

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Galway
<b>Centre ID:</b>	OSV-0003530
<b>Centre county:</b>	Galway
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Galway
<b>Provider Nominee:</b>	Anne Geraghty
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	10
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

**Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 08 April 2015 10:40 To: 08 April 2015 21:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This monitoring inspection report details the findings of a one day monitoring inspection of a designated centre which is part of the Brothers of Charity Services; Galway. The designated centre provided accommodation and support services for male and female adults with an intellectual disability. The inspector met with residents, staff members and members of the management team. The inspector observed practices and reviewed documentation such as personal plans, risk management documentation, medical records, policies and procedures.

The centre comprised of two residential units, both of which were single story bungalow/dormer style properties. All residents living in the centre had their own bedrooms which had been personalised to their individual tastes and to meet their specific needs. Some residents required restrictive practices in place in order to mitigate risk should free access be allowed to certain areas, for example, areas that stored chemicals used for cleaning. Other residents were prescribed harness restraints to ensure safety during transport where residents otherwise could open their seat belt during transit.

Residents living in the centre had previously lived in a congregated setting within the Brothers of Charity Service; Galway. Anecdotal evidence from staff informed the inspector that the move to community inclusive living had reaped positive benefits

for the residents. There had been a significant reduction in the severity and frequency of behaviour that challenge incidents. While there was encouraging evidence that residents' needs were better met in their current living arrangements, there was no documented evidence to substantiate this. This formed an action within this report.

Residents' personal plans were detailed and up to date. Intimate care plans were detailed and comprehensive. Residents' health care was well supported and there was evidence of prompt referral to allied health professionals for review and intervention when a need or risk was identified. However, nutritional risk was not adequately monitored and a risk measure in place for a resident with epilepsy needs required review.

Overall the inspector was satisfied residents received a quality service which catered for their individual needs and provided positive behaviour support. There were non compliances found however, for example, Outcome 1 in relation to night time checks and residents privacy, Outcome 7 in relation to fire doors in one residential unit that were ineffective and Outcome 11 in relation to the management of epilepsy and nutritional risk identification. These are outlined in the body of the report with associated actions at the end of the report.

**Section 41(1)(c) of the Health Act 2007. Compliance 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.**

**Outcome 01: Residents Rights, Dignity and Consultation**

*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

Privacy and dignity for residents was the only aspect reviewed in this outcome.

At the time of the inspection a procedure was in place for most residents to be checked half hourly during the night whilst they slept. Staff spoken with were not clear on the reason to support this procedure being implemented for otherwise healthy residents. They also told the inspector that some residents woke up when they were being checked upon reducing the quality of their sleep. The practice of half hourly checks impacted on residents' privacy and sleep and required review.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

Each resident's well-being and welfare were documented in their personalised folder which included information about their backgrounds and their personal goals for the current year. A personal outcomes assessment tool formulated the goals for residents based on their interests, abilities and identified needs.

From a sample of resident's personal plans reviewed they were found to be individualised and person centred, for example; the resident's needs, choices and aspirations were clearly identified. There was also evidence of a multi-disciplinary team input documented in the resident's files, such as occupational therapy, physiotherapy and speech and language therapy. (SALT)

There were opportunities for residents' to participate in meaningful activities appropriate to their interests and capabilities. Residents were supported by staff to participate in recreational in their local community; such as attending hurling and rugby matches. Residents were supported to use electronic devices, such as an 'Ipad', which enhanced their leisure time and also provided the resident with a communicative device which facilitated choice.

Residents were supported to engage in social care activities from their home. The centre was allocated specific supports which were allocated in hours per day; some of those hours were allocated to the evening and weekends.

The inspector found that residents participated in their personal plan assessments and the developments of their outcome goals. Some goals identified from the sample of plans reviewed included holidays and trips away, attending a concert and attending a family wedding. These goals were reviewed at least annually. Residents' families were actively involved in personal planning meetings for residents and fund raised to provide enhanced living and leisure arrangements for residents in the centre.

