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 Failte
Name of provider:	Peter Bradley Foundation Company Limited by Guarantee
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	10 April 2019
Centre ID:	OSV-0001521
Fieldwork ID:	MON-0023307

About the designated centre

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

Teach Fáilte is a midlands residential designated centre and transitional home to individuals with acquired brain injuries (ABI). It is home to a maximum of 12 persons. The centre is a large wheelchair accessible building comprising of two floors. There is an outdoor accessible garden area. Each person living there have their own bedroom in the centre. The centres focus is on readjustment to community living following brain injury, the improvement of functional skills, and health and medical management. The service is open and staffed on a 24/7 basis. The clinical team is comprised of a Clinical Psychologist, Local Service Manager, Assistant Psychologist, Senior Occupational Therapist, Basic Grade Occupational Therapist, Case Manager, Team Leader and a team of Rehabilitation Assistants. The Midlands team works closely together with the neuro-rehabilitation teams both at a local and national level in an interdisciplinary approach. The Neuro–Rehabilitation Team focuses on the persons' served assessment, intervention, outcome monitoring and evidence based practices, together with the provision of support through family liaison services to the person with an Acquired Brain Injury and other individuals and family/carers affected by the ABI.

The following information outlines some additional data on this centre.

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
10 April 2019	09:30hrs to 18:00hrs	Sinead Whitely	Lead

Views of people who use the service

The inspector had the opportunity to meet five residents on the day of inspection. Three of the residents spoke with the inspector on a one to one basis. In general, residents expressed satisfaction with the service being provided and the staff supporting them. One resident showed the inspector around their home to include their bedroom, en-suite, kitchen, dining area and living area. This resident voiced their high level of happiness with the staff and their home.

Care being provided appeared person centred and residents appeared to have choice and control in their daily lives. The inspector observed residents going about their daily routine. Some residents were attending individualised daily activities and using adaptive technology equipment with assistance from staff. The inspector observed some residents at meal times and these appeared to be relaxed and comfortable. Residents had ample choice at mealtimes and also had the opportunity to partake in preparing and cooking meals. Interactions between staff and residents appeared warm, friendly and respectful. Residents independence and rehabilitation was promoted an supported.

One resident voiced satisfaction with the service but also voiced their frustrations regarding the duration they had been waiting for their discharge to another placement. This was known to the provider and efforts were being made to facilitate a move when possible.

Capacity and capability

Overall, the registered provider was endeavouring to provide a quality service which promoted residents rehabilitation. There was a clear management structure in place. However, some actions from the previous inspection had not been addressed and some areas in need of improvements were identified on the day of inspection.

Appropriate staffing levels were in place to support the assessed needs of the residents. There was an actual and planned staff rota in place and staffing numbers and skill mix were in line with centres whole time equivalent outlined in the centres statement of purpose. There were rehabilitation assistants (RA) in place in the centre, who worked with a team of allied healthcare professionals to support residents individual rehabilitation needs. Staff spoken with appeared knowledgeable regarding the residents individuals assessed complex needs and personal plans in place. All staff had the required Schedule 2 documents in place. Regular supervision of care was being completed by a team leader.

There was a staff training program in place, and this included training in manual

handling, fire safety, safeguarding, positive behavioural support, epilepsy management and food safety. Staff spoken with appeared knowledgeable regarding the training they had received and this appeared to be guiding good care and practice. However, following a review of training records it was found that three staff members had not received all mandatory training. This included training in the safe guarding and protection of vulnerable adults and fire safety. The inspector acknowledges this training was scheduled to be delivered on a date close to the inspection day.

There was a defined management structure in place with lines of accountability. Staff were familiar with this structure and knew who to raise concerns with. There was a team leader who directly reported to the person in charge. There was an on-call system in place for staff to contact members of management outside of regular working hours, should the need arise. There was an annual review completed that appeared to drive some improvements in the designated centre. Six monthly unannounced audits were also completed by a person nominated by the provider. Staff were subject to regular performance management reviews and supervisions. These were used to highlight areas in need of improvement and to discuss key-worker responsibilities. However, a number substantially compliant and non-compliant judgements were identified by the inspector on the day of inspection. These were issues in areas statement of purpose, training, notification of incidents, healthcare, risk management, and fire-safety. Audit systems had not identified these areas of concern, or had not addressed them within time frames previously outlined to the authority.

