

**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-0004949
<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>	Florence Farrelly; Jackie Warren
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	18
<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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
21 April 2015 09:15	21 April 2015 21:20
22 April 2015 09:45	22 April 2015 17:45

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 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This report sets out the findings of a two day unannounced inspection. The inspection was carried out in response to unsolicited information received which detailed allegations of poor practice and alleged abuse against residents in the Brothers of Charity Service, Galway. The location of the alleged abuse was not specified.

In response to receiving this information The Authority carried out an unannounced triggered inspection in a designated centre located in one of the congregated settings for Brothers of Charity Service, Galway. The designated centre comprised of three residential units/bungalows. Residents living in the centre had severe to profound intellectual disabilities with associated significant health care issues in some cases.

This inspection had a specific focus on Safeguarding and Safety. Inspectors focused on aspects related to safeguarding and safety across the outcomes reviewed in this report.

Inspectors observed staff engaging with residents in a caring, genuine and respectful way throughout the two days of inspection. Narrative notes reviewed were equally

written in a manner which conveyed respect and care towards the resident. There were areas of robust safeguarding and safety practices. Outcome 8: Safeguarding and Safety, met with substantial compliance. Stringent auditing checks of residents' finances ensured robust safeguarding. There was also evidence to indicate a positive strive towards a restraint free environment in the centre was promoted. Outcome 12: medication management met with compliance as a direct result of reduced instances in which chemical restraint was administered to residents.

Inspectors were satisfied that the staff working in the centre were carrying out their duties to the best of their ability with reduced staffing resources. However, they were concerned in relation to staffing numbers, particularly at night time. One care staff was allocated to work at night in each residential unit of the centre. If an emergency evacuation of a residential unit was necessary the inspectors formed the view that the evacuation procedure/practice in place was unsafe and posed a risk to residents. Inspectors met with the provider, person in charge and person participating in management on the second morning of inspection and asked for an immediate review of this procedure.

Inspectors were also concerned that some staff working at night time were not trained to administer emergency medication for the management of epileptic seizures. A night supervisor (trained in emergency management of epilepsy) was allocated to the congregated setting campus at night time. They were delegated responsibility for the whole campus. Inspectors were not satisfied that the night supervisor could attend to a medical emergency in adequate time if they were for example, involved in another emergency in another part of the campus. Inspectors requested this to be urgently reviewed also. The issue of reduced staffing numbers in this centre, particularly at night time contributed to a number of non compliances found in the Outcomes reviewed on this inspection.

Major non compliance was found in Outcome 17: Workforce in relation to reduced staffing numbers. The number of risks identified during this inspection also led to a Major non compliance for Outcome 7: Health and Safety and Risk Management. Moderate non compliance was found in Outcome 1: Residents Rights and Consultation, Outcome 5: Social Care Needs and Outcome 14: Governance and Management.

Details of the findings in each outcome are detailed in the body of the report with an action plan at the end

**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:**

While inspectors found good practices within this Outcome, there were some improvements required. These were in relation to resident consultation practices and the complaints policy and procedures. Residents did not have a choice of time they went to bed and evening activities and night time checks, on otherwise healthy residents, impacted on their privacy and sleep.

During the course of the inspection, inspectors observed staff working in a respectful manner. Direct care practices were carried out in a way that maintained residents' dignity. For example, staff discretely assisted residents in personal hygiene and toileting and residents requiring help with feeding were assisted to do so in a gentle, patient way that met their needs.

Residents had their own bank accounts with bank cards and individual PIN numbers. They had full inclusion and supported autonomy in accessing banking services as needed. There were robust auditing procedures for the management of residents' finances to ensure safeguarding. An example of the auditing procedures included, balance checks by staff, maintenance of receipts and audits each month.

Each resident had their own bedroom which was decorated to their individual preferences with personal possessions and keep sakes on display. Each residential unit had space for residents to meet with visitors in privacy and comfort. For example, the conservatory was used in one of the residential unit when family members came to visit.