**Judgment:**

Compliant

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The health and safety of services users and staff was provided for in the centre. However, there were some areas that required review in relation to fire doors, risk assessments for residents identified likely to abscond, visitors and infection control.

Vehicles used to transport residents were road worthy and insured. The health and safety statement for the centre was up to date.

Fire extinguishers in had been serviced in July 2014. The fire alarm panel had been serviced October 2014 in both residential units. Each resident had an individualised personal evacuation plan that documented the type of assistance they would need during an evacuation of the centre. These were located discreetly in their bedrooms at the side of their bed in most instances. A fire evacuation procedure was located in a prominent position in the centre with pictorial explanation of the procedure and location of exits. Emergency lights were over exit doors. Staff spoken with demonstrated good knowledge of fire safety procedures, they outlined what they would do in the event of a fire and evacuation procedures.

Fire compliant units, to hold an emergency key for exit doors, were fitted at each exit point throughout both residential units. This enhanced evacuation procedures within the centre. A clearly marked assembly point was located in the grounds of one of the residential units. However, in the other residential unit, the bus (used to transport residents) was designated as the assembly point. This required review as the bus was not a permanent marker for where residents could learn to mobilise to during a fire drill.

A visitors' sign in book was not maintained in either residential unit. Therefore it could not be used in the event of an evacuation to cross check who was present in the building and who had been evacuated, for example.

There were other risks associated with fire identified on this inspection. In one residential unit one fire door that separated two zones and three fire compliant bedroom doors did not close fully on release and stayed ajar. Some could not close fully even when pushed by the inspector. Fire and smoke containment measures in this residential unit were ineffective and required urgent action. This was relayed to the person in charge by the inspector during the course of the inspection. They undertook to contact the relevant professionals to fix the serious issue as a matter of urgency.

Infection control measures in the centre were adequate in the most part. A household staff member engaged in cleaning of each residential unit. There was a high standard of cleanliness observed in both residential units of the centre. There were also adequate hand washing facilities for residents and staff.

In one residential unit scratches to staff and residents had a high risk of occurring. Robust hand hygiene and nail care was necessary to mitigate risk of infection caused by scratches. On the day of inspection a staff member received a scratch injury. Some days previous another member of staff had also received a scratch that had broken the skin. Infection control and risk reduction measures for scratches required robust implementation and review to reduce the injury potential and risk of infection occurring as a result of a scratch injury to both residents and staff.

Potential risks and hazards in the centre were documented in a 'risk register'. This identified and documented potential risks. Each documented risk had an assessment of the level of risk and risk reduction strategies documented. Each resident also had individualised risk identification and associated risk reduction plans in place.

Despite robust measures in place and implemented by staff, as observed during the course of the inspection, one resident, identified at risk of absconding, did not have an associated risk assessment. This required review.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

Policies and procedures for the prevention, detection and response to allegations of abuse were in place.

Staff working in the centre had received training in the protection of vulnerable adults, (client protection). Newly appointed staff had received training in this area also. However, most staff had received training in 'client protection' as once off training without refresher training to ensure skills were adequately maintained in this area.

Of staff spoken with during the course of the inspection they demonstrated knowledge and understanding of what constituted abuse, the types of abuse and demonstrated an understanding of appropriate actions that should take place in response to witnessing abuse. They were aware of the name and contact details of the designated contact person.

Residents had intimate personal care plans. From the sample reviewed they were found to be comprehensive and detailed. They outlined in detail each personal care activity and the level of assistance the resident would require, for example, shaving or tooth brushing.

All residents living in the centre had the potential to display behaviours that challenge. During the course of the inspection, the inspector did not observe any significant



behaviour that challenges incidents. When behaviour that challenges did occur they were managed well by staff using de-escalation strategies. Staff working in the centre had received training in a 'low arousal' behaviour management model and demonstrated skills in the implementation of this during the course of inspection.

