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:	Glen 3
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	19 August 2021
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0033646

About the designated centre

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

The designated centre consists of three bungalows located in a campus setting and provides a residential service for up to 16 adult ladies who have an intellectual disability and require moderate to high support interventions. The centre is located in a suburb of Co. Dublin with access to a variety of local amenities. Residents are supported 24 hours a day by a team comprising of a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff. Residents are supported to engage in a range of activities which were meaningful to them both in the community and on the campus where the centre was located. The houses in the centre are purpose built and there is a living room, shared dining and kitchen area, a smaller sitting room, two bathrooms, an office and staff room, laundry room and attic space for storage. Each resident had their own bedroom which was decorated in line with their individual preferences and needs. Each house has a shared garden and patio area which leads on to the main campus gardens.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Thursday 19 August 2021	09:25hrs to 17:50hrs	Erin Clarke	Lead
Thursday 19 August 2021	09:25hrs to 17:50hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The governance and management arrangements in place were not effective at ensuring a quality driven service was available to residents. Inspectors found that the service was not adequately resourced to effectively self-identify quality improvement areas. Issues were identified across a number of regulations which, at times, were negatively impacting the lived experience of residents.

On arrival to the setting, it was noted by the inspectors that each bungalow was well kept, with mature gardens surrounding each home. The centre comprises three separate bungalows in a campus setting. Each of the homes consisted of one large communal kitchen, dining and living room, a separate sitting/visitors room, individual bedrooms, several bathrooms, laundry room, staff office, and staff changing room/bathroom. The bungalows were clean and well kept. A back garden led from each bungalow into a communal courtyard. The gardens were brightly painted with well-maintained seating areas and flower beds. This area could be accessed from a sliding door in the communal living room, and staff reported that residents enjoyed spending time in the garden.

On the day of inspection, two of the three homes in the designated centre were visited by inspectors. In the first bungalow, one inspector met with two residents. The other three residents were out on a barge trip; the inspectors viewed photographs of the residents enjoying themselves on the trip later in the day. On arrival to the house, the inspector met a resident who was sitting at the kitchen table. A restrictive practice was in place for this resident, and the inspector noted it was appropriate to their assessed needs and completed in a way to ensure that the resident's dignity and appearance were respected. Staff were aware and spoke to the inspector for the rationale for its use.
The inspector visited the homes during the mealtime experience. The resident was waiting for their meal. The resident was observed to smile and vocalise at different times, but they did not communicate directly with the inspector due to their specific communication skills. Hot meals were provided from the central kitchen on the campus by trolley. The trolley was usually delivered to the back door of the home between 12.00 and 12.30, and staff would bring the meals from the trolley into the homes. Both dinner and the residents' tea were provided by the central kitchen at this time. There were facilities in each of the houses to cook, reheat food, and bake. The staff informed the inspector that residents and staff baked regularly together.

There was an accessible version of the menu on the table, with condiments available. The meal was prepared by modifying its texture according to the resident's specific needs and presented to them. The resident took a few mouthfuls of the meal and indicted to the staff member that they did not want it. No other choice was offered to the resident at this time, and no drink was provided. The staff indicated that they would put the meal away and reheat it later if the resident wanted it. It was noted that the mealtime experience in the home was affected by the times of delivery of the meals. On discussion with staff, residents sometimes had

their breakfast between 9 am, and 11 am, and dinner was then presented to the residents between 12.00 pm and 12.30 pm, not leaving sufficient time between the two meals. Discussions between staff and inspectors indicated that another choice would be offered if residents did not want a particular dinner. However, this practice was not observed on the day of inspection.

The other resident in the home was observed to be eating their meal independently in another part of the home. The resident had a separate living and sleeping area from the rest of the home due to their assessed needs. A number of restrictive practices were in place for this resident. This will be discussed further in the report. The resident was sitting at a table and chair in the hall of their separate living area. The resident chose not to engage with the inspector. The resident's living area consisted of a bedroom, sitting area with a locked kitchenette. The resident was unable to access the main house independently. The inspector asked to view the kitchenette, and the staff member went to get the key and opened it for the inspector. There was a kettle in the kitchenette with some breakfast cereals and fruit. The resident had no free access to drinks or food. This had not been identified as a restrictive practice. Both the bedroom and sitting room were sparsely decorated in line with the resident's assessed needs and preferences. A television was on in the background playing music videos. This television was behind a perspex screen, and the resident did not have access to the remote. Again this had not been identified as a restrictive practice. The residents' bedroom had a glass viewing panel that was uncovered and could be viewed by any staff member passing the resident's room. This practice was not upholding the residents' right to privacy and dignity.

