 are completed

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Risk Management Policy has been revised to reflect paragraph 16 of schedule 5 19/2/19	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire precautions reviewed by PIC 17/2/19. Fire precautions placed as an agenda item on all team meetings in the centre.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Medication Audit Tool is currently being reviewed by the Nurse for the Service. The revised Audit tool will come into effect 2nd & 3rd Quarter Audits.	
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:
All residents files have up-to date Annual Health Checks 21/1/19
The long term goals and progress of goals is an agenda item of PIC meetings.
The Annual Report highlighted PCP long term goals and a review of the PCP Goals will take place in Quarter 2 following PCP Audit.
Two Personal Plans have been completed in the centre and the remaining will be completed 31/3/19.

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
Registration Regulation 7(2)(b)	Notwithstanding paragraph (1) of this regulation, the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 3.	Not Compliant	Yellow	01/02/2019
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	17/01/2019
Regulation 23(1)(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	17/01/2019

	management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	05/03/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	19/02/2019
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to	Not Compliant	Orange	19/02/2019

	in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	19/02/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	19/02/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate	Not Compliant		17/02/2019

	arrangements for reviewing fire precautions.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	27/06/2019
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	27/06/2019

Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	21/01/2019
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	21/01/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant		21/01/2019

Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant		31/03/2019