Residents that displayed behaviours that challenge had multi-element model behaviour support plans in place. These were detailed and outlined comprehensively the procedures staff should take to prevent or respond to behaviour that is challenging.

There was evidence of restrictive practices in use within the centre, more so in one residential unit. Each restrictive practice measure had an associated risk assessment and had been referred to and reviewed by a Human Rights Committee to ensure the restrictions were justified and in the best interest for the resident.

Most restrictions in place were to limit residents' access to certain areas that could pose a danger to some residents, for example, areas that stored chemicals for cleaning purposes. Harnesses were used by some residents that refused to wear seat belts while driving. Some exit doors were locked due to the high risk for a resident to abscond from the centre. This is further discussed in Outcome 7.

Anecdotal evidence from staff spoken with suggested there had been a significant decrease in the level of challenging behaviour exhibited by residents since they had moved to the residential units they lived in today. Previously those residents had lived in a congregated setting within the organisation. While this was certainly encouraging there was no other evidence to substantiate this. Periodic service reviews or audits as to the effectiveness of behaviour support interventions or restrictive practices in place were not documented and available for review at the time of inspection.

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The inspector reviewed a sample of health care plans for residents in both residential units of the centre and found residents were supported to have their health needs met in the most part.

Residents were supported to access health care services relevant to their needs. The inspector found that they had access to a general practitioner (GP). There was evidence

that residents had access to allied health professionals such as dietician, speech and language therapists (SALT), physiotherapy, psychiatry services and occupational therapy. They were supported by staff and/or family members to attend appointments and undergo necessary interventions, for example, blood tests relating to epilepsy management.

Both residential units had adequate space for storage of food with an additional stand alone freezer was observed in one of the residential units. Residents had the choice to eat out, order in takeaway or prepare meals in the centre as they wished. Fresh and frozen foods were in good supply in the centre. There was a good selection of condiments, oils, spices and herbs which were used in the preparation of nutritious meals for residents. Staff kept a record of the food choices offered to residents and if they liked or disliked them. This information formed the decision making around what menu choices were for residents each day/week.

Residents identified at risk of choking, due to compromised swallowing ability, had been referred to SALT for review and a modified consistency meal and fluids plan was prescribed.

Residents' weights were monitored regularly, however, a body mass index was not calculated to identify if the weight measured was one that indicated nutritional risk for the resident, for example, was the resident's weight correct for their height. Associated nutritional risk assessment tools were not used to assess if residents required referral to dietetic services based on any nutritional risk identified. Monitoring of nutritional risk was not robust enough and required review.

Residents that lived with epilepsy were supported well within the centre. Risk assessments and person specific management plans were in place to ensure residents maintained as much independence as possible taking into consideration their safety. Residents that experienced seizures were prescribed as required (PRN) emergency medication which could be administered during a seizure. Detailed protocols were also in place to guide staff in relation to emergency procedures.

However, some risk control measures in place for residents that may experience seizures at night time were not effective. For example, a listening device was switched on at night time as a method to alert staff if the resident was experiencing a seizure during their sleep. The type of seizure the resident has does not elicit noise that could be picked up on a listening device and therefore the intervention was not a useful risk management strategy.

Another risk management intervention was necessary whereby the night staff could be alerted should the resident stop breathing due to seizure activity.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**

Health and Development

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

Overall the inspector found medication management met with good compliance. Written operational policies and procedures were in place for the safe storage, administration and recording. The policy however, required some improvement to include guidance for staff in relation to safe disposal of medication procedures specifically to soiled or rejected medications.

Medications were securely stored in a locked cabinet in the staff office of both residential units. No resident required refrigerated or controlled medications at the time of inspection. Medication prescriptions were written into administration chart by the resident's medical practitioner as per the organisation's policy.

The person in charge was a safe administration of medication trainer and had oversight to ensure staff carried out safe medication practices. There was evidence to indicate staff carried out medication management audits on a monthly basis. Although this was good practice, copies of the original prescriptions were not maintained in residents' files and therefore were not used as part of the medication audit of administration charts. The robustness of medication auditing required review in light of this.

