Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Garden Lodge
Name of provider:	GALRO Unlimited Company
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	19 January 2022
Centre ID:	OSV-0005652
Fieldwork ID:	MON-0031633

About the designated centre

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

The service provided was described in the providers statement of purpose, dated April 2020. The centre provides residential care for up to six residents over the age of 18 years with a diagnosis of autism and or an intellectual disability and behaviours that challenge. The centre consists of a two storey detached bungalow located in a residential suburb of a medium sized town in county Westmeath. There is a large garden to the front and rear of the centre for use by residents. Each of the residents has their own en suite bedroom which has been personalised to their own taste and there are large conformable communal living areas for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 19 January 2022	10:00hrs to 18:00hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall the inspector found that residents enjoyed a good quality of life, and the centre was well resourced to meet residents' assessed needs. However, there were improvements required in relation to staffing, governance and management, premises and fire precautions. These issues are discussed further in the next two sections of the report.

The inspector had the opportunity to meet with five of the six residents that lived in the centre. Residents with alternative communication methods, did not share their views with the inspector, and were observed at different times of the inspection in their home.

Staff were observed to communicate with the residents in the house using a mixture of verbal language and gestures. Residents were observed relaxing and at times interacting with staff. They were observed spending time in different areas of the house, for example some spent time in the dining room and had snacks or their dinner, others relaxed in one of the sitting rooms watching television and others chose to spend some time in their bedrooms. On the day of the inspection each resident had a one-to-one staff that facilitated activities out of the house at different times of the day. Residents went for walks along canals or to a nearby wood, they went out for lunch and others went for coffee or hot chocolate.

The majority of residents in this centre availed of an external recreational and educational programme operated by the organisation Monday to Friday. On the day of inspection some residents participated in a mindfulness class and an art class in that centre. As part of the programme residents often participated in gardening projects, baking and cooking classes, life skill classes, and dog walking. One resident chose to participate in a more individualised day programme but still had the option of participating in the recreational and educational programme if they decided.

One resident spoke to the inspector and said that the house was nice and that they liked to go shopping. Two staff and the resident were observed to have a jovial interaction about the resident love of shopping and buying things. The resident appeared to like this interaction as they smiled and nodded their head in agreement. The resident later went on to have further jovial interactions with their support staff and appeared to be very relaxed in their company.

Another resident was observed to use some basic sign language when communicating with staff. Staff appeared to understand their needs and were responsive to the residents requests.

The house appeared clean and had sufficient space for privacy and recreation areas for residents to use. There were many DVDs, art supplies, games, jigsaws and sensory objects available for use. Each resident had their own bedroom that was individually decorated to their personal preferences. There were adequate storage

facilities for their personal belongings and there were personal items and pictures displayed in their bedrooms.

The property had a large front and back garden. The back garden contained a spider web swing, a covered seating area, a picnic bench, a trampoline built into the ground, a basketball hoop, and football goals for residents use.

There was a high staff ratio available during the day and two staff on duty at night. There were six staff on duty on the day of inspection. Staff spoken with demonstrated that they were knowledgeable on the residents' care and support needs required. They were observed to engage in a manner that was respectful and attentive.

As part of the annual review the provider had given residents and their representatives the opportunity to give their thoughts on the service provided to them. Feedback received indicated that people were extremely satisfied with the service and feedback was particularly complimentary with regard to the staff in the centre.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

Overall, the inspector found there were management systems in place to ensure safe quality care was being delivered to the residents. There were some improvements required in relation to staffing and governance and management.

There was a defined management structure in place which included the person in charge who was employed in a full time capacity and had the experience and qualifications to fulfil the role. They appeared familiar with the residents care and support needs.

The provider had carried out an annual review of the quality and safety of the centre. While there were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis, the most recent audit had not been unannounced as prescribed by the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations) which would not give an accurate representation of what an unannounced visit to the centre would provide.

From a review of the annual review and the six-monthly visits the inspector found that any actions identified had been followed up on. The annual review of the service had included consultation with residents and family representatives. There were other local audits, reviews and unannounced visits conducted within the centre

in areas, such as safeguarding checks, finance, infection prevention and control, and health and safety audits. Actions identified from the previous Health Information and Quality Authority (HIQA) inspection had been addressed by the time of this inspection.

