Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	An Áit Chonaithe
Centre ID:	OSV-0004977
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	G.A.L.R.O. Limited
Provider Nominee:	Joe Sheahan
Lead inspector:	Maureen Burns Rees
Support inspector(s):	
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
15 November 2017 09:30	15 November 2017 17:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was a seven outcome inspection carried out to monitor compliance with the regulations and standards. The previous 18 outcome inspection was undertaken on the 16 September 2016. The centre was granted its registration on the 18 October 2015.

How we gathered our evidence:
As part of the inspection, the inspector met with one of the three residents in the centre. This resident told the inspector about the many activities that she was involved in and how she enjoyed spending time with staff. The resident also outlined how she would rather be living nearer to her home but indicated that staff in the centre were good to her and that she was safe in the centre. The inspector observed warm interactions between the resident and staff members.

The inspector interviewed the person in charge, the area manager, deputy person in charge and two social care workers. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and staff supervision files.

Description of the service:
The service provided was described in the providers statement of purpose. The centre provided residential care for up to four residents over the age of 18 years. At

the time of inspection, there was one vacancy in the centre.

The centre consisted of a two storey bungalow which was located in a rural setting but in close proximity by car to a large town. There was a garden to the front and rear of the property for use by residents.

Overall Judgement of our findings:
Overall, the inspector found that the residents were well cared for in the centre and that the provider had arrangements in place to promote their rights and safety. The inspector was satisfied that the provider had put systems in place to ensure that the majority of regulations were being met. The person in charge demonstrated adequate knowledge and competence during the inspection and the inspector was satisfied that she remained a fit person to participate in the management of the centre. Of the seven outcomes inspected on this inspection, a moderate non compliances was identified in one outcome. All other outcomes inspected were found to be compliant as outlined below.

Good practice was identified in the following areas:
- Each resident's well being and welfare was maintained by a high standard of evidence-based care and support. (Outcome 5)
- The health and safety of residents, visitors and staff were promoted and protected. (Outcome 7)
- There were appropriate measures in place to keep residents safe and to protect them from abuse. (Outcome 8)
- Resident's healthcare needs were met in line with their personal plans (Outcome 11)
- There were systems in place to ensure the safe management and administration of medications.(Outcome 12)
- There were appropriate staff numbers and skill mix to meet the assessed needs of residents and to promote the safe delivery of services. (Outcome 17)

An area for improvement was identified:
- The provider had not complied with the regulatory requirements to complete an annual review of the quality and safety of services.(Outcome 14)

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Each resident's well being and welfare was maintained by a high standard of evidence-based care and support. The arrangements to meet each resident's assessed needs were set out in a personal plan that reflected their needs, interests and capacities.

Each resident's health, personal and social care needs had been fully assessed. There was documentary evidence to show that resident's family representatives were involved in assessments to identify the resident's individual needs and choices. In addition, there was a multidisciplinary input into assessments. The providers multidisciplinary team included a clinical psychologist, behavioural specialist and occupational therapist.

Each resident had a personal plan in place which detailed their assessed needs and choices. Short and long term personal goals were set for residents and there was evidence that implementation of these goals were monitored. Each of the residents had an allocated key worker. A record was maintained of proposed key working sessions for the month and key working sessions undertaken. A separate key worker sessions review was undertaken on a monthly basis.

All personal plans had been reviewed within the last 12 months with input, where appropriate from the resident's families and multidisciplinary team.

Each of the residents were engaged in a good range of activities within the local community. Examples included, horse riding, art class, music group, special Olympics, healthy eating group and reflexology. A weekly schedule of activities were maintained for each of the residents and an activity participation record was maintained.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The health and safety of residents, visitors and staff were promoted and protected.

There was a policy on risk management and emergency planning, dated July 2017, which met with the regulatory requirements. The inspector reviewed a sample of individual risk assessments for residents which contained a good level of detail and were specific to the resident. There were appropriate measures in place to control and manage the risks identified. There was a formal risk escalation pathway in place and a risk register in place. There was a safety statement in place. Written risk assessments pertaining to the environment and work practices had been undertaken with appropriate controls identified. Hazards and repairs were reported to the providers maintenance department and records showed that requests were attended to promptly. There was evidence that a number of health and safety checks were completed on a weekly basis.