Residents' medications were stored in individually and segregated in the storage presses within each residential unit. A log was maintained when medications were received from the pharmacy and a balance record maintained.

The organisation had a comprehensive medication management policy which gave robust, best practice procedures in relation to most aspects of medication management. However, there was no policy or associated procedures relating to the safe disposal of soiled or rejected medications.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and*

**Theme:**

Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

The centre was managed by a suitably qualified person in charge with knowledge and experience commensurate to his role. He had multiple nursing qualifications in intellectual disability, sick children's, respiratory care and a Masters in healthcare management which he completed in 2010. He had experience of working in behaviours that challenge also and had been in management positions within the organisation for a number of years.

The person in charge outlined to the inspector that improvements were due to take place in relation to this. Persons participating in management, (team leaders and service coordinators) were undertaking an 18 month performance management course

There was documented evidence to show that the centre had been included as part of a quality audit carried out by the provider and nominated persons participating in management six months previous. However, the audit was not specific to the centre. The centre had been part of a larger designated centre with multiple residential units. Though the audits were detailed they were not centre specific and therefore were not entirely useful to direct quality improvements within this designated centre. Since the reconfiguration of the designated centre no further quality audit had been carried out since March 2014. This required review.

The person in charge of the centre worked in a full time capacity of 39 hours per week. He reported to the area manager (PPIM) who in turn reported to the adult west sector manager and the director of services. The person in charge was allocated responsibility for a number of designated centres. To ensure adequate governance arrangements in those centres, team leaders were allocated to each residential unit to ensure supervision and oversight of the day to day. However, they had not been notified to the Chief Inspector as persons participating in management despite engaging in managerial responsibilities. This required review.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**

Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**

This was the centre's first inspection by the Authority.

**Findings:**

There was a planned and actual staff rota in all of the houses. The Statement of Purpose identified the allocated staffing hours for each unit in the centre.

The person in charge had identified the necessity for three staff to work in one of the residential units due to the particular needs of residents living there. They had ensured in the staffing budget for 2015 that this extra resource would be part of the staffing compliment going forward. The inspector found staffing numbers met the needs of residents on this inspection.

Staff files were reviewed during the course of inspection. In the most part they were found to contain the matters as set out in Schedule 2. However, there was improvement required in relation to details and documentary evidence of any relevant qualifications or accredited training of the person maintained in staff files.

Staff had appropriate training to meet the needs of residents living in the centre in the most part. Some mandatory training, for example, client protection had not been kept up to date. This is further outlined in Outcome 8. The inspector identified that hand hygiene for the prevention of infection was necessary for staff working to support residents in one residential setting. This training had not been given.

Volunteers that worked in the centre were appropriately vetted. A volunteer coordinator was responsible for the supervision and allocation of volunteers to meet the needs of residents.

The person in charge engaged in supervision of staff working in the centres he managed. Staff spoken with confirmed he was approachable and available to speak with and run issues by as the need arose. He visited the designated centre at least once a week and sometimes more often should it be necessary. Though the person in charge was present and involved in the running of the centre, and staff confirmed they were appropriately supported, there was no formalised system for supervision within the centre.

**Judgment:**

Non Compliant – Moderate

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Ann-Marie O'Neill  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Galway
<b>Centre ID:</b>	OSV-0003530
<b>Date of Inspection:</b>	08 April 2015
<b>Date of response:</b>	15 May 2015

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Night checks of healthy residents not identified at risk was an invasion of those residents privacy and required review

**Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**

We have reviewed the requirement for the ½ hourly checks at night as recommended, and have reduced these for 9 individuals who reside in the designated centre. We intend to review the frequency of the remaining night-time checks in 3 months with a view to further reducing the frequency as appropriate to each individual. We are continuing to monitor one individual on a ½ hourly basis following consultation with their family and the MDT.