The second inspector visited a house, where five residents resided, on their return from an activity on campus. One resident greeted the inspector at the door and opened the door with a swab key. There had been attending a graduation ceremony for the participants of the 'Get Fit for Life' campaign. This programme consisted of healthy eating and exercise over a five week period. Staff explained they were slightly late returning to the house, which had caused some distress for one resident. One resident was supported to have their meal separate from the other residents in line with their assessed needs. However, as observed by the first inspector, the inspector witnessed residents were not offered a choice in meals. One resident put their dinner in the bin, and while the inspectors were informed at the opening meeting that alternatives could be sought from the canteen, the resident was offered chips alone that arrived with the meal. The inspector also had to intervene and direct care to non-adherence to one resident's dysphagia plan.

During the meal, it became apparent that there was someone in the house unannounced to staff. When staff when to look for the unidentified person, they confirmed it was a staff member from the maintenance department. While person arrived before the residents arrived back at the house, the sign-in procedures were not followed, and the person did not announce themselves to staff and residents. The inspector also witnessed a dignity and privacy risk for one resident while they engaged in some behaviours of concerns in a communal area while unauthorised staff were in the building.

The inspector was also not satisfied that the compatibility of residents had been

reviewed in this house, given the resident mix in the house. One resident was visibly upset, engaging in distressing behaviours and vocalising loudly. As a result, three residents moved out of the space. From speaking to different members of staff throughout the inspection, it was apparent this was a regular occurrence, and residents 'often were upset', and some behaviours resulted from 'fear' due to a different resident. These incidents had not been identified as safeguarding concerns, and therefore safeguarding plans had not been implemented to address these concerns. At this time, the impact of staff breaks and understaffing was evident as one staff member was alone with four residents when this prolonged incident occured. The inspector observed the staff member provide support to the resident in a reassuring and caring manner but was apologetic they could not leave the house when the resident indicated to go out the front door as they had to stay in the house with the other residents.

This issue was quickly identified by an inspector shortly into visiting the house, this raised concerns regarding the level of oversight for this designated centre. Taking into account poor findings under other regulations during this inspection, the provider's monitoring systems were not ensuring that the service provided was safe, appropriate to the needs of all residents, consistent and effectively monitored.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection was completed to verify the actions outlined by the provider following the centre's last inspection in November 2020. This inspection aimed to assess the improvement made by the provider in key areas since the previous inspection, such as the governance and monitoring of the care and quality of the centre, staffing and training. The inspectors found there was a poor level of compliance on this inspection. Significant improvements were required in the development and implementation of effective management systems to ensure appropriate oversight and delivery of services that were of a good standard, consistent and appropriate to the needs of residents.

It was noted in the previous inspection that the person in charge had been on unplanned leave since May 2020. The provider had notified the Chief Inspector in December 2020 to inform them this person had vacated their post, and recruitment was underway. However, this post remained unfilled at the time of this inspection as the recruitment processes in place had been unable to source a qualified person for this role. As a result, the provider had appointed the services manager, who facilitated the inspection, in a dual role as person in charge on 09 June 2021. The inspectors found this arrangement unsatisfactory due to the service manager's large

remit, which impacted their capacity to fulfil the role of the person in charge, demonstrated by their absence of knowledge of some concerns brought forward by the inspectors, as discussed throughout the report. Furthermore, the service manager briefed the inspectors that they were leaving the organisation in eight days and that they were unaware of the governance contingency plan after their finish date. The inspectors were particularly concerned considering the provider had applied to renew the centre's registration with the service manager named at two levels of governance. Information received post inspection indicated the provider had planned to appoint a CNM3 as in interim measure while the position of the service manager was being recruited. While the provider had initiated additional support during this transition, the inspectors were not fully assured it would address all oversight and monitoring concerns identified.

While there were two supernumerary clinical nurse managers (CNM1 and CNM3) also involved in the management in the centre, they also held other roles within the centre. For example, worked shifts were required and covered staff breaks, and also the person in charge for another designated centre on campus due to staff shortages. Therefore the inspectors were not assured the centre was effectively monitored.