From a review of the rosters the inspector saw that there was a planned and actual roster in place that accurately reflected the staffing arrangements in the centre and it was maintained by the person in charge. The inspector reviewed a sample of staff files and found that the person in charge had ensured that most of the required documents and information under Schedule 2 of the regulations were present for employees in order to ensure recruitment procedures were safe. However, a recent employer reference was not available for one staff.

Staff had access to necessary training and development opportunities in order to carry out their roles effectively and to meet residents' assessed needs. For example, staff training included, fire safety training, positive behaviour support training, safeguarding of vulnerable adults, medication management, and infection prevention and control trainings.

There were formalised supervision arrangements in place and staff spoken with said they felt supported and would be comfortable bringing matters of concern to the person in charge if required. There were also monthly staff meetings occurring in the centre.

The provider had suitable arrangements in place for the management of complaints. There was a complaints policy in place in place along with an easy read version which was displayed in the centre. A review of the complaints log showed there were six formal and informal complaints in 2021. All complaints received were recorded, followed up on, included learning from the complaint, and they were managed as per the policy.

Regulation 14: Persons in charge

The person in charge was employed in a full time capacity and they had the experience and qualifications to fulfil the role. They demonstrated a good knowledge of the residents' needs in the centre and provided good leadership to their staff team.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements were in line with the statement of purpose for the centre to meet the needs of the residents. There was a planned and actual roster in place

that accurately reflected the staffing in place.

A sample of personnel files showed that they contained the majority of information required to be maintained under the regulations. However, a recent employer reference was not available for one staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had been provided with training to ensure that they had the skills necessary to support the residents in the centre and assure a safe service. Some refresher training was organised to take place in the coming weeks. There were formalised supervision arrangements in place and staff spoken with said they felt supported in their role.

Judgment: Compliant

Regulation 23: Governance and management

There were effective management arrangements in place that ensured the safety and quality of the service was consistent and closely monitored. The centre was well resourced to meet the assessed needs of residents.

The provider had carried out an annual review of the quality and safety of the service, and there were action plans in place where necessary. However while there were arrangements for auditing of the centre carried out on the provider's behalf on a six-monthly basis, the most recent audit had not been unannounced as prescribed by regulations which would not give an accurate representation of what an unannounced visit to the centre would provide.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. There was a complaints policy in place in place along with an easy read version which was displayed in the centre. A review of the complaints log showed there were six formal and informal complaints in 2021. All complaints received were recorded, followed up on, included learning from the complaint, and they were

managed as per the policy

Judgment: Compliant

Quality and safety

Overall, residents were receiving good quality care and supports that were individualised and focused on their needs with residents receiving one-to-one staffing for periods of time each day. However, some improvements were required in relation to premises and fire precautions.

There were arrangements in place for comprehensive annual assessment of residents needs and review the efficacy of the support plans in place with input from family and allied healthcare professionals as appropriate. There were personal plans in place for any identified needs and these included plans to support residents with specific health care needs and their communication.

Residents' health care needs were seen to be assessed and appropriate healthcare was made available to each resident. Residents had access to a range of allied health professionals which included a general practitioner (G.P), dentist, occupational therapy, and opticians as required.

The inspector reviewed the arrangement in place to support residents' positive behaviour support needs. Where required, residents had access to members of a multidisciplinary team to support them to manage behaviour positively. These included a behavioural support specialist and a psychologist. There were positive behaviour support plans in place as required to guide staff as to how best to support the resident and staff spoken with were familiar with the strategies within the plans.

While there were restrictive practices in place, these were assessed as clinically necessary for residents' safety, were subject to a monthly review by the person in charge and behavioural support worker, and an annual review by the organisation's rights committee. Consent had been sought from family representatives. Restrictions in place included specific seating positions for residents in the centre's vehicle and the chemical press was locked at all times when not in use.

There were arrangements in place to protect residents from the risk of abuse. There was a safeguarding policy and staff were appropriately trained. There were systems in place to safeguard residents' finances whereby staff counted and signed off on the finances once daily, a finance audit was completed weekly and every month. Residents had intimate care plans to guide staff on how best to support them and inform staff of their preferences.

The inspector found that there were adequate systems in place to promote residents' rights. These included, weekly house meetings, regular key-worker

meetings and a choice and schedule board were in place in the kitchen.

From a walkabout of the centre the inspector found the house to be spacious and adequate to meet the needs of the residents. There were some areas that required attention, for example, some areas required minor repair to the plastering and some areas required repainting. There was some slight mildew observed in two areas. The provider had started to address some of the identified issues prior to the end of the inspection.