**Proposed Timescale:** 29/04/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Despite robust measures in place and implemented by staff as observed during the course of the inspection, one resident, identified at risk of absconding, did not have an associated risk assessment.

**Action Required:**

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**

We have scheduled a MDT review to update the risk assessment pertaining to the individual identified to include the risk of absconding.

**Proposed Timescale:** 22/05/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Infection control and risk reduction measures for scratches required robust implementation and review to reduce the injury potential and risk of infection occurring as a result of a scratch injury to both residents and staff in the centre.

**Action Required:**

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.



**Please state the actions you have taken or are planning to take:**

Individual behavioural management guidelines indicate the need to ensure that individuals who are identified as being likely to scratch others, have their nails kept short and clean.

Hand sanitizers have been installed in suitable locations throughout the designated centre, to augment the hand hygiene facilities already in place.

Staff have been scheduled to attend Infection Control and Hand Hygiene training on the 8th and 25th of June 2015.

**Proposed Timescale:** 25/06/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A visitors' sign in book was not maintained in either residential unit. Therefore it could not be used in the event of an evacuation to cross check who was present in the building and who had been evacuated, for example.

**Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**

A visitor's sign in book has been introduced across the designated centre.

**Proposed Timescale:** 13/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

In one residential unit one fire door that separated two zones and three fire compliant bedroom doors did not close fully on release and stayed ajar. Some could not close fully even when pushed by the inspector. Fire and smoke containment measures in this residential unit were ineffective and required urgent action.

**Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**

The doors identified were repaired on the 09/04/2015 and an invoice evidencing the repair was forwarded to the Lead Inspector.

Monthly checks with regard to the functionality of all automatic release doors have been included in the regular Health and Safety checks undertaken and documented in the

designated centre.

**Proposed Timescale:** 09/04/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

In the other residential unit, the bus (used to transport residents) was designated as the assembly point. This required review as the bus was not a permanent marker for where residents could learn to mobilise to during a fire drill, for example.

**Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**

We have amended the fire evacuation procedure in place in the identified residential unit in order to comply with the recommendation to have one fixed assembly point for both day and night evacuation.

**Proposed Timescale:** 15/05/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Periodic service reviews or audits as to the effectiveness of behaviour support interventions or restrictive practices in place were not documented and available for review at the time of inspection.

**Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**

Following discussion with the Team Leaders in both units, the CNS in Behaviour and the Psychologist who supports the designated centre, it has been agreed that a review of the various behavioural interventions required for each individual will be carried out and documented on a quarterly basis.

**Proposed Timescale:** 04/07/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Most staff had received training in 'client protection' as once off training with no refresher training to ensure skills were adequately maintained in this area.

**Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**

All staff in the designated centre have undertaken Client Protection Training and following this participated in the Good Practice Guidelines, which covers on Client Protection issues and the reporting of abuse procedures of the organisation, at team meetings.

The Brothers of Charity Galway Services has recently introduced a mandatory Client Protection Refresher training for all staff which will be undertaken every 3 years. All staff in the designated centre will have undertaken this Client Protection Refresher training by 30/06/2015.

**Proposed Timescale:** 30/06/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Another risk management intervention was necessary whereby the night staff could be alerted should a resident stop breathing due to seizure activity.

**Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**

In consultation with the identified individual's family we have removed the alert system that was in place. We are continuing to check the individual concerned on 1/2 hourly basis in a sensitive manner, as the individual concerned is a sound sleeper and is not disturbed by these checks.

**Proposed Timescale:** 29/04/2015

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Associated nutritional risk assessments were not used to assess if residents required

referral to dietetic services based on any nutritional risk identified. Monitoring of nutritional risk was not robust enough and required review.

**Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**

- All individuals residing within the designated centre have been referred to a nutritional therapist or a dietician, for assessment.
- A Nutritional Assessment Tool will be incorporated into the organisations current policy on food and nutrition to facilitate a standardised approach to nutritional risk. The organisations best practice committee on health is currently reviewing the MUST Assessment tool to this end.