The Brothers of Charity Service, Galway has a 'service users council' they meet generally

four times a year. The council is attended by residents from throughout the organisation. One of the residents in the centre attended the council meetings. Information discussed at the council meetings was brought back to the centre. However, the resident did not bring the views of residents in their centre to the 'service user council'. Communications with the council were not two way. Improvement was required in relation to how residents in the centre were consulted on the service they received.

An inspector spoke to a resident's father during the course of the inspection. He indicated he was happy with the service his son received. He had good communication with staff and requested weekly emails detailing his son's health and welfare. He identified there were no restrictions for visiting times and he found staff working in the centre approachable. He also indicated he could make a complaint if he needed to and it would be addressed.

However, the complaints procedure and policy for the centre required review to ensure it met with the matters as set out in the care and welfare regulations. The complaints procedure was not centre specific. It did not identify the nominated person to deal with complaints by or on behalf of the residents. The procedure did not outline a nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints were appropriately responded to and a record of all complaints was maintained.

Complaints logs did not adequately document if the complainant was satisfied with how the complaint was addressed. The organisational policy for the management of complaints was dated 2008 and made reference to the Health Act 2004 it required updating and review to reflect the matters as set out in the Care and Welfare Regulations 2013. There is further discussion on complaints and concerns in Outcome 18 where an overlap in the terminology was used in some documentation reviewed.

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.

Staff working in the centre on day shift finished work at 9pm. One care staff worked in each of the residential units from 9pm till morning. Many residents, living in the centre's three residential units, required at least two staff to assist them to bed. All residents were assisted to bed before 9pm due to reduced numbers of staff working in each residential unit at night.

Residents could not choose the time they went to bed. This practice also meant residents could not engage in evening or night time activities due to reduced staffing after 9pm. The provider was required to review this as it negatively impacted on residents' rights, choice and access to social and meaningful opportunities.

**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:**

Residents' personal plans were reviewed in each residential unit within the centre. Residents' identified goals tended to focus on their health care needs, such as using physiotherapy equipment, rather than goals focused on actualising and maximising residents' potential.

Personal plans were large, detailed documentation folders. They contained information about residents such as their likes and dislikes, important people in their lives, their life story and narrative notes. Narrative notes included detailed, respectful language that formed a narrative of how a resident's day was spent or how a resident participated in an activity.

They also included assessments and recommendations by allied health professionals with associated recommendations. Allied health professionals accessed by residents included GPs, behaviour support specialists, psychiatrists, dieticians, occupational therapists and speech and language therapists. There was also a 'best possible health' section in each personal plan which contained detailed health care plans and recommendations for residents.

While personal plans were detailed and comprehensive goals identified for residents were health care focused. They did not adequately outline the supports required to maximise the resident's personal development in accordance with his or her wishes. For example, one resident's goals were identified as attending a doctor in relation to their ear, and for staff to take care of their skin integrity. While these goals were important they were not social care goals.

There were other instances where residents' social care goals had been identified but had not happened. One personal goal for a resident was to go bowling in 2014. The resident had not gone bowling in 2014. The barrier to the resident not achieving that goal was documented as 'not enough staff and wheelchair broken'. This required consideration and review by the provider and person in charge.

Some residents were observed by inspectors to engage in minimal activities throughout the course of the inspection, for example, an inspector observed a resident move from one part of their home to the other for extended periods of time without participating in meaningful engagement apart from going for walk around the grounds of the campus of which the designated centre was located.

Inspectors identified that inadequate staffing levels for the centre impacted negatively on residents' achievement of identified goals. Some goals identified in residents' personal plans were based on the availability of staff to help them achieve them rather than residents' wishes or aspirations. This required review. The issue in relation to inadequate staffing is further detailed in Outcome 17.

**Judgment:**

Non Compliant - Moderate

**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:**

Health and safety and risk management in the centre required significant review to ensure hazards and risks were appropriately addressed by the provider and person in charge.

