Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

| | |
|---|---|
| Name of designated centre: | Glenveagh |
| Name of provider: | Glenveagh |
| Address of centre: | Dublin 9 |
| Type of inspection: | Unannounced |
| Date of inspection: | 08 August 2018 |
| Centre ID: | OSV-0002381 |
| Fieldwork ID: | MON-0024605 |

## About the designated centre

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

Glenveagh is a bungalow located within the main St Michael's House complex on the Ballymum Road. Glenveagh is within walking distance of lots of local amenities which residents frequently use. Glenveagh is a residential house which provides 24 hour support for six service users. It is a fully wheelchair accessible house. Glenveagh provides support for individuals with physical and intellectual disabilities with co-existing mental health concerns, individuals on the autism spectrum disorder, epilepsy and behaviours that challenge. The needs of residents are assessed on an ongoing basis through Personal Assessment Planning, Well Being reviews, Care Planning and Daily recording. Should a specific requirement arise for an individual service user, a meeting is organised known as an individual co-operation meeting (ICM).The dynamic staff team in Glenveagh have a wide range of experience and skills in varying fields. Staff members engage in ongoing training and development, both inside the organisation and independent of the organisation.

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

| | |
|---|---|
| Current registration end date: | 02/10/2019 |
| Number of residents on the date of inspection: | 6 |

## How we inspect

To prepare for this inspection the inspector or 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 |
|---|---|---|---|
| 08 August 2018 | 09:30hrs to 17:45hrs | Michelle McDonnell | Lead |
| 08 August 2018 | 09:30hrs to 17:45hrs | Sinead Whitely | Support |

## Views of people who use the service

Inspectors met with four residents who lived in the designated centre all of whom had a variety of communication supports. One of the residents spoke of activities they were taking part in that day and another showed inspectors their 'All about me' book.

Inspectors observed staff interacting with residents with dignity and respect and residents appeared to be happy in their home.

## Capacity and capability

The inspection was completed in response to risk and therefore a small selection of regulations were examined. The inspectors found that overall there were leadership and management systems in place and these provided a good structure of support for staff and it was found that residents were provided with a good service. Some improvements were required in the monitoring and reviewing of the service to ensure effective oversight.

A selection of audit and monitoring systems were reviewed and these captured the changing needs of the residents. There was monitoring of incidents and risks within the centre and these informed staff practice to ensure appropriate support was given to residents. However inspectors found that there was inconsistency in identifying, managing and minimising risk. An immediate action was issued relating to the provider's response to a risk in medication management. This was rectified subsequent to the inspection. The inspectors found that whilst all staff spoken with were knowledgeable about the residents and their needs, the support mechanisms to share information was not consistently monitored as staff meetings were one of the main ways information was shared but not all staff attended each meeting and it was not recorded if staff had read and understood the minutes.

The skill mix of staff, which included care and nursing staff, met the needs of residents. There were good communication systems that allowed staff to be responsive to resident's individual needs. For example, in discussions with staff members and reviewing personal files, it was evident that there had been a responsive change to staffing to support a resident with their particular needs and this had had a positive effective.

There were clearly defined management structures which provided support for staff and those spoken with outlined supervision that had taken place. Although staff were up to date with mandatory training, on the day of inspection not all staff

were trained to fully meet the needs of the residents as noted from specific training requirements, in particular in relation to oxygen therapy.

## Regulation 15: Staffing

There was an appropriate mix of staff to meet the needs of the residents.

Judgment: Compliant

## Regulation 16: Training and staff development

On the day of inspection not all staff were trained in practices that were the assessed needs of residents, for example positive behaviour support and oxygen therapy.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Monitoring systems in place were not effectively utilised and overseen as not all staff attended staff meetings and there was no record that absent staff had read meeting notes.

Judgment: Substantially compliant

## Quality and safety

The inspection found that were some systems in place to ensure that residents were provided with a safe and quality service. However, there were some areas where improvement was required. In particular an immediate action was issued in relation to medication required and the procedures to be followed by staff. Sufficient improvements were made subsequent to the inspection.

The person in charge had ensured that medicines errors and suspected adverse reactions were recorded. However, some practice relating to the storage and the administration of medication was not in line with best practice. The inspector observed medications with no expiration dates evident on the packaging which

would not facilitate staff to administer medication safely according to the ten rights of medication. There were not suitable practices in place relating to the secure storage of medicines on the day of inspection. Medicines had been locked within a locked press, however the key for this press was not stored securely. Staff were not facilitated to administer emergency epilepsy medication according to one resident's epilepsy protocol.

A sample of residents' files were reviewed and these showed that there was an assessment of need completed and this informed the care provided to residents. There was evidence of continued multidisciplinary team input from appropriate allied health professionals. There was also information from other services which was reviewed and changes made, as required, to the service provided to residents. However, some parts of the plans had no evidence of review since 2016 and others contained inconsistent information. Documentation reviewed and discussions with staff outlined that the staff was responsive to the changing needs of residents and that residents had been provided with opportunities to complete varied goals; from attending local amenities to flying to Lourdes.