The inspectors reviewed the provider's systems to monitor the quality and safety of care and support provided as required by regulation. These included carrying out unannounced provider visits at six-monthly intervals, with such visits reflected in written reports. However, despite the provider conducting unannounced inspections and an annual review of quality and care, the provider failed to self-identify critical issues identified during this inspection. This highlighted that the arrangements in place were insufficient to drive the quality improvement required to enhance residents lived experience within the centre. The inspectors viewed the centre's quality improvement plan, collated through auditing of practices and the outcome from all audits and reviews of the service. It was found that the majority of the active actions on the centre's quality improvement plan were identified through the previous inspection in November 2020, not through the providers' own auditing systems. Consequently, no improvement was identified in the areas of staffing, person in charge, training, supervision, residents rights, compatibility, restrictive practices and safeguarding, all areas ascertained by inspectors on the day of the inspection that required addressing.

On discussion with staff, it was noted that they indicated that they required more support to complete their role effectively. On review of supervision records, many staff had no records present for 2021. The person in charge was unaware that not all supervision records were available to the inspectors for evaluation. On further review of the available supervision records, the inspectors found in some instances, the supervisor was the same grade as the supervisee. For example, a social care worker was supervising another social care worker. Inspectors queried the training made available to staff to effectively provide supervision to another staff member, especially considering the requirement for staff to work alongside each other. The person in charge was not aware this was the practice in the centre and was in agreement this was not best practice and confirmed that staff did not receive

training in this area.

A review of the staff rosters found that while there was continuity of care and support in the centre, overall, there was insufficient numbers of staff members employed to meet the assessed needs of residents. On the day of the inspection, there were 3.5 whole-time equivalents (WTE) vacancies for a number of roles. While the inspectors were informed that staff could call upon members of management to cover breaks, the inspectors did not observe this arrangement in one of the houses visited resulting in the centre being understaffed at break times.

A staff training matrix indicated mandatory training completed and timelines to when refresher training was due. In addition, the CNM3 had oversight of a training need analysis document which identified some essential and desirable training to be completed in 2021. On review of the documentation, it was noted that not all staff had completed mandatory training in behaviours of concerns. Also, from reviewing residents' assessed needs, training was needed in the areas of dysphagia, epilepsy, dementia and autism. There were no records available on the day of inspection in regards to staff completing the training in these areas or COVID-19 specific training. These training areas were also not on the training matrix, so the person in charge and their deputy (CNM1) had no oversight.

An area of improvement identified by inspectors since the previous inspection involved the notification of incidents when the person in charge is on leave. Submitting such notifications is required under regulations in order to inform the Chief Inspector of events occurring that can potentially negatively impact the residents living in a designated centre. Submission of such notifications is the direct responsibility of the person in charge under the regulations. The provider had ensured notifications continued to be notified when the person in charge was absent.

Regulation 14: Persons in charge

The person in charge's post had been vacant since May 2020 since an extended leave of absence. This post was advertised in December 2020, but the inspectors were informed there were difficulties recruiting the required staff and also maintaining staff in this position. As a result, this post had alternated between the clinical nurse manager 3 and service manager. However, both of these individuals had a large governance remit and were not involved in the centre's day-to-day operation. Therefore, it was not evident that they could ensure the designated centre's effective governance, operational management, and administration. For example, they were not based in the designated centre when they were on duty, did not attend staff meetings, did not complete supervision for staff or were involved in the review of residents care plans.

Judgment: Not compliant

Regulation 15: Staffing

The inspectors reviewed the staffing levels in the centre and found they were not always sufficient to meet the needs of the residents. At the time of the inspection, there were vacancies for two whole-time equivalents (WTE) staff nurses, 0.5 WTE social care worker, and a vacant Clinical Nurse Manager (CNM2) post. This CNM2 post was identified as the person who would take on the role of person in charge. There were interviews scheduled for the 0.5 WTE social care worker.

While the above gaps were being covered by relief staff, there was an identified shortage of appropriately staffing arrangements to cover staff breaks when they left the designated centre. The service manager informed the inspectors there was some difficulty planning some residents' activities at midday as staff breaks occured from 12pm to 2pm. The inspectors also observed some residents unable to leave their house while staff took their breaks. While the CNM1 was covering breaks in one house, it was unclear how staff could take their breaks in the other two houses while still maintaining appropriate staffing levels that did not negatively impact residents

Judgment: Not compliant

Regulation 16: Training and staff development

The training records viewed indicated that staff had completed the majority of mandatory training. Some of this included fire safety, hand hygiene, safeguarding vulnerable adults, and challenging behaviour training. However, the records viewed indicated that 16 people had not completed training in behaviours of concern, and out of the 18 staff that had completed this training, two required refresher training. In addition, a specific de-escalation training had been identified as a control measure to a recognised risk; however, no staff had completed this training. This has been addressed further in regulation 7.

