**Health Information and Quality Authority Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Brothers of Charity Services Galway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011446</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Galway</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:marybracken@galway.brothersofcharity.ie">marybracken@galway.brothersofcharity.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Brothers of Charity Services Galway</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Anne Geraghty</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Mary Bracken</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nan Savage</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Marian Delaney Hynes</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>18</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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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 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 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>24 March 2014 14:30</td>
<td>24 March 2014 19:00</td>
</tr>
<tr>
<td>25 March 2014 09:30</td>
<td>25 March 2014 18:00</td>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
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<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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<tr>
<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection

This announced monitoring inspection took place over two days. As part of the inspection, inspectors met with residents and staff members. Inspectors observed practices and reviewed documentation including personal plans, policies, procedures and staff files. Part of the inspection took place in the evening, when residents had returned from their day activities.

The centre comprised of three houses and two apartments. There were 18 residents, one vacancy and one resident on holidays. Inspectors visited each unit within the centre and found them to be comfortable, clean, warm and there was a friendly atmosphere throughout. It was evident that residents and staff knew each other well and residents were observed to be relaxed with staff.

Inspectors observed good practice in all areas of the service that were inspected. Inspectors found that staff supported residents to make decisions regarding their preferred daily routine, aspirations and life choices. Residents were supported to pursue their interests and fulfil their goals in areas including education and employment.

Residents were actively involved in the development of their personal plans and there was evidence of regular review.
Some areas of non-compliance with the Regulations were identified relating to aspects of medication management and fire safety. Other areas for improvement included the implementation of a written contract for provision of services for each resident.

The non-compliances are discussed in the body of the report and included in the action plan at the end of this 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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

<table>
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<tr>
<th>Theme:</th>
<th>Effective Services</th>
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</thead>
<tbody>
<tr>
<td>Judgement:</td>
<td>Non Compliant - Moderate</td>
</tr>
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Findings:
The inspectors found that residents did not have an agreed written contract in place, which set out the services to be provided to the resident and all the fees to be charged. Inspectors were shown a draft contract which had been finalised and the provider had intended to furnish this contract to all residents and/or their representatives.

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.

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<thead>
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<tr>
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<td>Compliant</td>
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Findings:
Inspectors found that residents had opportunities to participate in meaningful activities, appropriate to their individual interests and preferences. Arrangements were in place to meet residents’ assessed needs and these were documented in individualised personal plans. Residents were actively involved in the development of their personal plans and staff provided a high standard of social support to residents.

The inspectors viewed a sample of residents’ care files including residents’ personal plans and found that they were individualised and person centred on the residents’
needs, choices and aspirations. Residents were actively involved in the assessment and development of their plans. There was evidence of a multi disciplinary approach and a number of residents told inspectors of their involvement in their plans and that of others including family and key workers. There was also evidence of ongoing review to reflect residents' current needs and how objectives were being achieved. Each resident had their own personalised copy in a folder that they kept in their bedrooms, which included descriptions of their personal outcomes and photographs to illustrate some information recorded in the folder. Residents proudly showed inspectors their personal plans which included important information about the residents’ backgrounds and the goals they planned to accomplish and had already fulfilled.

Personal profiles contained guidance to staff on supporting residents in areas including intimate care and individual protocols to enable each resident’s participation in activities. Some staff spoken with described clearly residents’ interventions and inspectors saw staff implementing the personal plans with residents.

Inspectors noted that residents were supported and guided to acquire the necessary skills for new living arrangements within the service. Inspectors read how arrangements were put in place to promote residents’ independence and choice in moving within the service. This was accomplished through a consultative process with the resident and family to ensure measures were appropriately implemented to safeguard the resident during the transitional period and achieve the resident’s desired outcome.

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

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

**Theme:**
Effective Services

**Judgement:**
Non Compliant - Minor

**Findings:**
The provider and person in charge had measures in place to promote and protect the safety of residents, staff and visitors to the centre. Improvement was required in aspects of risk management and fire safety.

There was a risk management framework in the process of being developed, which included a health and safety statement and risk register for each unit. There was also a national policy on risk management and a policy on the identification, recording, investigation and learning from accidents and incidents. Both of these policies were in draft format. Formal precautions were in place for specific risks such as self harm and assault.

