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 Heron
Name of provider:	Dundas Unlimited Company
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	24 August 2021
Centre ID:	OSV-0005890
Fieldwork ID:	MON-0026927

About the designated centre

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

Glen Heron is situated close to a village in Co. Louth. Facilities offered within Glen Heron support residents to experience life in a home like environment and to engage in activities of daily living, typical of those which take place in many homes with private access to laundry, cooking and personal care facilities, with additional supports in place in line with residents' assessed needs. Glen Heron provides a residential service for six adults, both male and female, over the age of 18 year of age. It is a two-storey community house. Its design and layout replicates a family home and the comfortable and welcoming feel of the house is consistent with a home like environment, where possible. There are six individual bedrooms for residents; two bedrooms are on the ground floor and they share an adjacent bathroom and shower facilities. There is an additional toilet on the ground floor. The remaining four bedrooms are on the first floor, two of which are en-suite and two which have shared bathroom and shower facilities. All bedrooms are fitted out to a very high standard and residents are encouraged to bring personal items which will ensure their environment is as homely as possible. There is a domestic kitchen-diner and a separate dining room where residents are encouraged to get involved with the grocery shopping and with the preparation of meals and snacks. The house has three living rooms as well as an open plan sitting room off the kitchen area. There is also a southwest facing sun room off the kitchen-diner and a utility room and storage area off the kitchen. Glen Heron is surrounded by a large garden and a private driveway with ample parking outside. The centre is staffed by a full-time person in charge, direct support workers and has access to nursing care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Tuesday 24 August 2021	10:20hrs to 18:20hrs	Anna Doyle	Lead
Tuesday 24 August 2021	10:20hrs to 18:20hrs	Karena Butler	Support

What residents told us and what inspectors observed

Overall, residents appeared to have a good quality of life in this centre and were relaxed in their home. Notwithstanding this, significant improvements were required in fire safety and some minor improvements were required under governance and management, residents' goals and staff files.

Inspectors had the opportunity to meet with five of the residents on the day of inspection and one was at home with family. Overall, they appeared relaxed in their home and comfortable in the company of staff members. Some residents used Lámh (the manual sign system used by children and adults with intellectual disability and communication needs in Ireland) to communicate and staff were observed encouraging a resident to use the sign for hello when they met the inspectors.

In fact some of the staff and a resident had recently attended Lámh training via video conferencing. This informed inspectors this resident was included in their care and support needs.

One resident spoke to an inspector and showed them their bedroom. They had a large room and it was decorated to their personal tastes. There was 3D art work on the ceiling and a feature wall. They said they loved their room, liked living in the centre, and that the staff were nice. They said that when they raised a concern to a staff member in the past about the way the staff phrased something to them, that their preference was respected by staff. Inspectors saw this preference included in the resident's personal support plan. This informed the inspectors that the resident's preferences were being respected.

Staff members were observed sitting down with residents enjoying activities which residents appeared to enjoy. One resident was observed having one-to-one time with a staff member enjoying a hand massage while listening to music. The staff member seemed to know the resident well and interacted with them in a patient and friendly manner. One resident was observed making coffee for themselves, and some relaxed watching television or using sensory objects.

The premises were decorated to a high standard, were spacious and homely. Residents each had their own bedrooms and some also had en-suite bathrooms.

There was a large garden to the back of the property where a sensory garden was being developed by residents and staff. Some walls had been painted in bright colours and there were tyres painted and stacked in a decorative manner. Staff and residents had also made and painted chimes which were hanging on the trees in the garden. There was also a trampoline and adequate seating areas provided and some residents were observed sitting out enjoying the good weather on the day of the inspection.

Residents' meetings were held in the centre and included a number of topics

including reminders about hand washing practices during COVID-19, planning activities and meals in the centre and fire safety.

Inspectors viewed a sample of family questionnaires from 2021. Family responses demonstrated that they were very satisfied with the care their family member received and felt that the staff were "fantastic". An inspector got the opportunity to speak to two family representatives over the phone. Both reported that they were very satisfied with the services provided and said their family member was very happy living there. They said that staff kept them informed about all changes and that they also had the opportunity to attend annual reviews about their family members.