Not all risks in the centre had been identified with associated control measures in place. Inspectors were concerned that residents' safety could not be ensured when carrying out emergency evacuation procedures at night time. Reduced staffing levels at night time contributed to this risk. Inspectors were also concerned not all staff working at night were trained to administer emergency medication to manage seizures. There was limited evidence of learning from adverse incidents in the incident recording system used by the organisation and there was also a security risk identified by inspectors which required review in each residential unit of the centre.

There were organisational policies and procedures relating to health and safety and the health and safety statement was up to date. There was also a risk management policy in place that covered the identification and management of risks. A risk register was in use in the centre indicating risks had been identified, assessed and their management. However, as mentioned previously, not all risks had been identified on the register, for example, reduced staffing numbers at night time. Not all risks were adequately reviewed and up to date either. Approximately 50% of falls risk assessments were not up to date. A resident had fallen in the centre five times in 2015 without an up to date falls risk assessment completed after any incident. This required review.



A computerised system captured data on accidents and incidents in the centre. However, preventative action and learning from adverse incidents was not identified on the incident/accident recording system. For example, there had been an incident where a sling (a piece of equipment used during the mobilisation of residents with a hoist) broke. There was documented evidence to indicate appropriate action had been taken by the staff at the time but no future prevention control measures were documented. This required review.

Inspectors could enter all residential units without impediment throughout both days of inspection. Though security had been identified on the risk register, control measures were vague and did not mention locking of doors as a security measure, for example. The provider was required to review security for the centre to ensure adequate measures were in place without impacting on residents' rights and freedom of movement to and from the centre.

Inspectors identified the numbers of staff working in the residential units of the centre at night time were inadequate to meet the evacuation needs of residents. Staff informed inspectors that they would leave a residential unit and go to another unit that required assistance in the event of an emergency evacuation. Inspectors were concerned this left residents unsupervised and was not safe to do so given that some residents had significant health care needs such as epilepsy.

Not all staff that worked at night time were trained to give emergency medication for the management of seizures and relied on the night supervisor to come to a residential unit and administer the medication in the event of an emergency. Inspectors were equally concerned in relation to this as the night supervisor had a remit to provide support and assistance to the wider campus the centre was part of and may not be able to assist in the event of an emergency.

These issues were brought to the attention of the provider, the person in charge and person participating in management (PPIM) on the second morning of inspection. The provider was asked to address this issue with urgency and provide inspectors with an appropriate plan of action which would address the issue. At midday the provider and PPIM had drafted an emergency evacuation procedure for the centre which outlined evacuation procedures which did not include leaving residents unsupervised. Inspectors were also given assurances that the staff working night duty would be trained in how to give emergency epilepsy medication that night.

Though inspectors were given some assurances from the redrafted fire evacuation procedure they requested the provider, person in charge and ppims to carry out a drill of the emergency evacuation procedure to ascertain its effectiveness before inspectors could be satisfied that evacuation systems were robust. At the time of writing the report the provider had not performed the evacuation drill at night therefore inspectors remained concerned and this outcome remains in major non compliance with the regulations.

**Judgment:**  
Non Compliant - Major

**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:**

On this inspection, inspectors did not find evidence that there was a risk to the safeguarding and safety of residents living in the centre in relation to abuse. There was some improvement required in relation to ensuring up to date policies and procedures were available to staff working within the centre.

As mentioned in the summary of this report, this unannounced inspection was triggered by information received by the Chief Inspector alleging that abuse of residents was happening in the Brothers of Charity Service, Galway. The unsolicited information did not make reference to where the abuse took place.

Inspectors reviewed aspects related to safeguarding and safety of residents across a wide range of outcomes on this inspection. This was to ensure a robust review of the services provided by the Brothers of Charity Service, Galway to the vulnerable cohort of residents that lived in this designated centre.

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

Most staff working in the centre had received training in the protection of vulnerable adults. 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. An action relating to this is given under Outcome 17.

Staff spoken with during the course of the inspection 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.

All staff spoken with throughout the course of inspection were given the opportunity by inspectors to disclose any knowledge of abuse practices they may have witnessed while

working in the centre. No staff spoken with reported any abuse to inspectors and denied witnessing any abuse over the time they had worked in the centre.