The health and safety coordinator had recently completed clinical and environmental risk assessments for each unit in March 2014 and had also provided training on risk management to staff. Hazards relating to areas including transport, manual handling
and use of stairs in some units had been risk assessed. Associated action plans had been developed to address specific risks identified. While control measures had been implemented for identified risks, inspectors were concerned that adequate measures had not been taken in response to one risk that related to the fire evacuation procedure from the first floor of one unit. Prior to the inspection, the provider and person in charge had made arrangements for a fire safety advisor to formally assess this risk on 26 March 2014. Inspectors requested that on completion of this assessment, a report detailing findings be submitted to the Authority. The provider informed inspectors that resources had been allocated to extend this unit and remove the bedrooms from the first floor.

Staff spoken with were familiar with the centre’s procedures on fire evacuation and some residents were able to tell inspectors about what they would do if the fire alarm went off. Training records viewed confirmed that some staff had not received formal fire safety training while others had not completed this training since 2008. Inspectors noted that prior to the inspection fire safety training had been scheduled on 26 March 2014. Fire drills had taken place regularly and the effectiveness of the drill and any subsequent corrective action was clearly documented. However, it was not clear from records viewed that all staff had attended these drills.

Other fire safety measures were adequately implemented including a programme for the servicing and checking of fire safety equipment. The procedures to be followed in the event of fire were displayed in prominent locations in each unit including a user friendly version for residents. Records reviewed also demonstrated that staff completed regular internal safety checks and that personal emergency evacuation plans had been developed for each resident. Staff were familiar with residents' individual plans.

There was an emergency plan in place which identified what to do in the event of emergencies. The plan also included evacuation procedures and arrangements for emergency accommodation.

Some residents spoken with confirmed that they felt safe in the centre and attributed this mainly to the staff and the secure access to their homes.

**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

**Judgement:**
Non Compliant - Minor
**Findings:**
Inspectors found that arrangements were in place to safeguard residents and protect them from the risk of abuse. Some improvement was required in the area of training as there was evidence that not all staff had attended training.

The policy on protecting residents from abuse contained guidelines on how allegations of abuse would be managed. The organisation's designated person was identified as the person who would investigate and manage allegations of abuse. Inspectors found that the person in charge was knowledgeable regarding protection and competently demonstrated how an investigation would be carried out.

Inspectors found that staff were knowledgeable about what constituted abuse and how they would respond to any suspicions or reported allegations of abuse. The majority of staff had received formal training in this area and the person in charge confirmed that training for the remainder of staff had been scheduled.

Residents confirmed that they felt safe and described the staff as being very kind and were able to indicate to inspectors staff whom they could speak with if they had an issue. Throughout the inspection staff interacted with residents in a kind, caring, respectful and patient manner. Staff had developed an intimate care plan for each resident to ensure privacy was respected and to protect the resident from any risk during the delivery of intimate care.

Inspectors reviewed a sample of residents’ finances and found that they were managed in a safe and transparent manner, guided by an associated policy. Residents were supported to manage some of their own finances where possible. However, robust systems were not in place for the management of one aspect of residents’ finances that related to the arrangements in place for the payment of residents’ holidays. While there were guidelines in place residents’ did not have a contract of care detailing these arrangements as noted in Outcome 4.

At the time of inspection, there were no residents who required behavioural support interventions.

**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Judgement:**
Compliant

**Findings:**
Inspectors were satisfied that there were appropriate arrangements in place to support residents’ healthcare issues as they arose although, improvement was required.
regarding the availability of medical records which were not kept in the designated centre.

Inspectors were unable to review residents’ medical file. The person in charge and staff told inspectors that these have always been retained at the GP surgery and not at the designated centre which is not in line with Regulation 21(1) (b). A required action in relation to this issue is documented under Outcome 18.

Both residents and staff confirmed that there was good access to a general practitioner (GP), including an out of hours service. There was evidence that residents also accessed other health professionals such as chiropodists, opticians and physiotherapy services as required.