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

Capacity and capability

Overall, inspectors found the centre was adequately resourced. There were management systems in place to ensure good quality care was being delivered to the residents; however, as stated earlier, significant improvements were required under fire safety and some improvements required for residents' goals and staff files. In addition, given some of the findings on the day of the inspection, improvements were required under some of the governance and management systems in the centre.

There was a defined management structure in place which consisted of an experienced person in charge who worked on a full-time basis. The person in charge demonstrated a good knowledge of the residents and their support needs. They were supported in their role by two team leaders, both of whom worked in the centre on opposite shifts to ensure oversight of the care and support provided.

The provider had completed an annual review of the quality and safety of the service and had carried out unannounced audits twice per year as required by the regulations. There were a range of local audits and reviews conducted in areas such as incident reviews, medication management, and health and safety. However, as discussed under fire safety in section 2 of this report, the provider's own auditing systems had not picked up on some of the issues identified on the day of the inspection, therefore this required review.

The actions from the last inspection had also been addressed and contracts of care were now signed, issues pertaining to food and nutrition had been addressed and fire drills had been completed during the day and at night. Improvements were still

required in fire safety as discussed under section 2 of this report.

There was a planned and actual roster in place that was maintained by the person in charge. From a review of a sample of rosters, there was a consistent staff team employed in the centre. There were sufficient staff on duty to meet the needs of the residents. A number of relief staff were also consistently employed to cover planned and unplanned leave. This meant that residents were ensured consistency of care during these times.

The staff inspectors spoke with said they felt supported in their role and were able to raise concerns, if needed, to the person in charge, through regular staff meetings and supervision. A senior manager was also on call in the wider organisation 24/7 should staff need support around the needs of residents. A sample of supervision records viewed found that they were comprehensive and staff could raise concerns if required. The records viewed also indicated that regular staff meetings took place in the centre. Agenda items discussed included risk management, the management of COVID-19 and the wellbeing of residents in the centre.

A sample of personnel files showed that some improvements were required in one file viewed as it only contained one reference from a previous employer and there were gaps in the employment history. This information is required to be maintained under the regulations and therefore required improvement.

The staff training records reviewed indicated that staff were provided with a number of training sessions to enable them to support the residents. This included; positive behaviour support, safeguarding vulnerable adults, fire safety, the safe administration of medication, and first aid. A sample of records viewed indicated that all staff employed at the time of the inspection had completed these. This meant staff had the skills necessary to respond to the needs of the residents in a consistent and capable manner.

From a review of incidents that had occurred in the centre since January 2021, the person in charge had also notified the Health Information and Quality Authority (HIQA) in line with the regulations when an adverse incident had occurred in the centre.

Regulation 14: Persons in charge

The person in charge is a qualified social care professional who worked full time in the centre at the time of the inspection. They demonstrated a good knowledge of the regulations and the needs of the residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

From of a sample of rosters viewed, there was a consistent staff team employed in the centre to meet the needs of the residents. A sample of personnel files showed that some improvements were required in one file viewed as it did not contain all information required under Schedule 2 of the regulations.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff training records reviewed indicated that staff were provided with a number of training sessions to enable them to support the residents. A sample of records viewed indicated that all staff employed at the time of the inspection had completed these such as positive behaviour support, safeguarding vulnerable adults, fire safety, the safe administration of medication, and first aid. From a sample of staff supervision records, staff were suitably supervised in the centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined management structure in place. However, as discussed under fire safety in section 2 of this report, the provider's own auditing systems had not picked up on some of the issues identified on the day of the inspection, therefore this required review.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The action from the last inspection had been addressed in relation to this regulation

and a sample of contracts of care showed that they had been signed by the residents' representative. No other aspects of this regulation were reviewed.

Judgment: Compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre since January 2021, the person in charge had notified HIQA in line with the regulations.