Assessed needs of residents possibly indicated that staff would need training in the following areas, dysphagia training, dementia, autism and epilepsy. However, there were no records available to indicate if staff had completed training in these areas. Records of infection prevention and control training, or COVID-19 training, were also not available for review for inspectors.

Although some staff had been in receipt of supervision, there were no supervision records for a number of staff on the day of inspection. Due to the number of staff, a matrix was devised to indicate supervisor and supervisee. The information on this matrix indicated that staff at the same grade were supervising each other. There was no supervision training provided, and some staff stated that they required

additional supervision to complete their role effectively.

While staff were having regular team meetings and were facilitated by the CNM1 these were not attended by the identified person in charge. On review of meetings over a seven month period the named person in charge had attended one meeting.

Judgment: Not compliant

Regulation 23: Governance and management

Taking into account findings under other regulations during this inspection, the provider's monitoring systems were not ensuring that the service provided was safe, appropriate to the needs of all residents' needs, consistent and effectively monitored. The inspectors found that a recently completed provider visit to the centre did not recognise many of the concerns and non-compliances identified by the inspectors during the course of the inspection.

On account of COVID-19, the provider had modified its approach to unannounced auditing and review of the centre, and onsite visits and direct engagement with residents did not occur. As a result, the results of the reports complied within the past 12 months were primarily based on a conversation between an assessor appointed by the provider and the person in charge. Upon reviewing the latest report dated 09 June 2021, the inspectors identified the service manager had completed the unannounced visit on the day the provider had notified the Chief Inspector that the service manager was the named person in charge. Thus invalidating the purpose of an unannounced audit and resulting in a role conflict.

Furthermore, the narrative contained in the report was lacking. The majority of the report listed the systems in place as opposed to a review of the systems. Many areas that were pertinent to the quality and safety of the centre were left blank and did not include observation of practice or discussions with staff to determine the lived experience of residents.

The annual review of the quality and safety of care for 2020 did not include the voices and views of residents and their families.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the designated centre was maintained. The Chief Inspector was given notice in writing of most of the required incidents in line with the requirements of this Regulation. This has been addressed under regulation

7 positive behaviour support and regulation 8 protection.

Judgment: Compliant

Quality and safety

The inspectors found that this centre's governance and management arrangements did not ensure that the quality and safety of care delivered to residents was maintained to a consistently high standard. A number of non-compliances with regulations were identified in relation to residents' positive behaviour support, residents' rights, food and nutrition, and fire precautions. Significant improvements were required to ensure a quality driven, safe service was provided to residents. At times residents lived experience was impacted by the limited oversight of the service and the failure to drive quality improvement as part of the service delivery. Particular concerns were identified regarding the resident mix in one house of this designated centre. This contributed to concerns around safeguarding and affected residents' exercise of their rights in their home.

Several restrictive practices were observed in the centre, with a number of these practices reported to the Chief Inspector and applied in line with national guidance. Good practices had been identified, such as the use of communication aids with residents to explain the rationale for the restrictive practice, restrictive practice reduction plans, and quarterly review of these practices by the multi-disciplinary team. However, the inspectors identified two restrictive practices that had not been considered restrictive to the residents during the inspection. One of these restrictive practices impacted a resident's ability to access food and drink. There appeared to be no evidence to indicate if they were the least restrictive practices in place. Consequently, they were not subject to regular review or reported in line with regulations. Positive behaviour support plans were not available in each person's personal plan folder. The section in this folder also contained a number of historical positive behaviour support plans, and it appeared, at times, unclear which was the correct plan to follow to support the resident effectively.

The provider's risk management policy contained the required information as set out in the regulations. Improvements were required regarding the updating of all risk documentation to reflect risk management practices. For example, in some assessments, the ratings as outlined were not consistent with the risk described. In addition, it was identified that many of the measures in place to reduce the risk of identified hazards were aimed at reducing the likelihood of such events occurring. However, often both the likelihood and impact scores were reduced. This resulted in inaccurate risk assessments. It was also identified that not all hazards had been assessed; for example, there were no assessments of COVID-19 related risks in a house register viewed by inspectors.

Fire precaution measures were reviewed by the inspectors, who found that there

was a fire alarm and detection system in place along with appropriate emergency lighting. Fire containment measures were in place with fire doors and automatic closures. There were personal emergency evacuation plans in place for each resident, which outlined the individual supports required in the event of a fire or similar emergency. While fire drills were taking place in the centre, no stimulated night time drills had occurred to demonstrate residents could be safely evacuated with the reduced staffing numbers using evacuation aids.