Inspectors were satisfied that there were suitable arrangements in place to support residents’ healthcare needs as they arose including those with epilepsy. Each resident had a personal plan which outlined the services and supports to be provided to achieve a good quality of life and to realise their individual personal goals. Personal plans were in an accessible format and each resident's plan of care was reviewed frequently and when there was a change in needs or circumstances. Additional information was also maintained regarding each resident’s personal profile which was used to guide staff practice.

Inspectors reviewed personal plans for residents with epilepsy and found that they were comprehensive and guided practice. The personal plans identified the first aid and advanced care required by a resident when a seizure occurred. Residents with a diagnosis of epilepsy had a "seizure diary" which recorded the date, time, type, duration and comments regarding the seizure. Monitoring included blood screening and review of anti-epileptic drugs (AEDs) took place.

The person in charge told inspectors that residents had their main meal in their home at a time that suited them and residents who attended day services had their main meal in the evening when they returned to the centre. Some residents that spoke with inspectors confirmed this to be the case. Residents were encouraged in deciding what they wanted for their meal and if any resident did not like what had been prepared; there was a range of alternatives available. Residents told inspectors that they assisted with both the menu planning, shopping and assisting the staff in the preparation of meals. Residents also confirmed that they could have snacks at any time. One resident told inspectors that they really enjoyed their evening meal together as it gave them an opportunity to chat about the activities of the day both with each other and the staff.

Although there were no residents receiving end-of-life care at the time of inspection, the person in charge told inspectors that end-of-life care was provided in a manner that meets the needs of residents including access to specialist palliative care.
**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Moderate

**Findings:**
Inspectors found that the provider had put arrangements in place to support the person in charge in protecting residents in relation to medication management and good practice was noted in some areas. However, inspectors were concerned about aspects of medication management including the unsafe custody of medication that required special control measures.

Inspectors reviewed the medication policy, which was informative and guided practice. The policy required all staff to undertake a medication management training programme before being allowed engage in the administration of medication. A review of training records confirmed that this had been implemented in all of the units.

Inspectors reviewed a sample of medication charts which were clear and legible. Photographic identification was available on the medication sheets for each resident to ensure the correct identity of the resident receiving the medication and to reduce the risk of medication error.

Staff were knowledgeable regarding the procedure for the administration of medication and checking the prescription, the medication description and that the correct medication was being administered. Staff knew about the procedures for reporting medication errors.

A medication fridge was in place and an inspector noted that it was kept in a locked room. However, the temperature of the fridge was not recorded as required and staff were not aware of the required temperature for the storage of specific medications including insulin.

Improvements were also required to the medications requiring special control measures (MDAs). These were not stored in line with the required professional guidelines and there was no MDA policy or register in place.

The prescription sheets reviewed were clear and distinguished between “as required” (PRN) and regular medication. However, the maximum amount for PRN medication was not indicated on prescription sheets in the sample viewed.

The person in charge confirmed that she would address these issues without delay.
**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

**Judgement:**
Compliant

**Findings:**
The inspectors found that the provider had established effective management systems that supported and promoted the delivery of safe, quality care services, which included a clearly defined management and staff structure that identified the lines of authority and accountability.

Mary Bracken fulfilled the role of person in charge and inspectors found that she was suitably qualified, skilled and experienced. The inspectors noted that the person in charge was supported in her role by the provider and management team. These supports included the team manager, area manager, human resources manager and the quality and enhancement development department.

The person in charge was also the service coordinator. She had good clinical knowledge and was well informed about the support needs and personal plans of residents. She also demonstrated a clear understanding of her legal responsibilities under the Regulations and Standards. Throughout the inspection process she displayed a strong commitment to delivering good quality care to residents and to improving the service delivered. The person in charge had engaged in continuous professional development. She had attended a number of courses in areas such as person centred care, epilepsy, behaviour therapy and diabetes. The person in charge had also completed training on risk management and the Regulations.
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

Judgement:
Non Compliant - Moderate

Findings:
Recruitment processes were in place and inspectors noted that staff and volunteers had been suitably recruited, selected and vetted in accordance with best recruitment practice. At the time of inspection staffing levels and skill mix appeared adequate to meet current residents' needs and the safe delivery of the service. From staff rosters viewed there was evidence that residents' received continuity of care. Although most staff had received mandatory training some had not received this training while some other staff had not received up to date mandatory training.

