Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Teach Failte
Name of provider:	Peter Bradley Foundation Company Limited by Guarantee
Address of centre:	Offaly
Type of inspection:	Short Notice Announced
Date of inspection:	23 July 2020
Centre ID:	OSV-0001521
Fieldwork ID:	MON-0029979

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:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Thursday 23 July 2020	10:00hrs to 16:00hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

There were four residents residing in the centre on the day of inspection and the inspector had the opportunity to meet with three of them. Overall, the inspector found that residents spoken with appeared happy living in the centre.

One resident was observed laughing and enjoying a game of snooker with a staff member in the centres communal reception area. The resident said they were happy and had no complaints when asked. Interactions observed between staff and residents were familiar and respectful.

One resident spoke with the inspector one to one about living in the centre. The resident expressed that they were very happy there and liked all the staff that supported them. The resident showed the inspector some woodwork pieces they had created. The resident also showed the inspector around the centres garden area and some flowers they had planted in recent times.

Some of the residents normal activities had been impacted due to COVID-19 restrictions. Residents were supported to continue to engage in meaningful in-house activities safely during the lockdown period. Residents were supported and encouraged to partake in daily meal preparation. A wheelchair accessible kitchen was available for residents to use if needed.

Capacity and capability

The registered provider demonstrated capacity and capability to provide a safe and effective service to the residents living in Teach Failte. The centre and staff working there were supporting residents rehabilitation following an acquired brain injury and care and support was tailored specifically to each residents rehabilitation needs. Non compliance's identified on the centres most previous inspection had been addressed appropriately by the provider.

The service was staffed on a 24/7 basis and the staff team comprised of a Clinical Psychologist, Local Service Manager, Assistant Psychologist, Occupational Therapist, Case Manager, Team Leader and a team of Rehabilitation Assistants. Appropriate staffing levels were in place to meet the needs of the residents. Clear staff rotas were in place and specific roles and task were allocated to each staff member daily. Regular formal staff supervisions were being completed by line managers every four months. Clear schedules were in place for these to occur. Performance reviews were also being completed six monthly.

Following a review of Schedule 2 documents, it was found that not all required

pieces of information were in place in all staff files. Some staff did not have up to date photo identification and evidence of qualifications. Service policy stipulated that refresher Garda vetting should take place every three years. Two staff members had evidence of initial Garda vetting in their staff file but no evidence of refresher vetting since 2012. One staff did not have a second working reference in place. The service human resources team had recently moved to an online system and the person in charge communicated that these pieces of information were available in hard copy in files off site. The inspector had requested two days prior to the inspection date, that all Schedule 2 documents be available for review on site on the day of inspection.

Training was provided to meet the needs of the residents. Training was provided in areas including safeguarding, children first, infection control, first aid, behaviour management, fire safety, food safety, epilepsy management, and manual handling. However two new staff had not completed all mandatory training prior to commencing work. This included training in safeguarding and fire safety.

There was a clear management structure in place and clear lines of accountability. There was regular auditing and review of the service provided. The person in charge was supported by a team leader. The inspector observed evidence that there was regular oversight and auditing to drive improvements in the centre. Service audits and review had continued during the COVID-19 lockdown period. Six monthly audits had been completed by the service manager. These identified some actions where there were areas in need of improvements and clear plans and time lines to complete these actions. The person in charge had completed the centres most recent annual review. This used the standards and regulations as a tool for making judgements on the quality of service provided. This ws then reviewed by the service quality officer.

There was a clear complaints procedure in place. The inspector observed the centres complaints records and found that complaints were managed in a serious and timely manner. Residents spoken with expressed no complaints regarding the service provided when asked. The complaints procedure was prominently displayed in the centre and there was a designated person responsible for the management of complaints. There was a box in place in the reception area of the centre for residents to submit any comments or complaints they had confidentially. Surveys were issued to residents and their families annually and these were an opportunity for residents and family to submit feedback on different areas of the service provided including staffing, complaints management, premises and dignity and respect. One survey commented that the centre provided invaluable support to their family member.

Regulation 15: Staffing

Appropriate staffing levels were in place to meet the needs of the residents. However, following a review of Schedule 2 documents, it was found that not

all required pieces of information were in place in all staff files.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training was provided to meet the needs of the residents. However some new staff had started working in the centre and had not completed all mandatory training prior to commencing work.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in place and clear lines of accountability. There was regular auditing and review of the serivce provided.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. Complaints were managed in a serious and timely manner.

Judgment: Compliant

Quality and safety

Overall the inspector found improvements were evident since the centres most previous inspection. Safe systems were in place to provide care, support and rehabilitation to residents. Residents appeared to have choice and control in their daily lives including their daily routines, activities, mealtimes and environment. Residents spoken with appeared happy and content living in the centre.