Judgment: Compliant

Quality and safety

Overall, the residents here had a good quality of life, however the arrangements in place to contain fire and ensure a safe evacuation of the centre needed significant review. Improvements were also required under personal plans

While the provider had fire safety management systems in place on the day of the inspection. An inspector observed a number of improvements to the fire containment measures following a walk around the centre. This included a fire door which was not fully closing with a noticeable gap in the door. In addition, there were also two holes affecting a wall along the stairs that would reduce the integrity of the wall in the event of a fire. The provider's own audits had identified only one of these holes.

In addition, it had been identified by the provider that a fire drill should be completed with one resident in the centre. This had not been completed. The arrangements in place for this resident to safely evacuate the centre in the event of a fire also required review as the plan viewed did not guide practice and staff were unclear when asked what they would do to support this resident.

The premises were spacious, clean and homely. Some areas that required attention had already been identified by the provider through their own audits and had been reported to the maintenance department for their attention. There were some minor repair works required to the premises observed by inspectors such as peeling wall paper, broken plaster and minor holes and a missing handle from a bedside locker.

All staff had been provided with training in safeguarding adults. Staff spoken with were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. Residents also had detailed intimate care plans in place which outlined their personal preferences in relation to supports provided.

Each resident had a personal plan which had been developed into a concise easy-to-read version. A more detailed version of the plans were stored on a computer database which all staff had access to. Inspectors observed a sample of these records and found that residents' needs were assessed, monitored and reviewed on a regular basis. A community nurse was available in the wider organisation to provide assistance and support to the staff and residents in the centre.

Regular and timely access to a range of health and social care professionals also formed part of the service provided. This included access to general practitioner (GP) services, an occupational therapist, dietitian, and a speech and language therapist. Care plans were also in place to support residents in achieving best possible health and these were reviewed regularly. Residents had also been supported to access national health screening services. In instances where the screening services were not clinically indicated, it had been discussed with the resident's doctor and agreed by the resident's representative. This was also kept under review and the decisions were reviewed annually.

Goals had been developed for residents and some had been postponed due to COVID-19 restrictions. These goals were being reviewed; however, some of the goals were not very meaningful and this needed to be improved. This was discussed at the feedback meeting.

Inspectors reviewed a sample of behaviour support plans in place and found that they clearly guided staff on how to support residents with their anxieties. These plans were reviewed regularly and residents had access to health and social care professionals such as psychologists and behaviour specialists. Staff spoken with were able to communicate the main supports in relation to one of the plans for a resident. There were restrictive practices in place for residents' safety; for example, a window restriction was in place on certain upstairs windows to prevent falls. From a sample viewed, restrictive practices were appropriately identified and reviewed by the provider.

There were individual risk assessments in place for each resident in order to support their safety and wellbeing. From viewing a sample of the risk assessments they were being reviewed regularly.

There were systems in place to manage and mitigate risk in the centre. A review of the medication errors since January 2021 showed that appropriate action was taken. A review of incidents in the centre showed that since January 2021, 29 incidents had occurred in the centre. These incidents were reviewed by the person in charge and the staff team. Control measures were put in place to help minimise risks to the residents. For example, following an increase in incidents for one resident, significant supports fromhealth and social care professionals had been arranged to support the individual. A risk register and health and safety statement were also in place for the centre.

Infection control measures were in place to prevent and or manage and outbreak of COVID-19. Staff had been provided with training in infection prevention control, the use of personal protective equipment (PPE) and hand washing techniques. PPE was

available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff when social distancing could not be maintained. All residents had been vaccinated in the centre. There was adequate hand-washing facilities and hand sanitising gels available throughout the house and enhanced cleaning schedules had been implemented.

The provider had a contingency plan in place to outline the strategies in place to prevent/manage an outbreak and this had recently been updated. Residents' plans had arrangements in place to support them if they were suspected or confirmed of having COVID-19. There was a senior management team in the organisation to oversee the management of COVID-19.

Regulation 17: Premises

The premises was well decorated, spacious was designed and laid out to meet the assessed needs of the residents. Some minor repair works were required but there were plans in place to address these.