There were arrangements in place for investigating and learning from serious incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. Overall, there were a low number of incidents reported in the preceding three month period. The inspector reviewed staff team meeting minutes which showed that specific incidents were discussed and learning agreed.

There were satisfactory procedures in place for the prevention and control of infection. There was an infection control policy, dated July 2014. This required review so as to ensure that staff had access to the most up-to-date best practice in this area. The inspector observed that all areas were clean and in a good state of repair. Colour coded cleaning equipment was used and appropriately stored. There was a cleaning schedule in place and records maintained of tasks undertaken. The inspector observed that there were sufficient facilities for hand hygiene available and paper hand towels were in use. Posters were appropriately displayed. There were adequate arrangements in place for the disposal of waste. The inspector observed that a first aid kit was available in the centre and the car used by the centre. Records were maintained of checks regarding its content on a monthly basis.

Adequate precautions were in place against the risk of fire. A fire safety management

policy was in place and an emergency plan in the event of fire, dated December 2015. There was adequate means of escape and all fire exits were unobstructed. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Appropriate fire drills were undertaken with residents at regular intervals. A fire risk assessment had been completed. Staff who spoke with the inspector were familiar with the fire evacuation procedures. There was documentary evidence that the fire equipment, fire alarms and emergency lighting were serviced by an external company and checked regularly as part of internal checks in the centre.

Judgment:
Compliant

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were appropriate measures in place to keep residents safe and to protect them from abuse.

The centre had a policy on the prevention, detection and response to abuse, including reporting of concerns and or allegations of abuse, dated July 2017. This was found to be in line with national guidance and included the name and contact detail for the area manager who was identified as the designated officer responsible for care and protection. The inspector observed staff interacting with residents in a respectful and warm manner. Staff who met with the inspector were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. Staff had attended appropriate training. There had been no incidents, allegations or suspicions of abuse in the preceding 12 month period. There was a protected disclosure policy, dated July 2017, to promote there being no barriers for staff or families disclosing abuse.

The centre had an intimate care policy in place, dated July 2017. Intimate care assessments and plans were noted to be included as part of residents personal plans.

These plans were found to provide a good level of detail to guide staff in meeting the intimate care needs of residents.

Resident's were provided with emotional and behavioural support. There was a policy on provision of behavioural support, dated July 2017. The inspector found that the residents assessed needs and behaviours were being appropriately responded to. Individual behaviour management plans were on file for residents identified to require same. These had been developed by the provider's behaviour support specialist and psychologist. Records showed that staff had attended training in a recognised positive behaviour management support method adopted by the provider. It was noted that two staff required refresher training to be completed but that this was booked.

There was a policy on the use of restrictive procedures and physical, chemical and environmental restraints, dated July 2017. There were minimal restrictive practices in use in the centre. Protocols were in place for restrictive practices identified to be required. All usage was monitored by the multidisciplinary team and recorded. Staff interviewed told the inspector that all alternative measures were considered before a restrictive procedure would be put in place.

Judgment:
Compliant

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Resident's healthcare needs were met in line with their personal plans and assessments.

Residents living in the centre had minimal healthcare needs. Each resident's health needs were appropriately assessed on admission and met by the care provided in the centre. Each resident had their own general practitioner and access to allied health care services which reflected their care needs. The inspector reviewed up-to-date hospital passports on file for each of the residents. A log was maintained for each resident of all contact with their GP and any other health professionals. Multidisciplinary team involvement and reports on file included, occupational therapy, dietician, psychology and psychiatry.

There was a policy on monitoring and documentation of nutritional intake, dated July 2017. The centre had a small but fully equipped kitchen come dining area. There was a

food safety policy, dated July 2017. There were nutritional plans, food planners and food diaries on file for residents identified to require same. A weekly meal planner was agreed with residents at the residents weekly meeting. Residents were supported to buy and prepare their own meals. It was noted that a range of healthy and nutritious meals and snacks were provided in the centre. A number of the residents were members of a healthy eating club in the local community. One of the residents spoken with told the inspector about how she enjoyed attending the meeting and preparing some of the healthy meals promoted in the group.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were systems in place to ensure the safe management and administration of medications.

There was a policy on medication management, dated July 2017. The processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation. Staff interviewed had a good knowledge of appropriate medication management practices and medications were administered as prescribed. The inspector reviewed a sample of prescription and drug administration sheets and found that they contained all of the required information. There was a secure press for the storage of all medicines. There was a 'PRN' or as required medication administration rationale recording sheet which was signed off by the staff member administering the medicine, the team leader and the area manager.