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, an intimate care plan for a resident detailed how they liked to have a shower and how staff should speak to them to reassure them and explain what was happening. This had been reviewed in April, September and December of 2014 and updated accordingly.

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. However, not all plans were up to date with one resident's support plan dated July 2013. A request for review of the plan had been submitted by the team leader in relation to this.

The 'policy and procedural guidelines on moving towards a restraint free service' dated September 2013 advocated an emphasis on the least restrictive measure in place for the resident for the shortest length of time. It also outlined that there must be evidence that alternatives were trialled or attempted and found ineffective before restrictive practice was used.

There were some restrictive practices in use within the centre. 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. For example, bed rails were used in the centre. Risk assessments had been completed for their use. Those risk assessments identified the level of risk associated with their use and control measures to mitigate any risk identified.

The organisation had 'procedures on protected disclosures of information in the workplace'. While this was evidence of organisational commitment to promoting a culture of openness and accountability, the policy available to inspectors in the centre was out of date (2009) and did not reflect the recently ratified legislation in relation to protected disclosures. The provider informed inspectors the organisation did have an up to date policy on protected disclosures but this was not available in the centre on the two days of inspection. This required review and an action is given in relation to this in Outcome 18 Records and Documentation.

**Judgment:**

Substantially Compliant

**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:**

The use of chemical restraint was the only aspect of this outcome reviewed during this inspection.

An inspector reviewed the prescribing practices for chemical restraint and found that prescribed chemical restraint was used minimally in the centre. In some instances where it was prescribed it was used to relax residents if they were attending a dental or health care appointment which may cause them distress. An inspector spoke with the pharmacist for the centre. They carried out regular medication audits in the centre. They informed the inspector that PRN (as required) chemical restraint was used infrequently this was confirmed by the review of prescriptions carried out.

Overall, inspectors were satisfied that chemical restraint was used in accordance with best practice National policy guidelines

**Judgment:**

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 responsibility for the provision of the service.*

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

During the course of the inspection, inspectors conducted an interview with the person in charge and found her to be a suitably qualified person with knowledge and experience commensurate to her role. She had worked in management positions within the Brothers of Charity Galway service for a number of years and had held the position of service co-ordinator/person in charge since 2010.

She worked in a full time capacity, 39 hours per week. She reported to the area manager (PPIM) who in turn reported to the adult west sector manager and the director of services. She was allocated responsibility for the designated centre and also as a person participating in management of the other centres located on the campus.

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

Due to some issues found on this inspection the person in charge needed to ensure her dual management roles did not impact on the time she spent engaged in direct management of the designated centre. During the course of the interview the person in charge identified areas that she would focus on more after the inspection.

Inspectors also conducted an interview with the provider. At the time of the allegation of abuse to the Brothers of Charity Service, Galway the provider was on annual leave. On her return she wrote a letter to all staff working in the Brothers of Charity Service, Galway. In the letter she asked for any staff member who had a concern to contact and speak to her anytime any place, she also included her contact details. The provider outlined to inspectors that it was her intention, by writing the letter, to tell any staff member with a concern that they could come forward in confidence.

She had begun an investigation into the allegation of abuse as outlined in the summary of this report. Inspectors were provided with a copy of the investigation process and its status at the time of inspection. Some of the investigation processes included a meeting between the provider and local managers in the organisation held on 17 April 2015 to review the allegations made and to outline a response and future actions.

At the time of this report, terms of reference had been drawn up and an external consultant had been asked to undertake a service review of the organisation. The initial review would focus on areas where service users are unable to speak for themselves and where residents displayed significant behaviours that challenge.

**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:**

Inspectors had significant concerns in relation to the numbers and skill mix of staff for

day and night shifts as they did not meet the assessed needs of the residents. Not all staff working at night time had appropriate training to meet the specific health care needs of residents in the residential unit where they worked. Not all staff working in the centre had received client protection training; while other staff had received the training they had not received adequate updates or refresher training to maintain their skills. The provider outlined that this was being reviewed at an organisational level. However, at the time of inspection there were still staff that had outstanding training needs in this area.