Regulation 17: Premises

The premises were designed and laid out to meet the number and needs of residents in the centre. The houses were found to be clean, comfortable, suitable decorated, and well maintained both internally and externally. Residents had access to private and communal spaces and could meet friends and family privately if they wished.

Judgment: Compliant

Regulation 18: Food and nutrition

Improvements were required to ensure each resident's needs in relation to nutrition were met and that residents were provided with variety and choice at mealtimes. For example, residents were not provided with a choice for their dinner on the day of inspection; instead, they had to make their choices a week in advance of the meal. This did not allow for flexibility and change of mind by the resident. Inspectors also found that not all residents were provided with dinner at a suitable time to meet their preferred morning routine resulting in refusing their dinner at midday. The centre also evidenced that four out of six residents had refused dinner at midday during a mealtime experience audit. In addition, drinks provided to one resident was not consistent with their dietary needs or recommended by a multi-disciplinary professional.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspectors found that there was limited oversight of risk in the centre due to the systems in place that were difficult to follow. For example, each house had its own risk register; it was unclear how these risks aligned with the overall risk register. The centralised risk register recognised restrictive practice as a medium risk, and the

house risk register for the two houses the inspectors visited scored the risk as low. Safeguarding, self-injurious behaviours and behaviours of concerns were all risk-rated low or had missing risk ratings. These were not in line with the findings of this inspection.

Futhermore, identified control measures to reduce a risk rating had not been implemented in practice. For example, it was identified that all staff should be trained in specific de-escalation technique. However, this training had not been completed. This control measure had been in place since April 2019, and the risk assessment was reviewed on a regular basis. It had not been modified or changed to indicate that this training had not taken place. The risk register for one house was last printed in 2019, with risk assessments reviewed and updated in pen. While this practice was sufficient if new risks had not been identified, emerging risks relating to COVID-19 had not been accounted for in 2020.

Judgment: Not compliant

Regulation 28: Fire precautions

Overall, there were effective fire management systems in place. Suitable fire equipment was available and regularly serviced. There were adequate means of escape which were kept unobstructed, and emergency lighting was in place as required. Residents had detailed personal emergency evacuation plans in place, and the order of evacuation was clear, based on dependency levels.
Documentation of fire drills required some improvements to ensure that the outcomes of the drill and any recommendations arising were clearly and consistently recorded. For example, the exits used and the location of the drill. In addition, the time listed for evacuation did not consider the time it took for staff to support from other houses. The fire drills also did not demonstrate that residents could be successfully evacuated at night time. There was an overarching fire emergency plan for the campus dated 2016. Inspectors were told that no changes were required to this document as the plan was still effective. However, an additional building on campus was identified as a self-isolation unit in 2020, which could accommodate residents overnight and had not been included in the plan. Notably, the inspectors noted that the plan required review due to changing needs of residents and the requirement for the use of evacuation aids in this centre.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Inspectors found that not all staff were provided with the appropriate training in managing behaviours of concerns, including de-escalation and intervention

techniques. In addition, improvements were needed in the identification of the use of restrictive practices in the centre to ensure they were applied in line with national policy and evidence-based practices. Due to the observations made on inspection, the inspectors found the systems in place to review residents' behavioural support plans did not adequately assess the effectiveness of the plans.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found the mixed needs of some residents living together, and their incompatibility with one another did not ensure that residents were at all times free from harm. No safeguarding plans had been put in place to ensure residents were protected and these incidents would not re-occur. Residents did not have compatibility assessments completed following distressed behaviours that impacted negatively on other residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The rights of residents were not promoted and were not actively considered in decisions taken by the registered provider. This was particularly evident in consideration of the compatibility of residents and in the use of restrictive practices. While there was access to independent advocacy services, there was no active involvement from such services despite the significant restrictions which residents experienced. There were times that the residents' rights to privacy and dignity were not always upheld. For example, there was a viewing panel in a resident's bedroom that was not covered. In another house with an identified privacy and dignity risk for one resident, staff not involved in the care and support of residents had free access to the house using a swipe card.

