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:	Abbeytrinity Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Short Notice Announced
Date of inspection:	19 August 2020
Centre ID:	OSV-0004067
Fieldwork ID:	MON-0030143

About the designated centre

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

Abbeytrinity Services provides a full-time residential care service to people with an intellectual disability who have been identified as requiring a support level ranging from low to high, and also to people with intellectual disability and autism. This service can accommodate male and female residents from the age of 18 upwards. Abbeytrinity Services cannot accommodate individuals with complex medical or physical needs. The centre is a two-storey house with a garden in a residential area of a rural town. Residents at Abbeytrinity Services are supported by a staff team which includes a social care leader, who is the person in charge, in addition to social care workers and care assistants. Staff are based in the centre when residents are present and a staff member sleeps in the centre at night to support residents.

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
Wednesday 19 August 2020	10:30hrs to 16:00hrs	Jackie Warren	Lead

What residents told us and what inspectors observed

The inspector did not speak with any residents during the inspection, as residents were out with staff during the day.

Capacity and capability

Overall there was a good level of compliance with regulations relating to the governance and management of the centre and the governance arrangements in the centre ensured that a good quality service was provided to residents. However, some improvement was required to documentation and recording of information, including policies and procedures.

HIQA had received some unsolicited information relating to concerns regarding some care practices in the centre. The regulations regarding these issues were viewed as part of the inspection.

There was a suitably qualified and experience person in charge who was very familiar with residents' care and support needs.

The provider had ensured that staff were suitably trained for their roles. Staff who worked in the centre had received mandatory training in fire safety, behaviour support, manual handling and safeguarding, in addition to other training relevant to their roles such as medication management and feeding, eating, drinking and swallowing.

Improvement was required to the management of records and documentation. While some records viewed were maintained in a clear and orderly fashion, were up to date and were comprehensive, some records required improvement. For example:

- improvement was required in relation to some records provided to guide staff in various aspects of healthcare
- the support interventions in place to manage a specific behaviour of concern had not been documented as a plan of care to guide all staff
- some intimate care plans were not presented in sufficient detail and did not reflect the care being described in the centre
- some nutritional care guidance was disjointed and did not fully reflect required care.

Although there were no concerns about the delivery of healthcare, nutritional care or intimate care in the centre, the absence of clear recorded guidance increased the potential risk that staff may not be clear on all requirements and that care could be delivered inconsistently.

A range of polices and procedures were available to inform practice in the centre, and were accessible in both hard and soft versions. A sample of policies viewed were up to date. However, information in some policies was not sufficient to guide practice. For example, the complaints and infection control policies were not comprehensive and did not reflect the practices that were happening in the centre. The complaints policy did not include sufficient guidance on the process for receiving and recording complaints and the appeals process, while the infection control policy did not provide guidance on all the required interventions to be implemented to reduce the risk of any type of infection spread. It was evident that staff were managing these areas in line with good practice, but this was not captured in the policies. Furthermore, the policy on residents' personal property did not include any guidance on the appropriate disposal of residents' property when required.

The provider had developed a contingency plan to reduce the risk of COVID-19 entering the centre, and for the management of the infection should it enter the centre. The inspector viewed this plan and it was comprehensive and relevant. The contingency plan included training in hand hygiene, use of personal protective equipment (PPE) and provision of a range of up-to-date information and guidance regarding COVID-19 and it's management and control measures.The plan also included a range of safety measures which were being implemented, such as temperature monitoring, updated risk assessments and revised protocols for visiting.

There were arrangements in the centre for the management of complaints. There was a complaints procedure displayed as required, although a separate complaints policy required review to ensure that the policy content was informative and comprehensive.

Regulation 14: Persons in charge

The role of person in charge was full time and the person who filled this role had the required qualifications and experience. The person in charge was very knowledgeable regarding the individual needs of each resident.

Judgment: Compliant

Regulation 16: Training and staff development

All staff who worked in the centre had received mandatory training in fire safety,

behaviour support, manual handling and safeguarding, in addition to other training relevant to their roles.

Judgment: Compliant

Regulation 21: Records

Records viewed were maintained in a clear and orderly fashion, were up to date and were suitably stored. However, some improvement was required in relation to some records provided to guide staff in various aspects of healthcare.

Judgment: Not compliant

Regulation 23: Governance and management

There were effective leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality and safe service to residents. However, some organisational policies and procedures required review to strengthen the governance process. Improvement to documentation and records was also required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider's complaints management process required improvement. The organisation's policies and processes for the management of complaints were not clear and some were not in line with the requirements of the regulations. However, there had been a low level of complaints in the centre and any complaints had been taken seriously, recorded and investigated.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A range of policies and procedures had been developed and were available to staff in the centre. However, some of the policies viewed did not provide sufficient

information to guide staff.