There were appropriate procedures in place for the handling and disposal of unused and out of date medications, whereby they were returned to the pharmacy who signed off with staff receipt of same.

An assessment had been completed to determine if it was suitable for residents to be responsible for the self administration and management of their own medications. At the time of inspection, It was not appropriate for any of the residents to be responsible for their own medications. However, review dates had been set to reassess residents capacity in order to promote their independence where possible.

There was a system in place to review and monitor safe medication management practices. The inspector found that audits of medication management arrangements were undertaken on a weekly, monthly and six monthly basis which showed a good level of compliance and where issues were identified appropriate actions had been taken. In addition, the pharmacist who provided a service to the centre had completed an audit in October 2016 and it was proposed would be completing same again this year. All staff had received appropriate training in the safe administration of medications.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were management systems in place to ensure that the service provided was safe, consistent and appropriate to resident's needs. However, the provider had not complied with the regulatory requirements to complete an annual review of the quality and safety of services.

There was a clearly defined management structure which identified lines of authority and accountability in the centre. Staff who spoke with the inspector had a clear understanding of their role and responsibility. A deputy person in charge had recently been appointed to the centre and reported to the person in charge, who in turn reported to the area manager. Formal supervision arrangements were in place for the person in charge and her new deputy. There was evidence that the area manager visited the centre on a regular basis. On call arrangements were in place and staff were aware of these and the contact details.

Management meetings were held on a monthly basis with the area manager, persons in charge and deputy persons in charge in the area. There was evidence that complaints, incidents and any other clinical or operational issue were discussed at this meeting with shared learning agreed. There were also three monthly broader management meetings across the wider service.

The person in charge was in a full time position but also held responsibility for another two designated centres located nearby. A new deputy person in charge had recently been appointed to the centre. It was noted that deputy persons in charge were in place to support the person in charge in the other centres for which she was responsible. She held a bachelor of arts in social studies and applied social studies, and a diploma in child mental health. At the time of inspection, she was in the process of completing a masters in advanced social care practice. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards and had a clear insight into the assessed needs and support requirements for the residents. Staff interviewed told the inspector that she was approachable and supported them in their role. Residents were observed to interact warmly with her.

The provider had completed unannounced visits to the centre in January and July 2017 to assess the quality and safety of the service and produced a report. However, an annual review had not been appropriately completed, as per the requirements of the regulations. There was evidence that the person in charge and or her deputy had undertaken a number of other audits in the centre on a regular basis. Examples of audits completed included, medication practices, residents rights, audits against specific outcomes, fire safety, key working, infection control and safety audit.

Judgment:
Substantially Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were appropriate staff numbers and skill mix to meet the assessed needs of residents and to promote the safe delivery of services.

The staffing levels, skill mix and experience were sufficient to meet the needs of residents. The majority of the staff team had been working in the centre for an extended period. This provided consistency of care for residents.

There were effective recruitment procedures in place that included checking and recording all required information. There was a policy on recruitment and selection,

dated July 2017. The inspector reviewed a sample of staff files and found that all of the documentation required by schedule 2 of the regulations was contained in the files reviewed.

There was a policy on staff training and development, dated July 2017. A training programme was in place for staff which was coordinated centrally by the provider. Training records showed that overall staff were up to date with mandatory training requirements. Two staff required refresher training in the positive behaviour support model adopted by the provider but this was scheduled. Staff interviewed were knowledgeable about policies and procedures in place. The inspector observed that a copy of the standards and regulations were available in the centre.

There were staff supervision arrangements in place, whereby all staff were supervised by either the person in charge or newly appointed deputy person in charge. The inspector reviewed supervision records for four members of staff and found that they were of an adequate quality and had been undertaken in line with the frequency specified in the providers policy .

There were no volunteers working in the centre at the time of inspection.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by G.A.L.R.O. Limited
Centre ID:	OSV-0004977
Date of Inspection:	15 November 2017
Date of response:	7 December 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review had not been appropriately completed by the provider, as per the requirements of the regulations.

1. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care

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

and support is in accordance with standards. **Please state the actions you have taken or are planning to take:** We will ensure that the annual review of the quality and safety of care and support is complete in accordance with standards.
Proposed Timescale: 11/12/2017