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

Issued by the Chief Inspector

Name of designated centre:	Bridge Lands
Name of provider:	GALRO Unlimited Company
Address of centre:	Laois
Type of inspection:	Short Notice Announced
Date of inspection:	02 December 2020
Centre ID:	OSV-0005682
Fieldwork ID:	MON-0031044

About the designated centre

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

Bridge Lands is a residential designated centre which can provide full time accommodation for up to six adults, who present with autism and/or an intellectual disability. The centre is a large detached dormer style house situated in County Laois. There is a full time person in charge assigned to the centre. The person in charge reports to a senior head of care manager. The staff team within the centre is comprised of number of allied health professional services, from within G.A.L.R.O Limited, are also available to residents. There are a number of local amenities available to residents, including cafes, shops and clubs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 2 December 2020	09:30hrs to 17:00hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and speak with three residents on the day of inspection. Residents used both verbal and non verbal methods to communicate. The inspector did not have the opportunity to meet with two of the resident living in the centre.

The premises was clean, bright and homely on arrival. The centre had been personalised with pictures and photos. The inspector observed a poly tunnel in the centres garden growing vegetables and plants. There was also a bike and a tricycle in the garden for residents to use.

One resident used non verbal methods to indicate that they enjoyed writing in their book and going for drives. Another resident was observed baking a cake with support from staff on the morning of the inspection. Residents normal schedules and activities had been impacted by COVID19. However staff and residents continued to enjoy some in house and local activities including online cooking courses, walks, drives, gardening, baking and computer gaming. Some residents had enjoyed attending day services and taking part in Special Olympics activities prior to the COVID-19 restrictions.

Staff spoken with appeared familiar with the residents individual needs and the inspector observed positive interactions between staff and residents during the inspection day. In general, residents appeared happy and content living in their home.

Capacity and capability

This was a short term announced inspection. The inspections purpose was to review the centres ongoing levels of compliance with the regulations. Overall, the inspector found that residents appeared happy, and well supported living in Bridge Lands. Issues identified during the centres most previous inspection had been appropriately addressed. Infection control measures were in place due to COVID-19, and therefore the inspector donned a face mask and maintained a distance of 2 metres from staff and residents at all times. It was noted that some improvements were required to ensure that systems in place for medication management following a residents short term absence to hospital were safe and effective as detailed in other sections of the report.

There was a full time person in charge, who had the skills, experience and qualifications necessary to effectively manage the designated centre. There was a clear management structure in place and clear lines of accountability. Staff spoken

with were familiar with the services line managers. There was evidence of regular auditing and review of the care and support provided. A six monthly review had also been completed on behalf of the provider and this assessed the centres levels of compliance with 32 regulations. A feedback form was issued to residents annually as part of the annual review process. These looked at the residents levels of satisfaction with areas including complaints management, healthcare, choices, money management, safety, staffing, and the care and support provided. An accessible format was used to support residents. Suggestions for any changes to be made were also welcomed.

There were appropriate staffing levels in place for the needs and number of residents in the centre. All residents were supported one to one during the day. Forensic risks had been identified and specific staff were scheduled to work at specific times to mitigate identified risks. Staff meetings were held monthly and identified risks were a regular agenda at these meetings. The staff rota in place accurately reflected staff on duty on the day of inspection. A review of a sample of staff files found that all Schedule 2 documents were in place as required

Staff training was provided in areas including fire safety, safeguarding, first aid, safeguarding, childrens first, health and safety, medications management, manual handling, and hand hygiene. All mandatory and refresher training was up to date on the day of inspection. Regular review of training needs were being completed and refresher training scheduled when needed. Regular formal one to one staff supervisions were being completed between staff and line managers.

There was a designated complaints officer nominated for the management of complaints. The complaints procedure was available to residents in an accessible format. Complaints appeared to be addressed seriously and in a timely manner. Compliments were also being recorded and the inspector observed numerous compliments from mulit-disciplinary staff, family members and members of the community. Some residents had been supported to engage with advocates. Details of advocacy services, residents rights and the complaints officer were all prominently displayed in the designated centre.