There were positive behaviour support plans in place for identified residents and staff spoken with were aware of these plans. There was evidence that new needs were being identified and there were attempts to support residents with the least restrictive practice available. Although there were a number of residents that had positive behaviour support plans in place not all staff had received training.

## Regulation 29: Medicines and pharmaceutical services

Practices relating to the storage and the administration of some medicines was not in line with best practice.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Of the sample of resident files reviewed there were appropriate assessments in place however not all parts of the plan had been reviewed in the last year, in particular the quick reference guide in one plan was last dated 2016. In one plan front line staff were directed to contact allied health professionals for support whilst in another section the person in charge was responsible.

Judgment: Substantially compliant

| Regulation 7: Positive behavioural support |
| --- |
| Incidents of challenging behaviour were being recognised and responded to and attempts made to alleviate the behaviours without restrictive practices. |
| Judgment: Compliant |

**Appendix 1 - Full list of regulations considered under each dimension**

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| **Quality and safety** | |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support | Compliant |

# Compliance Plan for Glenveagh OSV-0002381

## Inspection ID: MON-0024605

## Date of inspection: 08/08/2018

### 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 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• All staff have appropriate training including refresher training as part of a continuous professional development programme.<br>• The CMN2 and CNM1 have a schedule of supervision meetings for all staff in line the SMH supervision policy.<br>• Regulation 16(1)(a): The Person in Charge will ensure that staff training in the area of Oxygen training in completed.<br>• Regulation 7 (1): The Person in Charge will continue to ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme.<br>• Regulation 7 (1) & (2): Positive Behaviour Support programme training is on going for all staff in Glenveagh this is subject to allocation of places for all staff members within St. Michael's House. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• The designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.<br>• There is a clearly defined management structure in the centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.<br>• Management systems are in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.<br>• There is an annual review of quality and safety of care and support completed for the designated centre. | |

- Six monthly unannounced reviews of quality of care and support are carried out and available for review
- Regulation 23(1)(c): The Person in Charge and Person in a Position of Management will establish a quarterly audit tool incorporating staff meetings, risk registers, service users Assessments of Needs, Medication management, Positive Behaviour Support Plans and individual support plans in order to ensure effect oversight.
- T Regulation 23(1)(c): The Person in Charge will ensure that staff meeting minutes are signed by members of staff not on duty to ensure effective oversight and communication.

| | |
|---|---|
| Regulation 29: Medicines and pharmaceutical services | Not Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- Regulation 29(4)(b): Protocol was developed by the Person in a Position of Management in liaison with Consultant Psychiatry in relation to administration of O2 therapy for a resident.
- Regulation 29(4)(b): The Person in Position of Management on day of the inspection sourced a locked box to be placed in residents double locked press within their bedroom in line with their epilepsy management protocol ensuring that quality and safety is maintained at all times for residents at all times.
- Regulation 26 (1) (a) and (b): The Person in Charge and Person in a Position of Management will establish a quarterly audit tool incorporating staff meetings, risk registers, service users Assessments of Needs, Medication management, Positive Behaviour Support Plans and individual support plans in order to ensure effect oversight. Reducing the risk of medication exceeding expiry dates through audits ensuring promotion of safe medication management.
- Regulation 29 (4): The Person in Charge consulted with Pharmacist to ensure that medication labels are appropriately to labeled to reflect each residents MAS including indications for use, expiry date so that staff can administer medication safely in accordance with the ten rights of medication administration.
- Regulation 29 (4): The Person in Charge will ensure that the key is stored securely within staff possession at all times. Board system implemented in relation to highlight shift leader and medication management.
- Regulation 29 (4) (a): Protocol devised on day of inspection in relation to the administration of emergency epilepsy medication relating to one residents epilepsy protocol.

| | |
|---|---|
| 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 have comprehensive assessments of need which are review annually or as required.
- All residents have personal plans that are meaningful to the person; these goals

are tracked and reviewed to ensure effectiveness.

- Personal plans are in an accessible format as required
- Regulation 5 (1) (b): The Person in Charge and The Person in a Position of Management along with the staff team will ensure that all quick reference plans will be completed for each resident to reflect their current needs.
- Regulation 5 (1) (b): The Person in Charge and The Person in a Position of Management along with the staff team will ensure that support plans and assessments appropriately reflect the member of the team responsible for corresponding and contacting allied health professionals. Ensuring that communications, reports and recommendations are communicated to the team and individual resident.

## Section 2:

## Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 16 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 | Training in identified areas will be completed 30/05/19 |
| Regulation 23(1)(c) | The registered provider shall ensure that management | Substantially Compliant | Yellow | 26/10/18 |

| | | | | |
|---|---|---|---|---|
| | 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 29(4)(b) | 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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. | Not Compliant | Red | 09 August 2018 |
| Regulation 05(6)(c) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan. | Substantially Compliant | Yellow | 26/10/18 |