Risk management arrangements ensured that risks were identified, monitored and regularly reviewed. The inspector observed that both vehicles were recently serviced, were insured and had an up-to-date national car test (NCT). There was a policy on risk management available and the centre had a recently reviewed risk register in place. Each resident had a number of individual risk assessments so as to support their overall safety and wellbeing. Learning from incidents were brought to team meetings for shared learning.

The inspector reviewed arrangements in relation to infection control management in the centre. There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19, with a contingency plan in place which included a staffing contingency and isolation plan for residents if required. Staff had been provided with several relevant infection prevention and control trainings. Personal protective equipment (PPE) was available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at all times due to social distancing not being possible to maintain in the centre. There were adequate hand-washing facilities and hand sanitising gels available throughout the centre.

There were fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which were regularly serviced. Staff had received training in fire safety and there were fire evacuation plans in place for residents. Fire evacuation drills had been conducted using minimum staffing levels to ensure all residents could be evacuated. However, one emergency lighting at the front door was not working and several fire containment doors did not close fully by themselves or had gaps at the frame in one corner. One fire door had a larger than recommended threshold gap. These identified issues required improvement to ensure residents could evacuate safely and were protected from the spread of fire and smoke in the event of a fire.

Regulation 17: Premises

The centre was spacious and adequate to meet the needs of the residents. There were some areas that required attention, for example, some areas required minor repair to the plastering and some areas required repainting as the paintwork was scuffed. There was some slight mildew observed around the silicone of a resident's en suite shower and on the ceiling of another resident's en suite shower. The provider had started to address some of the identified issues prior to the end of the

inspection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were risk management arrangements in place, including a risk management policy and procedures. Risk in the centre was assessed and there were comprehensive control measures in place.

The inspector reviewed evidence that documented that the centre's vehicles used to transport residents were roadworthy, insured and recently serviced.

Judgment: Compliant

Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre, including planned audits and infection control spot checks.

There were risk control measures in place with regard to risks associated with COVID-19.

The centre was maintained in a clean condition throughout and there were hand washing and sanitising gels available. Staff had received relevant trainings in the area of infection prevention and control.

Judgment: Compliant

Regulation 28: Fire precautions

While there were fire safety management systems in place improvements were required to some areas. For example, one emergency lighting at the front door was not working and several fire containment doors did not close fully by themselves or had gaps at the frame in one corner. One fire door had a larger than recommended threshold gap. These identified issues required improvement to ensure residents could evacuate safely and were protected from the spread of fire and smoke in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' needs were assessed on at least an annual basis, and reviewed in line with changing needs and circumstances. There were personal plans in place for any identified needs. Personal plans were reviewed at planned intervals for effectiveness.

Judgment: Compliant

Regulation 6: Health care

Residents were supported with their healthcare needs and they had access to a range of allied health professionals which included a general practitioner (G.P), dentist, occupational therapy and opticians as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, residents had access to members of a multidisciplinary team to support them to manage behaviour positively. Staff were knowledgeable about the residents' needs and support plans were in place to guide practice. While there were restrictive practices in place, these were assessed as clinically necessary for residents' safety, were subject to a monthly review by the person in charge and behavioural support worker, and an annual review by the organisation's rights committee. Consent had been sought from family representatives. There was evidence of removal of a restrictive practice when it was considered no longer necessary.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. Staff were appropriately trained, and any potential safeguarding risk was investigated and

where necessary, a safeguarding plan was developed.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that there were adequate systems in place to promote residents' rights. These included, weekly house meetings, regular key-worker meetings and a choice and schedule board were in place in the kitchen.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Garden Lodge OSV-0005652

Inspection ID: MON-0031633

Date of inspection: 19/01/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We will review staff personnel files to ensure all information required by regulation 15 is present, including the most recent reference for one employee	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We will ensure both provider evaluations are unannounced every 6 months	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: We will ensure the centre is repainted and any areas of the centre which require fixing of plaster is complete. We will ensure that any areas of the centre where there is mildew is re grouted and resealed.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: We will ensure that all emergency lighting is in working order in the centre and replace any fire doors throughout the centre which are not self-closing or have gaps identified in the architrave.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	01/03/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	01/03/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	10/02/2022
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	19/01/2022

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	20/01/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/04/2022