Residents living in the centre presented with significant health care needs. A number of residents living throughout the three residential units required at least two staff to implement safe manual handling techniques to help them in and out of bed or to use the facilities in the centre. Other residents required intensive one to one intervention in relation to eating and drinking to ensure nutritional risk was mitigated.

Inspectors reviewed the numbers and skill mix of staff in each residential unit of the designated centre and were not satisfied there were enough staff working during the day to ensure residents social care needs were met. For example, 'best possible health goals' were being adequately met as staff needed to prioritise residents healthcare needs. However, this left little time for staff to implement residents' identified goals or community participation. As mentioned in a previous outcome, a resident was unable to go bowling in 2014 due to staff shortages.

Inspectors also found that some staff working at night time were not trained in the administration of emergency medication of epileptic seizures, despite residents requiring a nurse to work in each residential unit during the day. Other residents required PEG feeding (Percutaneous endoscopic gastrostomy feeding). Staff working at night time did not have the necessary skills to manage this type of specialised feeding and relied on contacting the night supervisor if an issue arose.

The majority of non compliances found in outcomes of this report were directly or indirectly attributed to inadequate staffing numbers and skill mix within the designated centre day and night and required review.

**Judgment:**

Non Compliant - Major

**Outcome 18: Records and documentation**

*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**

Use of Information

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

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

**Findings:**

Aspects of this Outcome reviewed related to policies, procedures and documentation related to safeguarding and safety for residents.

The provider informed inspectors the organisation did have an up to date policy on 'protected disclosures' but this was not available in the centre on the two days of inspection.

There was some confusing documentation relating to complaints and concerns. For example, there was a 'complaints/concerns' form, which provided a log where staff could document a concern or complaint, on the same page. This required review as there was a risk of an allegation of abuse being treated as a complaint, for example.

Another example of where there was confusion with complaint/concern was the Brothers of Charity Service, Galway report to the Health Service Executive of their investigation into the allegation of abuse, which triggered this inspection report. The title was, 'Report to Health Service Executive in Relation to Complaints Received'. The last paragraph of the report set out what the Brothers of Charity Service, Galway complaints policy specifically states.

The overlap of concern and complaint language in documentation needed review. This was to ensure policies, procedures and documentation set out a clear distinction between what constituted a complaint and a concern/allegation of abuse. It would also ensure the correct policy and procedures were implemented should either be made.

**Judgment:**

Substantially Compliant

**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  
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-0004949
<b>Date of Inspection:</b>	21 April 2015
<b>Date of response:</b>	03 July 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:**

Residents could not choose the time they went to bed.

**Action Required:**

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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



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

The Person in Charge, Area Manager, Sector Manager and the Team Leaders have reviewed the current rosters, with a view to changing the current pattern of day staff finishing duty at 9.00pm be being rostered until 10.00pm. We have examined the existing budget and with changes in rosters we can facilitate some additional staffing on Saturday and Sunday to support individual activities of choice.

We are commencing a process of engagement with staff and their respective unions to implement this rostering change.

At least one staff member will be rostered on duty until 10.00pm each evening in the designated centre to support choice of the individuals in relation to evening activities and bed times; this change will mean that in this designated centre each night from 9.00pm to 10.00pm there will be 5 staff on duty.

In the interim we will continue to use the flexible hours in the existing budget to maximise the opportunities for individuals for social activities.

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

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

Communications with the service user council were not two way. Improvement was required in relation to how residents were consulted on the service they received.

**Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

A key worker from each house in the Designated Centre will support a service user to attend the Service Users' Council.

There will be 3 staff members nominated to support this and to arrange meetings with service users from each house in the Designated Centre on a bi-monthly basis to discuss issues, highlight achievements and challenges. This group will be the 'Speaking Up Group'. Minutes will be available in the Designated Centre.

The Service Users' Council has developed an accessible agenda template to support individuals to bring issues to the Council and have them on the agenda. The staff members will support the individuals to put any issues they may have on the agenda for the Council.