There was a complaints procedure in place that was prominently displayed in the centre. Residents were aware of this procedure. There was a labelled complaints box in the main reception area of the centre. One resident showed the inspector this and communicated they could submit comments or complaints in this box if they preferred to. There was a service policy in place that guided practice. A sample of the complaints records were reviewed and complaints were addressed in a serious and timely manner. There was a designated complaints officer in place to manage and respond to complaints and staff and residents were familiar with who to raise a concern with. In general, residents had no open complaints on the day of inspection. One resident, when asked, voiced they had no complaints regarding the service being provided but raised their frustrations with the inspector regarding the duration they had been waiting for their discharge to another centre. The provider was aware of this and efforts were being made to facilitate the move when possible.

In general, notifications were being submitted in line with guidance. The person in charge had submitted a report to the Office of the Chief Inspector at the end of each quarter of each calendar year as required. However, this did not outline all environmental restrictive practices observed in the designated centre on the day of inspection.There were nine locked doors observed around the building on the day of inspection that residents did not have access to or access to keys for. These had not been recognised by management as environmental restrictive practices.

The statement of purpose in place accurately reflected the service being provided. However, this did not contain all items set out in Schedule 1 including the

information set out in the certificate of registrations and a description of the rooms in the designated centre.

Regulation 15: Staffing

Adequate staffing levels were in place to support the assessed needs of the residents. There was an actual and planned staff rota in place. Staffing numbers and skill mix were in line with centres whole time equivalent.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were appropriately supervised by a team leader. There was a training program in place, however three staff members had not received mandatory training including training in the safe guarding and protection of vulnerable adults and fire safety. The inspector acknowledges this training was scheduled to be delivered on a date close to the inspection day.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was an annual review completed that appeared to drive improvements in the designated centre. Six monthly unannounced audits were also completed. Staff were subject to regular performance management reviews and supervisions. However, actions from the previous inspection had not been appropriately addressed. This included actions in relation to fire safety. Furthermore, auditing systems in place were still not identifying some areas in need of improvements as highlighted in other areas of the report.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose in place accurately reflected the service being provided. However, this did not contain all items set out in Schedule 1 including the information set out in the certificate of registrations and a description of the rooms

in the designated centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had submitted a report to the Office of the Chief Inspector at the end of each quarter of each calendar year. However, this did not outline all environmental restrictive practices observed in the designated centre on the day of inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place that was prominently displayed in the centre. Complaints were addressed in a serious manner.

Judgment: Compliant

Quality and safety

The registered provider, persons participating in management, person in charge and team leader were striving to meet the individuals needs of all residents living in the designated centre. While it was evident that residents were very happy living in the centre, some improvements were needed to ensure residents safety at all times. Particularly in relation to fire safety and areas of healthcare.

There was a comprehensive assessment of need in place for all residents in the designated centre and these were informing the personal plans. These were reviewed, updated and maintained to a high standard. Plans were guiding staff to support resident with their most current personal, health and social care needs. Personal plans were reviewed on a regular basis and residents were part of this review process. Regular individual personal planning meetings were held with residents and members of the multi-disciplinary team. Goals were in place to promote residents social and rehabilitation needs and these were reviewed three monthly or more frequently if needed. There was a key worker system in place that ensured residents assessments and personal plans were up-to-date and reflected residents most current needs. Key workers spoken with, were knowledgeable regarding the individual needs of their assigned residents and were positive and

enthusiastic about helping and supporting residents to achieve their set goals.