Some staff had not received mandatory training in adult protection and fire safety. As detailed in Outcomes 7 and 8 there was evidence that this training had been scheduled prior to this inspection. A small number of staff had not received up to date training in moving and handling. The provider and person in charge had also put in place arrangements for staff to attend this training.

While there was a policy on recruitment, selection and vetting this policy had not been updated since July 2008 and did not provide sufficient guidance to inform current practice. The person in charge confirmed that the policy was currently under review. Inspectors reviewed a random sample of staff files and found that information required by the Regulations had been obtained including Garda Vetting and evidence of mental and physical fitness.

The provider had allocated resources for staff training and the person in charge had facilitated staff to attend this training. Inspectors viewed a training matrix which outlined the planned and actual training for all staff. During 2013 and 2014 additional training had been provided in areas such as transport safety, person centred planning and medication management.

Volunteers attended the centre and provided a valuable service. A system was in place to vet volunteers appropriate to their role and a written agreement had been put in place outlining the roles and responsibilities of volunteers.
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

Judgement:
Non Compliant - Moderate

Findings:
As detailed in Outcome 11 inspectors were unable to review residents’ medical file as these records were not maintained at the centre in line with Regulation 21(1) (b).

As noted in Outcome 7 some policies were under review or in draft format and had not yet been implemented.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Nan Savage
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>Centre name:</th>
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<tr>
<td>Date of Inspection:</td>
<td>24 March 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>17 April 2014</td>
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</tbody>
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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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have an agreed written contract in place which dealt with the support, care and welfare of the resident including details of the services to be provided for that resident and the fees to be charged.

Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
The Individual Service Agreement form has been finalised. The person in charge and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
the Area Manager will arrange meetings with individuals and relevant family members over the next three months. Independent advocates will be sourced to be involved with some people who may require such support.

Proposed Timescale: 31/07/2014

**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:
Some staff had not received formal fire safety training while others had not completed this training since 2008.

**Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

**Please state the actions you have taken or are planning to take:**
Fire safety training has been provided on 26 March 2014 to 10 staff. There are two further fire training dates set for 25 April 2014 (9 staff) and 22nd May (7 staff). After this time all staff will have received up to date fire training for 2014.

Proposed Timescale: 31/05/2014

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate control measures had not been taken in response to a risk that related to the means of escape in the event of a fire from the first floor in one unit. The provider and person in charge had made arrangements for a fire safety advisor to formally assess this risk on 26 March 2014.

**Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
A Fire Officer visited the house on the 26 March. His report will be sent to HIQA with this action plan.

The fire escape window upstairs is being inspected on 17 April 2014 by engineer from
Galway City and Suburbs. He will measure to fit for a door and make a date to complete this work once door order has come through.

An Electrician has been booked to supply and fit appropriate emergency lighting at the back of the house after door fitted.

The long term plan is to move upstairs bedrooms for residents to the ground floor. Resources have been identified to provide this work. Draft plans have been drawn up and will be finalised within the next two weeks ready for submission to the County Council for planning permission. Once approval has been authorised, building will commence.

**Proposed Timescale:** 31/05/2014

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills took place but it was not clear from records of attendance at these drills could not be verified as records were held centrally.

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
A new fire drill form was introduced in March 2014 which states the names of staff who participated in the fire drill.

Team Leaders will review previous drills and coordinate a plan with dates for the year, to ensure all staff have opportunity to participate in a fire drill in each of the houses. The person in charge will ensure that all night staff have been involved in a night shift drill within the year.

**Proposed Timescale:** 31/12/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received the required training on the safeguarding of residents and protection from abuse.
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 have now completed Client Protection Training. The identified staff member who had not received this training at the time of the inspection, attended this training on 26th and 27th March 2014.

Proposed Timescale: 27/03/2014

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Adequate systems were not in place to ensure the safe storage of some medications.

1. Medications that required special control measures (MDAs) were not stored in line with the required professional guidelines.
2. There was no MDA policy or register in place.
3. The temperature of the medication fridge was not recorded as required and staff were not aware of the required temperature for the storage of specific medications including insulin.

Policy update to be completed by 31 July 2014.

Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
1) A locked cupboard within a locked cupboard has been placed in the drug storage room to store any MDAs
2) More information regarding the use and storage of MDAs will be added to our Medication policy and will be in line with An Board Altranais guidelines. A register has been put in place for the counting and recording of MDAs.
3) A temperature recording sheet has been put in place and weekly checks to record this information has commenced.

Policy update to be completed by 31 July 2014.

Proposed Timescale: 31/07/2014
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The maximum amount for PRN medication was not indicated on prescription sheets.

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:
Staff within each house has arranged times with local GPs to make adjustments around PRN medication as required.

Proposed Timescale: 30/04/2014

Outcome 17: Workforce

Theme:Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While plans were in place to provide training, some staff had not received refresher training in moving and handling of residents.

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:
There are three refresher trainings booked for staff to attend. They will take place in on 14 May, 16 July, 16 September 2014. After this time all staff will have completed up to date refresher training in Manual Handling. These dates were available at the time of inspection.

Proposed Timescale: 17/09/2014

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some policies were under review or in draft format and had not yet been implemented.
**Action Required:**
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures 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.

**Please state the actions you have taken or are planning to take:**
The policy on recruitment, selection and vetting is currently under review and will be updated by 23rd June 2014.
The National Risk Management policy has now been signed off and adopted by the service.
The Risk Register in the process of being developed and will be completed within 3 months.
With the exception of the four outlined below, all other policies have been prepared and in use as required in schedule 5 of the Health Act 2007.

A policy for the following 4 areas are in the process of being developed within the next 4 months as required within schedule 5:
3. Incidents where a resident goes missing. (We currently have procedural guidelines in the personal profile of individuals within each residential setting)
12. Monitoring and documentation of nutritional intake.
13. Provision of information to residents.
15. Health and Safety, including food safety, of residents, staff and visitors. (currently there are Health and Safety statements in each house)

**Proposed Timescale:** 31/08/2014
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were unable to review residents’ medical files as these records were not maintained at the centre in line with Regulation 21 (1) (b).

**Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
Under regulation 21.1(1)(b) we are required to have in each residence records and a medical file for each person as specified in schedule 3. This asks for;
All nursing or medical care provided to the resident, including a record of the resident’s condition and any treatment or other intervention.
Also, ongoing medical assessment, treatment and care provided by the resident’s medical practitioner where that information is available.
The system in place in maintaining records and medical files to comply with regulation 21 is within the Personal Profile for each individual, Section 4, Best Possible Health. This includes the following details:

- Contact details of Medical Personnel
- Ongoing medical issues
- Annual Medical Check Form
- Details of visits to General Practitioner
- Appointment Record - Doctor
- Weight Chart
- Care Management Plan

- Management Care Plans in relation to Physical illness
- Appointment Record – Preventative Health Screening Checks
- Appointment Record - Hospital
- Appointment Record - Optician
- Appointment Record - Dentist
- Appointment Record - Audiology
- Appointment Record – Chiropody

This section will contain the following forms if applicable. If not applicable, e.g.; Menstruation Chart, the forms are removed from Personal Profile Folder.

- Menstruation Chart
- Epilepsy Seizure Record
- Epilepsy Care Plan – My Epilepsy
- Record of temperature, Pulse & blood Pressure
- Record of Blood Glucose level
- Dementia Checklist
- Procedure for investigating possible Dementia in Learning Disabilities
- Early Signs of Dementia Checklist

After each visit to the GP or medical appointment, the staff accompanying the individual writes up the outcome and any actions or requirements arising from that appointment.

In addition to the written Profile, Medical appointments and related information is stored electronically on our client record and document management system called ADEST. This electronically stores previous medical history as well as non current information regarding each individual. Information from appointments are also transferred to ADEST. Any report received from medical personnel and consultants would be held in the profile and ADEST. Staff have access to the electronic file. All staff, within each house, take responsibility in maintaining these files and keeping them up to date. Social Care Leaders have responsibility for ensuring all staff are maintaining these files.

However, as part of ensuring the Medical Section in the Personal Profile is current and up to date, the person in charge and the Designated Centre Nurse advisor will undertake an audit of section 4 of the Personal Profile and the ADEST Medical Section regarding this information.
Audit to be completed by end of June 2014

| Proposed Timescale: 30/06/2014 |