Regulation 14: Persons in charge

There was a full time person in charge, who had the skills, experience and qualifications necessary to effectively manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

There were appropriate staffing levels in place for the needs and number of

residents in the centre. A review of a sample of staff files found that all Schedule 2 documents were in place as required.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training was provided to meet the needs of the residents. All mandatory and refresher training was up to date on the day of inspection. Regular formal one to one staff supervisions were being completed between staff and line managers.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and clear lines of accountability. There was evidence of regular auditing and review of the care and support provided.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a designated complaints officer nominated for the management of complaints. The complaints procedure was available to residents in an accessible format. Complaints appeared to be addressed seriously and in a timely manner.

Judgment: Compliant

Quality and safety

The premises was designed and laid out to meet the number and needs of the residents. The building was a large detached dormer style house and was maintained in a good state of repair internally and externally. All residents had their own bedrooms which were personalised to their suit their preferences.

There was a comprehensive assessment of need and a detailed individualised personal plans in place for each resident. Residents had personalised social goals in

place which were regular reviewed and updated. Residents had short term goals in place to support them to achieve long term goals. Goals included developing residents independent living skills, and seeking further opportunities in education, training and employment. Assessments of need were reviewed annually and detailed residents most up-to-date needs in areas including general health, sleep, communication, social needs, personal care, nutrition, safety, behavioural support, mobility, safeguarding, activities of daily living and sexuality.

Residents were safeguarded in the centre. All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. There was safeguarding officer in place who responded to and investigated any safeguarding concerns raised by staff or residents. All residents had intimate care plans in place which clearly identified support levels required during personal care. There were no safeguarding concerns on the day of inspection

The registered provider had ensured that systems were in place for the assessment, management and ongoing review of actual and potential risks in the designated centre. Risks were rated using a traffic light green, amber and red system. Levels of risk determined if they were subject to weekly, monthly or quarterly review. All resident had been assessed for potential risk of absconsion from the centre - staffing levels were in place to mitigate this risk. Emergency plans were in place for adverse incidents such as flooding, fires and loss of power. Individual risk assessments were in place which considered levels of risks and their consequences. Measures to reduce risks were also clearly and appropriately identified. Actual and potential risks were all discussed monthly with the staff team.

Appropriate measures were in place for infection prevention and control. Additional measures and protocols had been implemented due to the COVID-19 pandemic. The centre was visibly clean on the day of inspection. Enhanced cleaning schedules had been implemented, and regular symptoms checks were being completed by staff and residents. The centre had full supplies of personal protective equipment (PPE) and staff were observed donning PPE in line with national guidance for residential care facilities. A service contingency plan had been devised for in the event of an outbreak of COVID-19 which considered measures needed to ensure minimal impact to service provision for residents. Additional staffing had been identified for in the event of an outbreak. Staff were completing regular infection prevention and control checklists. There was designated infection control officers nominated and one of these was a resident. Spot checks and audits were being completed by the person in charge. Management had completed the self assessment questionnaire issued by the Authority and had devised an action plan following this which was subject to regular review.

The registered provider had ensured that safe and effective fire management systems were in place in the designated centre. All residents had individual personalised emergency evacuation plans in place. Evacuation plans were available to residents in an accessible version. Weekly fire safety checklists were being completed by staff. Fire drills were being completed monthly and these simulated both day and night time conditions. Additional assistive fire safety supports had been implemented for a resident with a hearing impairment. Fire fighting equipment

was locate around the centre and this was regularly serviced by a fire specialist. One staff member was the delegated fire officer. Residents were involved in ensuring fire safety and one resident had been nominated as assistant fire officer and was involved in completing the weekly fire safety checks.

Some improvements were required to ensure that medication was stored, administered and recorded safely in line with regulation 29 and national guidance. Medications were stored in a locked cabinet in the centres offices. The centre pharmacist completed regular reviews of the residents prescriptions. A clear protocol was in place for in the event that a resident refused medication. Staff had completed assessments with residents to determine if they could safely self administer medication. However, staff handover systems following a residents temporary absence to hospital required improvements. One incident reviewed, found that medication changes recommended by the hospital were unclear at times. A controlled drug had been prescribed in hospital and this had not been reviewed and charted as prescribed by the residents general practitioner (GP). This drug had also not been appropriately recorded, stored or counted daily in line with the centres own policy and national guidance. The resident was vulnerable, secondary to their diagnosis and therefore this posed many risks to them. The inspector observed one medication in the centres medication press that was not prescribed for any residents. A topical cream was also observed which did not indicate when it had been opened or how long it had been in the storage facility.

