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 2
Name of provider:	Avista CLG
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	05 June 2024 and 12 June 2024
Centre ID:	OSV-0001439
Fieldwork ID:	MON-0034771

About the designated centre

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

Glen 2 is a campus-based residential centre which provides full-time care and support for 18 residents with moderate to severe intellectual disability and/or a physical disability. Each of the three purpose built bungalows in the centre have the capacity for six residents. Each bungalow is homely and comfortable and each of the residents have their own bedroom which is decorated in line with their wishes. The centre is situated on the outskirts of Dublin City, close to a local village with access to local amenities such as a pub and restaurant within walking distance, a large park and local shopping centres. Residents have access to a number of vehicles to access their local community and leisure activities. Two of the houses are nurse led and one is a social care led house. Residents are supported by staff in the centre 24 hours a day, seven days a week.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 5 June 2024	09:00hrs to 17:00hrs	Sarah Cronin	Lead
Wednesday 12 June 2024	09:30hrs to 13:30hrs	Sarah Cronin	Lead
Wednesday 5 June 2024	09:00hrs to 17:00hrs	Carmel Glynn	Support

What residents told us and what inspectors observed

This inspection was carried out to assess the provider's regulatory compliance within one of their residential campuses and inform a recommendation to renew the registration of a designated centre. Over two days, inspectors of social services completed an inspection of each of the three designated centres on the campus. This included meeting senior management to discuss oversight and progress with quality improvement initiatives for the wider campus. Overall, the inspectors found improved and high levels of compliance with the regulations. Effective governance and oversight systems had identified and addressed issues in response to residents' needs and non-adherence to the regulations. In this centre, the inspector found that improvements were required in staffing, staff training and development and fire precautions.

From what residents told us, and what inspectors observed, it was evident that residents living in this designated centre were living in nice homes, and that the provider was endeavouring to promote a person-centred approach to care and support across the campus. The inspector found that improvements had been made in a number of areas since the last inspection, which were impacting positively upon residents. Some further improvements were required in staffing, staff training and development and fire precautions. These are detailed in the body of the report below.

The designated centre is located on a congregated mixed-use campus setting with six other bungalows, and an overall capacity of 52 residents. The centre comprises three purpose-built houses which are located side-by-side on the campus and each house is registered for six beds. On the day of the inspection, there was one vacancy. The designated centre provides services for adults with intellectual disabilities with complex health and social care needs related to medical diagnoses such as diabetes and epilepsy and age-related conditions. Other residents required support with their mental health, behaviour support and mobility. Two of the houses were led by nursing staff, while the third house was led by social care workers. This house operated differently to other houses on the campus, in that they cooked their own meals, shopped for groceries and generally operated similar to a house in a community setting. Each bungalow is laid out in the same way and comprises a kitchen and dining area with an open plan sitting room. Each sitting room had direct access to a garden area. There was a small sitting room, an office, a staff changing area, two accessible bathrooms, a toilet and hand basin and six resident bedrooms. Houses were warm and clean and had a homely atmosphere. In one of the houses, the small sitting room had been made into a lovely sensory space for residents, with LED lighting, calming music and a scent diffuser. Staff in one house had put artificial plants along the corridor, which made it appear more homely. Residents' bedrooms in all of the houses were nicely decorated and had ample space for residents to store their personal belongings. There were pictures on the walls and personal affects on display. Each resident had their own sink in their bedroom which was height adjustable. The campus had a day service located on site, a canteen,

administration offices, a chapel and a restaurant. The campus was located close to a park, but did not have close links to public transport, and therefore, residents relied on transport attached on the campus to access most community spaces. The person in charge and staff reported challenges relating to the vehicle, which was reported to be often out of service for extended periods of time. One of the staff spoke about the bus not being physically accessible for one of the residents. This required them to borrow a bus from another house on the campus when it was available.

The inspector had the opportunity to meet with all of the residents over the course of the inspection. Residents in the centre had a wide range of communication support needs. Some residents communicated using speech, others had some specific phrases and words they used, while others used a combination of signs, pointing and gesture, eye contact, body language and vocalisations to communicate. Some residents took the inspector and staff by the hand to areas or items they wanted. Residents who had more complex communication support needs were reliant on staff to know them well in order to interpret their responses to items presented to them, and to respond to their communication signals appropriately. The inspector viewed some visual supports up on walls in the centre such as a photo staff rota. There were visual menus available to support choice making. However, these were not accessible for all residents and staff spoke about how they knew what residents liked, and how they ordered enough food to offer a choice for residents each day. There was easy-to-read information available on a variety of topics. Residents were observed to request items in different ways, with some verbally requesting things and others leading staff to what they wanted, while others vocalised. Staff were noted to respond quickly to any requests made, and to reassure residents when speaking with the inspector in a respectful and kind manner.