Safe and appropriate practices were in place in relation to the ordering, receipt, prescribing, storage, disposal and administration of medicines. A sample of documentation reviewed, accurately reflected the administration of medication by suitably trained and qualified staff. The residents' medication prescription's was clear, regularly reviewed and accurately guided the administration of prescribed medication. Protocols were in place for the administration of emergency medication or medication to be administered as required (PRN). The residents availed of pharmaceutical services from a local pharmacy. Audits were carried out by staff to ensure this medication was dispensed as prescribed by the residents' general practitioner. A separate room with a secure storage facility was available to store medication in the house. This room had a keypad system to ensure security. Regular checks were being completed by staff to ensure drug balances were correct. Residents were facilitated to self administer medication when appropriate and safe, and self administration assessments had been carried out which mitigated any risk associated with this.

There was a system in place for the assessment and management of risk. There was a record of any risks identified in the designated centre and these had been assessed, risk rated and measures outlined to mitigate these risks. However some measures identified in risk assessments to mitigate risks were not in place in the designated centre. For example, actions outlined to mitigate risks associated with smoking in a designated area of the garden included regular checks on the area. However, there was no evidence in place that these checks were being carried out on a regular basis. Assurances were given on the day of inspection by management and staff that these checks are being completed but had not been documented appropriately. Furthermore, measures outlined in assessments for risks associated with working in the centres kitchen included staff training in the use of kitchen equipment. However, there was no evidence that this training was provided to staff.

Adequate measures were not in place for fire safety and the containment of fire in the designated centre. Numerous fire doors were observed as fixed open open around the centre for the duration of the inspection day. This was an action form the previous inspection and this had not been addressed within the dates outlined in the compliance plan submitted by the provider to the Office of the Chief Inspector. Some staff members did not have up to date fire safety training on the day of inspection. Staff were completing regular checks on exit routes, fire doors, emergency lighting, fire panels, emergency evacuation plans, assembly points and equipment. Equipment had been serviced regularly by an external company. However, issues relating to fire safety exit routes and emergency lighting identified by staff during routine checks on a number of occasions, were not addressed by the provider for a considerable period of time. Evidence of fire drills completed after June 2017 was not available on the day of inspection. There was no evidence of fire evacuation drills simulating night time conditions completed and not all staff members had taken part in a night time simulated fire drill. The person in charge communicated on the day of inspection that these had been completed but not appropriately documented.

In general, residents were supported to maintain their health. Residents had access to a general practitioner (GP) of their choice. The residents had access to a wide range of allied healthcare services and relevant referrals were being made by support staff when required. Supports were in place to promote individuals rehabilitation's following an acquired brain injury. Recommendations made by allied healthcare professionals were implemented into residents care plans and arrangements were in place to support these. However, details in relation to one residents specific healthcare plan for a care order was unclear at times. There were no records in the centre regarding who had decided this care order. Furthermore there was no record of review or referral for a review since 2017, no evidence of input from a healthcare professional available, no record of a capacity assessment and no records of discussion with the resident regarding this decision. The plan in place was contradictory to details discussed with staff and the person in charge at times. This posed a high risk to the residents health in the event of a medical emergency.

Positive behavioural support plans were in place where appropriate, that effectively guided staff to deliver care using a person centred approach. These were subject to review with regular input from allied healthcare professionals. Any actions from these reviews were addressed in a timely manner. Staff had access to training for the management of behaviours and intervention techniques. Staff spoken with had good knowledge of individual plans in place and training provided appeared to be guiding care provided. Evidence of therapeutic interventions being utilised was observed. These included a low arousal environment, use of technology equipment and personalised accessible calendars. Every effort was made to identify and alleviate the cause of the residents behaviours.

The registered provider had ensured that measures were in place to safeguard residents. Any incident or allegation of suspected abuse was investigated in line with national policy and notified to the Office of the Chief Inspector. Staff spoken with, appeared knowledgeable regarding signs of abuse, different types of abuse and steps to take in the event of an allegation or incident. There was a designated officer in place to investigate any safeguarding concerns in the designated centre. Safeguarding plans were in place where appropriate. The inspector reviewed a sample of progress reports and the centres accident and incident log and found that any issues in relation to safeguarding were escalated appropriately.