Judgment: Not 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	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0033646

Date of inspection: 19/08/2021

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A Person in Charge (PIC) with the relevant qualifications, skills and experience necessary to manage the designated centre has been appointed full-time with effect from 21/09/2021.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A PIC has been appointed to the Designated Centre. The registered provider is working to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents in the designated centre. The HR department are actively recruiting staff to fill these vacancies. The PIC will make every effort to ensure vacant posts are filled by regular relief/agency staff pending filling vacancies The PIC will review staff breaks and will make every effort to ensure appropriate staffing levels are in place to support residents.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will schedule staff supervision with all team members by 31/12/2021 The PIC will schedule and attend monthly staff meetings. The PIC will carry out a training needs analysis and develop a training plan to ensure all staff are provided with appropriate training to support the assessed needs of individuals.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A Person in Charge (PIC) with the relevant qualifications, skills and experience necessary to manage the designated centre has been appointed full-time with effect from 21/09/2021. Service manager interviews have taken place and it is expected that this position will be filled by the end of the October. A Governance & Support Oversight team which includes representatives from the organisations Executive Team has been established to support and ensure that a quality service is provided in the designated centre.. Quality walk-around visits will take place on a fortnightly basis by a member of the executive team. In addition the ACEO will be visiting the Centre on scheduled dates. A robust six monthly provider audit will be undertaken by 31/10/2021 All Residents and family members have been provided with the opportunity to complete a satisfaction survey. Both these surveys will be reflected in the 2021 Annual review of the quality and safety of care and support.	
Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: The PIC has ensured all residents are provided with a choice of meals each day and will	

be facilitated to have meals at a time of their preference. This information is provided to residents in accessible format.

A mealtime audit has been undertaken. Recommendations and actions have been updated in a guideline which has been circulated to the staff team.

The PIC has ensured that all staff are familiar with each persons specific supports in relation to eating and drinking. One resident has been referred to the Speech and language Department for an updated assessment.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC will develop an overarching risk register for the Designated Centre which will be reviewed at least quarterly.

Training on Risk Management will be provided to the staff team.

The PIC will ensure all risks are reviewed and that they are relevant, clear and the risk rating is proportionate to the risk with appropriate control measures in place and that they are updated regularly to reflect any changes in current risk or any emerging risks.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC will ensure that the documentation of fire drills is clear and any recommendations from same will be clearly logged and actioned.
Use of evacuation ski sheet is practiced weekly by staff.

The overarching Emergency Evacuation Plan for the campus has been update to reflect changes relevant to the Designated Centre.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All staff will be provided with training in Positive Behaviour Support by 20th December 2021.

The Clinical Nurse specialist (CNSp) will review positive behaviour support plans on a monthly basis, this will include reviewing incidents of behaviours of concern as well as progress of proactive and reactive supports.
Quarterly progress reports will be completed by the CNSp and information disseminated to the MDT during Quarterly MDT restrictive practice reviews.
Restriction reduction plans will be reviewed on a two weekly basis by the PIC with the CNSp.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC has raised further awareness with the staff team in relation to Safeguarding. Safeguarding will be included on monthly staff meeting agendas.

All staff working in the Designated Centre will be provided with additional training in safeguarding by the Social Work department to update them in practise, knowledge and understanding of the reporting and management of any abuse/concern issues.

The safeguarding policy will be enacted following concerns raised in the draft Hiqa report. A referral to safeguarding team will be done as per policy for all individuals in the identified home.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC has undertaken a review of all Restrictive Practices in the Designated Centre and will ensure all restrictive Practices are reported in line with the regulation.
All restrictive practices will be reviewed using a Human Rights approach in line with the organisations Restrictive Practice policy.
Restriction reduction plans will be reviewed on a two weekly basis by the CNSp with the PIC.

The PIC will ensure that any resident with significant restrictive practices will be referred to Advocacy Services.

The PIC will ensure that all staff complete Human Rights training modules on HSEland

The PIC and the relevant MDT members will review the small glass panel in the resident's bedroom door and develop a plan to ensure the residents privacy and dignity is respected at all times.
The PIC has ensured that the maintenance department and the staff teams are all aware of the visitor policy and that visitors must alert the house to their presence by first ringing the doorbell and then signing in to the visitor book in addition to any Covid-19 visitor recommendations.

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	21/09/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2021
Regulation	The person in	Not Compliant	Orange	31/12/2021

16(1)(a)	charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2021
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Not Compliant	Orange	30/09/2021
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Not Compliant	Orange	30/09/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability,	Not Compliant	Orange	30/11/2021

	specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	30/11/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and	Substantially Compliant	Yellow	30/11/2021

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	31/12/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/10/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/09/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/12/2021

Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/12/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/12/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	20/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2021
Regulation 09(2)(b)	The registered provider shall ensure that each	Not Compliant	Orange	31/10/2021

	resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/10/2021