In the first house, residents were going about their morning routines when the inspector arrived. One of the residents was eagerly awaiting a day trip to Wexford supported by the day service staff. They showed the inspector their bedroom which was beautifully decorated and were proud to show the inspector their clothes. Other residents were observed to relax in a sensory room while others were enjoying a lie on. In the second house, a resident met the inspector at the door and showed them a book which was of importance to them. They smiled in response to interactions. Another resident was also going out with the day service for a day trip and told the inspector they were excited to go. They also showed the inspector their bedroom and their photographs on the wall. In the third house, the inspector met with residents going about their morning routines with staff and later the inspector met them in the afternoon. Residents were observed to come and go over the two days to various activities - some went for a walk in a local park, others for coffee on the grounds while some attended day services. In the houses, residents were observed to watch television, to look at their books and in each house, residents came in and out of the office and moved about their homes freely. In one of the houses, a staff member was leading a sing-a-long session with their guitar and other staff members. Residents appeared to enjoy this, with some of them smiling along.

The inspector reviewed some of the residents' activity planners and saw that there had been an increase in the number of activities which residents were partaking in

off the campus. For example, residents were going to get their hair done, going for drives, shopping for personal items and having meals out. However, for some residents, they did not have much meaningful activities recorded in their planners. Person-centred planning was an area the provider had identified as requiring improvement and there was a focus on increasing opportunities for residents to engage in meaningful activities. One of the residents had expressed their wish to have a job and had been successful in getting a job locally.

Meals for residents were prepared in a centralised kitchen on the campus for two of the houses. This meant that routines around mealtimes were relatively fixed, and that meals were collected in a trolley and brought from the centralised kitchen. Meals were ordered each week following residents' meetings and staff showed the inspector how they managed to keep food hot for residents. There were a small number of snacks and alternative options available when residents chose not to eat the food which had been sent. The third house operated independently of the central kitchen for their meals and cooked their own food in line with residents' expressed preferences. In one house, a resident was observed to go to a freezer with a staff member and make a choice on their lunchtime meal, which was then cooked for them. Many of the residents in the centre had feeding, eating, drinking and swallowing assessments in place and required modifications to their diets. The inspector observed preparation for a meal in one house, and sat with residents for a short period of time during the meal in another house. Staff were able to tell the inspector what each residents' assessed needs were. Meals were noted to be nicely presented and where a resident indicated they did not like something, an alternative was prepared for them.

Staff had completed training in a human-rights based approach to health and social care. They had recently completed a bespoke training session on promoting a restraint-free environment which had considered restrictions and the impact upon residents' rights. Some of the staff members told inspectors about how they considered how they had made small changes in their approach to supporting residents. For example, one staff spoke about 'stepping back' and giving residents time to choose things in their daily routines such as their clothing, their meals and their preferred routines. Residents had access to an external advocate and one resident was facilitated to access these services to support them to make an informed decision related to their living situation. Sixteen of the residents now had their own bank accounts and had been provided with locked safes to store their own money in their bedrooms.

Staff were noted to support residents to advocate for themselves, and to make complaints, or raise complaints on their behalf. The inspector viewed the complaints log and saw that there had been 10 complaints which staff had supported residents to make, or made on their behalf in the past year. These complaints related to being unable to get out on the bus due to staffing, complaint about the bus being broken and complaints when planned activities did not go ahead. These complaints had been followed up by management, and actioned to ensure ongoing improvement of enabling residents to engage in their preferred activities outside their homes. There were some restrictive practices in place in the centre, largely due to health and safety concerns. For example, two of the houses had a magnetic fob/ swipe on the

front door which meant that residents could not leave the centre without staff members due to risks associated with this. There was evidence of some restrictive practices being successfully discontinued in the months prior to the inspection. For example, one resident had worn a restrictive piece of clothing for many years due to a risk related to their feeding tube. The resident was no longer wearing this clothing and wearing ordinary clothes. Staff reported that this had taken a long period of time to ensure that the risk was managed, while ensuring that the residents' privacy and dignity were upheld. One of the houses used to have a locked kitchen, but this had also been discontinued.