Regulation 26: Risk management procedures

There was a system in place for the assessment and management of risk. However some measures identified in risk assessments to mitigate risks were not in place in the designated centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Adequate measures were not in place for containment in the event of a fire. Some staff members did not have up to date fire safety training on the day of inspection. Furthermore, issues relating to fire safety exit routes and emergency lighting which was identified by staff during routine daily checks on a number of occasions, were not addressed by the provider for a considerable period of time. Evidence of fire drills completed after June 2017 was not available on the day of inspection. There was no evidence of fire evacuation drills simulating night time conditions completed and not all staff members had taken part in a night time simulated fire drill.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Safe and appropriate practices were in place in relation to the ordering, receipt, prescribing, storage, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need in place for all residents and these were informing the personal plans. Personal plans were reviewed on a three monthly basis and residents were part of this review process. Goals were in place to promote residents social and rehabilitation needs. There was a key worker system in place that ensured residents assessments and personal plans were up-to-date and reflected residents most current needs.

Judgment: Compliant

Regulation 6: Health care

Residents had access to allied healthcare professionals when appropriate and where medical treatment was recommended, this was facilitated. Residents had access to a

general practitioner (GP) of their choice.

However, details in relation to one residents specific healthcare plan for end of life care was unclear at times. There was no evidence of the plan in place on the day of inspection and no evidence of input or review from a healthcare professional available. This was contradictory to details discussed with staff and the person in charge. This posed a risk to the residents health in the event of an emergency.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Positive behavioural support plans were in place where appropriate. These were subject to review with regular input from allied healthcare professionals. Staff had access to training for the management of behaviours and intervention techniques. Evidence of therapeutic interventions being utilised was observed.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured that measures were in place to safeguard residents. Any incident or allegation of abuse was investigated and escalated in line with national policy and notified to the Office of the Chief Inspector. Staff spoken with, appeared knowledgeable regarding signs of abuse and steps to take in the event of an allegation. There was a designated officer in place to investigate any safeguarding concerns in the designated centre.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Teach Failte OSV-0001521

Inspection ID: MON-0023307

Date of inspection: 10/04/2019

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**
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 to work with ABII training Manager to set out local staff training plan Training to be monitored and discussed in individual staff supervisions All mandatory training for new starters current staff since inspection has been carried out Completed by 29th April 2019	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Review of recent audits to be completed and outstanding actions addressed. Any national service improvements identified through this audit will be notified to the Quality Committee to inform change to the audit form and audit completion nationally. Date for Completion by 31st July 2019	

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of Purpose reviewed and updated to include Conditions of Registration Completed by 9th July 2019	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Review of restrictive practices to be completed within the centre to ensure all such practices are appropriately recorded. Any unreported restrictive practices will be notified to HIQA, both on ongoing and retrospective basis as required. Date for Completion by 31st July 2019	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Review of current risks and controls to be completed and any outstanding unimplemented risks will be addressed. Date for Completion by 31st July 2019	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Upgrade of fire doors to support access to rooms and containment in the event of fire have been completed (10th of July 2019)	

Staff training completed April 29th 2019 (included night time evacuation training) All maintenance issues have been addressed relating to fire safety exit routes and emergency lighting. Maintenance Log Book available for staff to inform Management of maintenance concerns. All Fire Drills are currently recorded and filed appropriately. Staff to be supported to ensure accurate completion and reporting of daily and weekly fire checks Date for Completion by 31st July 2019

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Review of End of Life Plans for residents and, where identified, involvement of relevant healthcare professional to ensure clarity in relation to staff protocol at time of medical emergency. Date for Completion by 31st July 2019	

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(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	29/04/2019
Regulation 23(1)(c)	The registered provider shall ensure that 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.	Substantially Compliant	Yellow	31/07/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	31/07/2019

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/07/2019
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	29/04/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be	Not Compliant	Orange	29/04/2019

	followed in the case of fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	12/04/2019
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	31/07/2019