Residents had appropriate access to multi-disciplinary services to support them to manage their behaviours. All residents had positive behavioural support plans in place with regular input from behavioural specialists. Changes in the residents lives due to COVID-19 were reflected in their behavioural support plans. Evidence was observed that therapeutic interventions were utilised such as redirection techniques, reassurance, house rules and key working sessions. Known behavioural triggers, methods of communication and proactive strategies were also clearly outlined in support plans. Restrictive practices in place were subject ot regular review with the service rights committee and were implemented due to an identified risk. There was a centre restrictive practice register in place which highlighted rationale for use, review times, and persons responsible. Written consent for use of restrictive practices was gotten from residents when possible.

Regulation 17: Premises

The premises was designed and laid out to meet the number and needs of the residents. The building was maintained in a good state of repair internally and externally.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured that systems were in place for the assessment, management and ongoing review of actual and potential risks in the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate measures were in place for infection prevention and control. Additional measures and protocols had been implemented due to the COVID-19 pandemic.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that safe and effective fire management systems were in place in the designated centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Some improvements were required to ensure that medication was stored, administered and recorded safely in line with regulation 29.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment of need and a detailed individualised personal plan in place for each resident. Residents had personalised social goals in place which were regular reviewed and updated.

Judgment: Compliant

Regulation 6: Health care

Staff handover systems following a residents temporary absence to hospital, required improvements. One incident reviewed, found that medication changes recommended by the hospital were unclear at times and the resident had not been referred to their GP for review of these changes following their return to the centre.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had appropriate access to multi-disciplinary services to support them to manage their behaviours. Restrictive practices in place were subject ot regular review with the service rights committee and were implemented due to an identified risk.

Judgment: Compliant

Regulation 8: Protection

Residents were safeguarded in the centre. All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. All residents had intimate care plans in place.

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 - 2015 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bridge Lands OSV-0005682

Inspection ID: MON-0031044

Date of inspection: 02/12/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 29: Medicines and pharmaceutical services</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• PIC met with the pharmacist to ensure the correct and relevant information pertaining to medication for residents is provided to staff team.
• Staff have completed further training in relation to the practices relating to the ordering, receipt, prescribing, storage, disposal and administration of residents medication.
• We have introduced a controlled drug safe and register into the centre, in line with GALRO control drug policy and national guidance.
• We have Introduced a system where the GALRO compliance officer will review medication management in the centre monthly.
• We have amended the medical appointment form to include an additional section for control drug medications that have been identified by the pharmacist to complete. This is then reviewed by the PIC following residents medical appointment to ensure that we are following GALRO policy and national guidance.
• We have reviewed our medication system to ensure all medication stored including those not managed by staff team are recorded on residents Kardex by GP.
• As part of further training for staff. All protocols including open and expiry dates have been reviewed with staff.</td></tr>
<tr><td>Regulation 6: Health care</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 6: Health care:
• PIC met with the pharmacist to ensure the correct and relevant information pertaining</td></tr>
</table>

to medication for residents is provided to staff team.
• Staff have completed further training in relation to the practices relating to the ordering, receipt, prescribing, storage, disposal and administration of residents medication.
• We have introduced a controlled drug safe and register into the centre, in line with GALRO control drug policy and national guidance.
• We have Introduced a system where the GALRO compliance officer will review medication management in the centre monthly.
• We have amended the medical appointment form to include an additional section for control drug medications that have been identified by the pharmacist to complete. This is then reviewed by the PIC following resident's medical appointment to ensure that we are following GALRO policy and national guidance.
• We have reviewed our medication system to ensure all medication stored including those not managed by staff team are recorded on residents Kardex by GP.
• As part of further training for staff. All protocols including open and expiry dates have been reviewed with staff.

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 29(4)(a)	The person in charge shall ensure that the designated centre has 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.	Not Compliant	Orange	11/12/2020
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	11/12/2020