Judgment: Compliant

Regulation 18: Food and nutrition

The provider had addressed the action relating to food and nutrition since the last inspection. No other aspects of this regulation were reviewed.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to manage and review risks in the centre.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and person in charge had systems in place to manage or prevent an outbreak of COVID-19 in the centre; such as, a contingency plans and enhanced cleaning schedules.

Judgment: Compliant

Regulation 28: Fire precautions

A fire door did not fully close on the day of the inspection.

There were two holes affecting a wall along the stairs that would reduce the integrity of the wall in an event of a fire.

The arrangements in place for a resident to safely evacuate the centre in the event of a fire also required review as the plan viewed did not guide practice and staff were unclear when asked what they would do to support this resident.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan. The inspectors observed a sample of these records and found that residents' needs were assessed, monitored and reviewed on a regular basis. However, some of the goals planned for residents needed to be reviewed.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had regular and timely access to a range of health and social care professionals. This included access to GP services, an occupational therapist, dietitian and a speech and language therapist. Care plans were also in place to support residents in achieving best possible health and these were reviewed regularly.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had access to mental health and behavioural support specialists as required. Behaviour support plans clearly directed staff has to how best to support the resident. Staff spoken with were able to summarise the content of one of the plans to an inspector. Restrictive practices in use in the centre were identified and reviewed by the provider.

Judgment: Compliant

Regulation 8: Protection

All staff were trained in safeguarding vulnerable adults. Staff spoken with were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. Intimate care plans were detailed and expressed personal preferences.

Judgment: Compliant

Regulation 9: Residents' rights

Residents meetings included examples of how their rights were upheld. Documents were available to residents in easy-to- read format. Intimate care plans expressed personal preferences.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Glen Heron OSV-0005890

Inspection ID: MON-0026927

Date of inspection: 24/08/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A comprehensive review of all schedule 2 information contained in staff files will be completed by our HR department. To ensure the Person in Charge (PIC) has full oversight of this, the PIC will complete an additional Audit of Schedule 2 information. Any gaps in Schedule 2 information will be addressed by 10/10/21.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Weekly house checks of fire doors will be completed by staff. Staff will copy the Person in Charge (PIC) on any emails sent to maintenance. PIC will ensure all appropriate maintenance requests are logged on the maintenance log. This process was discussed with all team members and documented. The standard of maintenance works will be reviewed by the Person in Charge. Progress with maintenance requests will monitored during monthly governance meetings between the Person in Charge and Assistant Director of Services. Premises will be reviewed and reported on during each 6 monthly report on the safety and quality of care and support within the centre. This will provide assurances that all maintenance works and premises issues are being addressed in a timely manner.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A review of all fire safety arrangements within the designated centre was completed by a suitably qualified and experienced contractor. Any fire doors not closing appropriately, were repaired and intumescent strips were fitted as required.

Any damage to walls that could reduce the effectiveness of the fire containment measures, were repaired.

Arrangements for the evacuation of all residents within the centre were reviewed. Each residents Personal Emergency Evacuation Plan (PEEP) has been updated. An individual fire drill was completed 1:1 with a resident who required additional support and no barriers were identified. A full fire drill reflecting the centers minimum staffing level and maximum resident number will also be completed to ensure that all residents can be safely evacuated. Residents risk assessments have been discussed with the team to ensure they are fully aware of the procedures to be followed in event of fire. Residents PEEPs a standing agenda item in team meetings.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Person in charge spoke with keyworkers at team meeting. Outlined what is required during key working sessions and for goal planning (SMART). New template My SMART Goal-Setting Worksheet put in place to support residents and keyworkers in goal development. Person in charge to review progress of goals and will support keyworkers in ensuring goals met criteria and are progressed in timely manner. Meetings held with keyworkers and ongoing support through supervision. All residents who have expressed an interest in attending day services, have been referred and are now engaging with a day service.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/10/2021
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.	Substantially Compliant	Yellow	30/09/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and	Not Compliant	Orange	25/09/2021

	building services.			
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.	Not Compliant	Orange	01/10/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/09/2021