**Proposed Timescale:** 30/06/2015

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Provider is failing to comply with a regulatory requirement in the following respect:**

The organisation had a comprehensive medication management policy which gave robust, best practice procedures in relation to most aspects of medication management. However, there was no policy or associated procedures relating to the safe disposal of soiled or rejected medications.

**Action Required:**

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**

A section covering medication that is rejected or soiled has been inserted into the organisations medication policy, which has been reviewed and updated. This policy is currently being circulated to the relevant unions for consultation. We anticipate that this process will be completed by 30/07/15.

**Proposed Timescale:** 30/07/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Copies of the original prescriptions were not maintained in residents' files and therefore were not used as part of the medication audit of administration charts. The robustness of medication auditing required review in light of this.

**Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**

A copy of all prescriptions will be taken and will be held in resident's file to increase the robustness of routine audits, as recommended.

**Proposed Timescale:** 01/06/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was documented evidence to show that the centre had been included as part of a quality audit carried out by the provider and nominated persons participating in management some months previous. However, the audit was not specific to the centre.

**Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**

An unannounced 6 monthly provider audit was carried out in the designated centre on the 13/04/15.

We are currently in the process of carrying out the designated centre's annual review.

**Proposed Timescale:** 30/05/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

To ensure adequate governance arrangements in those centres, team leaders were allocated to each residential unit to ensure supervision and oversight of the day to day. However, they had not been notified to the Chief Inspector as persons participating in management despite engaging in managerial responsibilities. This required review.

**Action Required:**

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**

Team Leaders are noted to be Persons Participating in Management and their positions are outlined in the Organisational Structure Chart in the Statement of Purpose of Creg Services. The role of the Team Leader as a person participating in the management of the day to day running of the centre will be further clarified in the Statement of Purpose.

When the designated centre is invited by the Chief Inspector to apply for registration, the Team leaders will be included as Persons Participating in Management and all required documentation will be submitted to the Chief Inspector along with the application for registration.

**Proposed Timescale:** 30/07/2015**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Though the person in charge was present and involved in the running of the centre and staff confirmed they were appropriately supported there was no formalised system for supervision.

**Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**

The organisation is in the process of introducing a formalised system of staff support and supervision across all settings. This support and supervision process has already commenced with the Team Leaders of both units within the designated centre.

Team Leaders in the designated centre are currently participating in training with regard to the further roll out of the organisations system of support and supervision and will commence its roll out with frontline staff on completion of the training. This will be further embedded through the Team Based Performance Management Plan in respect of each unit.

**Proposed Timescale:** 01/10/2015

## Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Training certificates and evidence of continuous professional development was not adequately maintained in the files

**Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**

The organisation prepares and circulates a Training Plan of internal staff training courses on an annual basis. The Training Plan is updated throughout the year as new training courses are added to the Training Plan. The organisation's Training Department maintains a staff training database that outlines all training undertaken by individual members of staff, including internal courses and external courses and conferences that staff are supported to attend. The Individual Training record of each staff member can be printed or viewed by the Person in Charge in each designated centre.

The designated centre maintains a training matrix in respect of mandatory training required namely; Client Protection, Studio 3, Studio 3 Refresher, Personal Outcomes and Key Worker Skills, Manual Handling, and Fire Safety Training.

The Brothers of Charity Galway Services has recently introduced a mandatory Client Protection Refresher training for all staff which will be undertaken every 3 years, and will be added to the mandatory training schedule.

We are currently linking systems to facilitate Training and HR databases to exchange information so that each individual member of staff's training record is viewable on their HR file.

**Proposed Timescale:** 01/10/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The inspector identified that hand hygiene for the prevention of infection was necessary for staff working to support residents in one residential setting. This training had not been given.

**Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**

Hand sanitizers have been installed in suitable locations throughout the designated centre, to augment the hand hygiene facilities already in place.

Staff have been scheduled to attend Infection Control and Hand Hygiene training on the 8th and 25th of June 2015.

**Proposed Timescale:** 25/06/2015