The minutes of the Service Users' Council meeting will be available in the Designated Centre and will be reviewed at the local 'Speaking Up Group' meeting.

Feedback from or items for the Service Users' Council will become a standing item at team meetings so that everybody in the Designated Centre is aware of the issues being discussed/highlighted by the service users.

We will seek support from the Speech and Language Therapist in order to ensure the minutes 'Speaking Up Group' meetings are communicated in a format that individuals can understand.

**Proposed Timescale:** 31/07/2015

**Theme:** Individualised Supports and Care

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

The practice of half hourly checks impacted on residents' privacy and sleep and required review.

**Action Required:**

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

This practice no longer occurs and service users are now only checked when they need support, the frequency of checks on individuals at night time will vary depending on their individual needs on any given night. If an individual is unwell they may need to be checked frequently during the night. This will be recorded in the individual's notes.

**Proposed Timescale:** 31/05/2015

**Theme:** Individualised Supports and Care

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

Residents could not engage in evening or night time activities due to reduced staffing after 9pm.

**Action Required:**

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

The Person in Charge, Area Manager, Sector Manager and the Team Leaders have reviewed the current rosters, with a view to changing the current pattern of day staff finishing duty at 9.00pm be being rostered until 10.00pm. We have examined the existing budget and with changes in rosters we can facilitate some additional staffing on Saturday and Sunday to support individual activities of choice.

We are commencing a process of engagement with staff and their respective unions to implement this rostering change.

At least one staff member will be rostered on duty until 10.00pm each evening in the designated centre to support choice of the individuals in relation to evening activities and bed times; this change will mean that in this designated centre each night from 9.00pm to 10.00pm there will be 5 staff on duty.

In the interim we will continue to use the flexible hours in the existing budget to maximise the opportunities for individuals for social activities.

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

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

The complaints procedure did not identify the nominated person to deal with complaints by or on behalf of the residents.

**Action Required:**

Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

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

The Complaints Policy and Procedure has been reviewed and has been circulated in draft form for feedback. The revised procedure has identified an individual to deal with complaints from service users.

**Proposed Timescale:** 26/06/2015

**Theme:** Individualised Supports and Care

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

The procedure did not outline a nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Action Required:**

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

The Complaints Policy and Procedure has been reviewed and has been circulated in

draft form for feedback. The revised procedure has identified an individual to deal with complaints from service users.

**Proposed Timescale:** 26/06/2015

**Theme:** Individualised Supports and Care

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

Complaints logs did not adequately document if the complainant was satisfied with how the complaint was addressed.

**Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

The revised complaints log will include a section where the satisfaction of the complainant on how the complaint was addressed will be documented.

**Proposed Timescale:** 26/06/2015

**Theme:** Individualised Supports and Care

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

The organisational policy for the management of complaints was dated 2008 and made reference to the Health Act 2004 it required updating and review to reflect the matters as set out in the Care and Welfare Regulations 2013.

**Action Required:**

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

The Complaints Policy and Procedure has been reviewed and has been circulated in draft form for feedback. The revised policy and procedure will be compliant with legislation.

The Person in charge will ensure that all staff are aware of the revised policy and procedure and a copy is on display in the Designated Centre.

**Proposed Timescale:** 26/06/2015

**Theme:** Individualised Supports and Care

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

The overlap of concern and complaint language in documentation needed review.

**Action Required:**

Under Regulation 34 (1) (a) you are required to: Ensure that the complaints procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.

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

This has been reviewed and is taken into account in the revised complaints policy and procedure. Clarity in the language used to describe complaints will be communicated to all staff by the Provider.

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

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

There were instances where residents' social care goals were identified but had not happened. One personal goal for a resident was to go bowling in 2014. The resident had not gone bowling in 2014.

**Action Required:**

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

The Person in Charge and Team Leaders will coordinate a review on a quarterly of all personal outcomes individual plans to ensure that they are up to date and addressing the social goals of each individual. Themes from this review will be an agenda item and discussed at team meetings. Any barriers for the achievement of goals will be highlighted and discussed with a view to identifying solutions to achieve the goals. If there are significant barriers this information will be escalated by the Person in Charge to a more senior management level

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

**Theme:** Effective Services

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

While personal plans were detailed and comprehensive goals identified for residents many had a health care focus and did not adequately outline the supports required to maximise the resident's personal development in accordance with his or her wishes.

**Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

Team Leaders will support key workers to review all the current personal plans to ensure that there is a broad selection of personal goals including personal development goals that are in accordance with the service user's wishes.

**Proposed Timescale:** 31/07/2015

### 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:**

Not all risks were adequately reviewed and up to date. Approximately 50% of falls risk assessments were not up to date. A resident had fallen in the centre five times in 2015 without an up to date falls risk assessment completed after any incident. This required review.

**Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

1. Risk assessments will be reviewed on the nominated review date or prior to that if required by the Team Leader.
2. The local risk register will be updated to reflect any changes in risk or levels of risk by the Team Leader and the Person in Charge.

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

**Theme:** Effective Services

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

Though security had been identified on the risk register control measures were vague and did not mention locking of doors as a security measure, for example.

Not all staff that worked at night time were trained to give emergency medication for the management of seizures and relied on the night supervisor to come to a residential unit and administer the medication in the event of an emergency.

**Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

1. The locks on the doors of the bungalows in the Designated Centre will be changed so that they can be locked when needed to ensure that persons from outside cannot access the building but persons inside can exit.

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2. On 22nd of April the Area Manager trained night staff on duty in the administration of Midazolam.

Epilepsy awareness and Midazolam training was also provided for staff on the 15th and 19th of May by the Quality Enhancement Department. This training is provided by the Quality Enhancement and Development Department on an ongoing basis for staff who require it.

The night supervisors/nurse have up skilled care assistants on night duty in relation to peg care for the individuals in the Designated Centre. This will be done on an ongoing basis in order to ensure on any given night that the staff member on duty has been given the necessary skills to care for the individuals.

31/05/2015 and ongoing

**Proposed Timescale:** 1. 31/07/2015 2. 31/05/2015 and ongoing

**Theme:** Effective Services

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

Preventative action and learning from adverse incidents was not identified on the incident/accident recording system.

**Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

The Team Leader will prepare a quarterly report from the Accidents and Incidents Reporting System (AIRS) on preventative actions and learning outcomes identified from adverse incidents that have occurred. The report will be discussed at team meetings and further action identified.

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

**Theme:** Effective Services

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

Inspectors identified the numbers of staff working in the residential units of the centre at night time were inadequate to meet the evacuation needs of residents.

At the time of writing the report the provider had not performed the evacuation drill at night therefore inspectors remained concerned that residents could not be adequately evacuated from the centre during an emergency evacuation at night time.

**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:**

1.The night time evacuation plan for the Designated Centre was revised and changed on 22nd April in order to ensure that service users had the necessary supports to be evacuated safely.

2.Night time Fire drills were carried out following the new procedure in all bungalows in the Designated Centre.

3.Personal evacuation plans were changed and each individual now has a day time and night time evacuation plan.

**Proposed Timescale:** 31/05/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Not all behaviour support plans were up to date, with one resident's support plan dated July 2013.

**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:**

1. All Behaviour Support Plans will be reviewed and updated by 30th June 2015. Behaviour Support Plans will be reviewed on the agreed review date or earlier as required.

2. The person in charge will devise a form that will record the dates of all care plans, risk assessments and support plans. This will identify the date of reviews and by whom. This will be in each individual's personal profile. The key worker will ensure that these reviews are carried out.



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

#### **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:**

Team leaders 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:**

The Team Leaders are identified in the statement of purpose as being Persons Participating in Management. The Teams Leaders will be identified as PPIMS in the application for registration form and all the relevant documentation will be submitted to the Chief Inspector on application for registration.

**Proposed Timescale:** 31/12/2015

**Theme:** Leadership, Governance and Management

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

Due to some issues found on this inspection the person in charge needed to ensure her dual management roles did not impact on the time she spent engaged in direct management of the designated centre.

**Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

Management Structure: There is an Area Manager who has overall responsibility for both day and residential services on the campus. There is also a co-ordinator of Day Services. The Person in Charge supports the Area Manager in her role, but it has been clarified that the primary responsibility of the Person in Charge and her direct focus is on the management of the Designated Centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

The Person in Charge is:

- Physically present in the Designated Centre on a daily basis

- Meets with PPIMS in each unit (Team Leaders CNM1), staff and residents
- Oversees and regularly monitors residents' personal plans & other relevant documentation
- Ensures safety and quality monitoring systems are operational and up to date
- Continues the ongoing development of service improvement initiatives by managing resources in a flexible way to respond to the residents' requests and choices
- Liaises with the Multi-Disciplinary Teams
- Meets formally with all PPIMS monthly to plan future developments, disseminate information & share learning
- Conducts formal support and supervision with PPIMS (Team Leaders CNM1)
- Meets with the "Speaking Up" group (self-advocates who participate in the organisation's Service Users' Council supported by key workers) on a monthly basis
- Meets regularly with the Area Manager and Sector Manager in relation to resources, residents' needs, risk identification & management, complaints, and any other issue pertaining to the Designated Centre that requires communication or escalation to Senior Management within the organisation.

**Proposed Timescale:** In Place 03/07/2015

### Outcome 17: Workforce

**Theme:** Responsive Workforce

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

The numbers and skill mix of staff for day and night shifts were not appropriate to meet the assessed needs of the residents.

**Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

1. A full review of the rosters, numbers and skill mix for the Designated Centre was carried out by the Person in Charge, Team Leader and Area Manager.
2. Rosters will change to ensure skill mix is adequate.
3. If necessary the Person in Charge and Area Manager will highlight any deficits in resources to the Sector Manager and Galway Services Management Team.

**Proposed Timescale:** 30/09/2015

**Theme:** Responsive Workforce

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

Not all staff working at night time had appropriate training to meet the specific health care needs of residents in the residential unit where they worked.

Not all staff working in the centre had received client protection training, while other staff had received they had not received adequate updates or refresher training to maintain their skills

**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:**

1. On 22nd of April the Area Manager trained night staff on duty in the administration of Midazolam.

Epilepsy awareness and Midazolam training was also provided for staff on the 15th and 19th of May by the Quality Enhancement Department. This training is provided by the Quality Enhancement and Development Department on an ongoing basis for staff who require it.

The night supervisors/nurse have up skilled care assistants on night duty in relation to peg care for the individuals in the Designated Centre. This will be done on an ongoing basis in order to ensure on any given night that the staff member on duty has been given the necessary skills to care for the individuals.

31/05/2015 and ongoing

2. Client Protection refresher training has been arranged and the staff members who had not attended the training previously have been rostered to attend training arranged for 11/05/2015, 18/05/2015 and 08/06/2015.

It is now an organisational requirement that all staff attend a mandatory Client Protection Training once every three years. The Person in Charge will ensure that staff fulfil this requirement.

Team Leaders will ensure that the mandatory staff training matrix for staff is updated in the Designated Centre and will ensure that staff attend mandatory training and refresher training as required.

**Proposed Timescale:** 1. 31/05/2015 and ongoing 2. 08/06/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The provider informed inspectors the organisation did have an up to date policy on 'protected disclosures' but this was not available in the centre on the two days of inspection

**Action Required:**

Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

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

The up to date Protected Disclosure Policy will be displayed in the Designated Centre and will be discussed at the next team meetings.

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

**Theme:** Use of Information

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

The overlap of concern and complaint language in documentation needed review. This was to ensure policies, procedures and documentation set out a clear distinction between what constituted a complaint and a concern/allegation of abuse.

**Action Required:**

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The Complaints Policy and Procedure has been reviewed and has been circulated in draft form for feedback. Clarity in the language used to describe complaints will be communicated to all staff by the Provider.

The Person in Charge will ensure that all staff in the Designated Centre are aware of the revised policy and procedure.

**Proposed Timescale:** 26/06/2015