Judgment: Substantially compliant

Quality and safety

The provider had measures in place to ensure that the well-being of residents was promoted.

There were suitable systems to control the spread of infection in the centre. There was extensive guidance and practice in place to reduce the risk of infection, including robust measures for the management of COVID-19. These included adherence to national public health guidance, availability of PPE, staff training and daily monitoring of staff and residents' temperatures and health symptoms. All staff who worked in the centre had been tested for COVID 19 and all had received negative test results. Furthermore, the centre was maintained in a clean and hygienic condition, there was a supply of hand sanitising gels available for use.

The provider had protocols in place for the return of visiting to and from the centre in line with national public health guidance. Residents had resumed limited personal contact with family and friends subject to risk assessment and adherence with the required protocols. Staff had arranged for residents to keep contact with their families through phone calls and social media when personal visiting had not been possible during COVID-19 restrictions.

There were arrangements in place to ensure that residents' healthcare was being delivered appropriately, including measures to protect residents from COVID-19. There was evidence that the health needs of residents were assessed and involvement of the relevant health care professionals, such as general practitioners, speech and language therapist, dentists and specialist consultants was arranged as required. During the COVID-19 pandemic, access to general practitioners and healthcare professionals continued to take place as required, either by telephone or in person. Staff were reviewing residents daily for the signs and symptoms of COVID-19, and monitoring residents' temperatures.

The provider also had measures in place to support any resident with a behaviour of concern. All staff had received up-to-date training in this area and the person in charge discussed interventions in place to support and reduce risk associated with identified behaviour of concern However, a plan of care for a specific behaviour support had not been developed to inform staff. This presented a risk that some staff might not have ready access to consistent, up-to-date information to guide practice.

Regulation 11: Visits

Arrangements had also be made for residents to have personal visits with families. These visits were arranged subject to risk assessment and in line with national guidance.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had measures in place to ensure that the spread of infection in the centre was well managed. Additional practices and procedures had been introduced and implemented to reduce the risk of COVID-19 infection entering the centre.

Judgment: Compliant

Regulation 6: Health care

There were arrangements in place to ensure that residents' healthcare was being delivered appropriately, including measures to protect residents from COVID-19.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had not put suitable measures in place for the support and management of behaviour of concern.

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Abbeytrinity Services OSV-0004067

Inspection ID: MON-0030143

Date of inspection: 19/08/2020

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Records have been updated to reflect residents' healthcare needs. The content of healthcare plans will be discussed as part of the Agenda at monthly staff meetings to ensure all staff working in designated centre are aware of any specific issues. Any changes to healthcare needs will be recorded by the Person in Charge and all staff made aware through the healthcare records on file. Person in charge will continue to work on ensuring that all documents and records are maintained to a high standard.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Organisational Policies and Procedures are reviewed on a scheduled basis by the Policy Advisory Group to ensure compliance with regulatory and legal requirements. Amendments have been made to Service Users Finances procedures since this inspection was carried out. Records have now been updated to reflect service user's healthcare needs. Person in charge will continue to work on ensuring that all documents and records are maintained to a high standard.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The complaints policy and procedure has been reviewed and is in line with the regulations, however, the policy and procedure along with all flowcharts and local complaints processes will be presented by the Quality and Compliance Department at an information sharing session with the staff team.	

There is a flowchart available to staff to ensure they are familiar with and comply with current procedure in terms of management of any complaints that are submitted to service.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Organisational Policies and Procedures are reviewed on a scheduled basis by the Policy Advisory Group to ensure compliance with regulatory and legal requirements.
A number of flowcharts are available to staff to ensure familiarity with specific procedures such as complaints. All updated Schedule 5 documentation is available on the intranet for all staff to access.
Person in Charge will update staff at monthly staff meetings of any updates to the schedule 5 documentation on the intranet.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Contact has been made between Person in charge and the psychology Department in July 2020 with regards to behaviours of concern. A follow up meeting is scheduled for 17/09/2020 with the psychology department after which there will be further suitable clinically approved measures put in place for the support and management of behaviour of concern.
All staff will be made aware of the measures proposed by psychology department to ensure consistency of approach.

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	14/09/2020
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	14/09/2020
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is	Substantially Compliant	Yellow	31/10/2020

	in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.			
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/09/2020
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/09/2020