The premises was designed and laid out to meet the assessed needs of the residents and maintained in a suitable state of repair internally and externally. The centre was a large wheelchair accessible building comprising of two floors.

There was also an outdoor accessible garden area. Each person living there had their own bedroom which they had personalised in line with their own preferences.

The person in charge had ensured that all residents had a comprehensive assessment of need and personal plan in place. These were all regularly reviewed. All residents had personalised goals and aspirations in place. These were part of the resident overall rehabilitation goals. An new online system was being used for residents personal plans and assessments. Paper versions of residents plans were also in place if needed. The residents had key workers who were responsible for ensuring regular review of residents records and for supporting residents to achieve goals. One resident had a goal in place to practice regular mindfulness and engage more in the community. Staff were supporting them to take minor daily steps to achieve this goal. Plans in place clearly identified residents likes and dislikes. One resident had a longterm goal in place to move back out to the community and live independently. A comprehensive transitional plan was in place to support this. Plans were also in place to support residents socially, emotionally, physically and spiritually at the end of their lives

Appropriate systems were in place for the assessment management and ongoing review of actual and potential risks in the designated centre. The centre had a monthly health and safety checklist which looked at the centres heating systems, electrical systems, gas appliances, lighting and furnishings. The centre also had a building risk assessment in place and this identified potential hazards, people at risk and control measures to mitigate potential risks. There was a plan in place for the evacuation of all residents to another location, in the event of an emergency.

The registered provider and management had ensured that measures were in place to protect residents from health care associated infections. The centre had adapted new daily schedules and procedures in light of the COVID-19 epidemic. The service had ample supplies of personal protective equipment (PPE) on the day of inspection and the inspector observed numerous hand washing facilities around the centre. The inspector also observed the centres laundry room where appropriate facilities were in place for the safe washing and drying of residents clothing and laundry. Staff had completed additional training on the use of PPE and infection control. Residents had been facilitated to video call family members during the COVID-19 lockdown period. The centre was visible clean on the day of inspection and staff were observed following comprehensive timed cleaning schedules. Staff were also observed donning appropriate PPE in line with national guidance throughout the day of inspection. A specific COVID-19 folder was in place with up-to date guidance for staff to refer to.

The registered provider had ensured effective fire safety management systems were in place in the designated centre. The inspector observed fire fighting equipment, emergency lighting, containment measures and detection systems around the building. Magnetic door closures had been implemented in the centre since the most previous inspection. This facilitated wheelchair users. Evacuation routes in the event of a fire were clearly displayed around the centre. Simulated fire drills were taking place regularly with staff and residents. Staff were completing regular fire safety

checks.

Residents were supported to manage their behaviours. Positive behavioural support plans were in place where appropriate and residents had access to multi disciplinary supports when required. All staff had completed training in the management of behaviours that challenge. Staff spoken with were familiar with resident individual needs and behaviours secondary to their acquired brain injuries. Some resident enjoyed accessing music therapy in the centre.

Residents in the designated centre were safeguarded. The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse in line with national safeguarding guidance. All residents had intimate care plans in place and these detailed different levels of support needed in different specific daily personal care tasks. Staff spoken with were aware of who to speak with should a safeguarding concern arise and safeguarding protocols were in place where required.

Regulation 17: Premises

The premises was designed and laid out to meet the assessed needs of the residents and maintained in a suitable state of repair internally and externally.

Judgment: Compliant

Regulation 26: Risk management procedures

Appropriate systems were in place for the assessment management and ongoing review of actual and potential risks in the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider and management had ensured that measures were in place to protect residents from healthcare associated infections and had adopted new procedures in light of the COVID-19 epidemic.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured effective fire safety management systems were in place in the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that all residents had a comprehensive assessment of need and personal plans in place. These were all due to regular review. All residents had personalised goals and aspirations in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours. Positive behavioural support plans were in place where appropriate and residents had access to multi disciplinary supports when required.

Judgment: Compliant

Regulation 8: Protection

Residents in the designated centre were safeguarded. The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents appeared to have choice and control in their daily lives. Residents spoken with appeared happy and content living in the 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
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Teach Failte OSV-0001521

Inspection ID: MON-0029979

Date of inspection: 23/07/2020

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: • There has been a full review of all staff documentation as per the Schedule 2 requirement. • Any staff documentation that was noted as being outstanding has now been uploaded/ requested • Garda re-vetting process has commenced in respect of all staff in the service • The above will be completed by the end of November 2020	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A review of all training requirements has been completed • All staff noted as having mandatory training outstanding have now been enrolled in the requisite courses • A protocol is in place for new starters in the current Covid Environment whereby local Management will risk assess each training and oversee mandatory induction training and sign off same with the Training Department • This training will be completed by December 2020	

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	30/11/2020
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	31/12/2020