There had been a number of peer-to-peer incidents in the centre. Compatibility between residents in one house had been identified as an issue by staff and residents. The provider had responded to this by completing individual needs and preferences assessments and compatibility assessments. These assessments were underpinned by human rights and used the principles of Fairness, Respect, Equality, Dignity and Autonomy (FREDA) to consider their living arrangements.Since the last inspection, one resident had moved into a house in the community, while another had been given a place in a house. This had had a positive impact on residents in one of the houses, and also reduced the number of residents living in the house.

The inspector received 17 residents' questionnaires which had been sent out to residents prior to the inspection taking place. These questionnaires seek feedback on aspects of the service such as staffing, their home, daily choices and routines and having a say in the service. For the most part, questionnaires indicated that residents were satisfied with the service. One of the residents stated that they were supported to go out on trips or to events with the support of staff. To gain additional insight into the lived experience of residents, and family views, the inspector reviewed feedback which the provider had sought as part of their annual review. The family consultations highlighted some positive aspects of the service such as being welcomed into their relatives home, being informed, and one family member described staff as being "very helpful", while another stated that "Staff treat her like one of their own and I'm so happy with the car". Some concerns were documented which included the need to increase outings for residents and concerns in relation to some incidents occuring. Both of these concerns had been addressed by the provider by the time that this inspection took place.

Residents meetings were to take place on a weekly basis in each of the houses. There was a recommended agenda in place which was provided to staff in the organisation to cover items such as activity and menu planning in addition to rights, safeguarding and fire precautions. The provider had identified that there were some gaps in these meetings taking place and had a plan in place to improve the documentation relating to these meetings, and to ensure that they were occuring and that residents' input was recorded. In one house, the inspector viewed photographs which were taken in lieu of minutes of residents engaging with staff using easy to read materials.

In summary, the inspector found that residents were supported by a kind and caring staff team in houses which were comfortable and well-suited to their assessed needs. The next two sections of the report present the findings in relation to the

governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. There was a clinical nurse manager supporting the person in charge in their role. The person in charge reported to persons participating in management, who in turn reported to the service manager. The provider had also appointed two night managers which was reported to be a welcome development.

There were a number of audits in place, both at centre and provider level to ensure ongoing monitoring and oversight of key aspects of the service. The person in charge reported on progress in these areas each month in a meeting with the person participating in management.

Since the last inspection, the provider had recruited additional staff, which had reduced the vacancies in the centre. The inspector had identified concerns in relation to staffing arrangements in one house on the first day of the inspection, based upon a risk assessment on staffing, and conversations with the staff and person in charge. The provider had assigned an additional 0.5 post into that house to manage that risk. However, it remained unclear if the current staffing allocation was adequate to meet all of the residents' assessed needs, particularly those relating to personal care, ensuring residents could access meaningful activities and to support interactions. This is further discussed under Regulation 15: Staffing below.

Staff training and development had improved since the last inspection, particularly the number of staff who had completed supervision sessions since the last inspection. There remained some gaps in areas specific to residents' assessed needs and these are addressed under Regulation 16: Staff training and development.

The provider had prepared a Statement of Purpose which was found to be reviewed regularly and contain all information required by the regulations. Schedule 5 policies were reviewed and found to be in date and reviewed in line with regulatory requirements.

Registration Regulation 5: Application for registration or renewal of registration

The inspector carried out a review of all of the information which the provider submitted to the Office of the Chief Inspector to apply for renewal of their

registration. This met regulatory requirements.

Judgment: Compliant

Regulation 14: Persons in charge

The inspector carried out a review of the Schedule 3 information relating to the person in charge which was submitted with the application to renew the registration of the centre. The person in charge was found to meet the requirements of Regulation 14 in that they had the required experience and qualifications to enable them to fulfil their duties. The person in charge worked on a full-time basis and was in the centre four days a week. They were supported in their role by a clinical nurse manager. It was evident that they knew residents well and that they had good systems in place to monitor and oversee the quality of care which residents were receiving.

Judgment: Compliant

Regulation 15: Staffing

The skill mix in the centre included nurses, social care workers and healthcare assistants. Each house had between two and four staff on by day and one at night. The provider had recently held a recruitment fair and successfully recruited two new staff nurses, who had commenced in the centre. There were two staff nurse vacancies on the day of the inspection. A review of rosters from the previous six weeks was carried out and found that vacant shifts were covered by some staff who worked in the houses and a small number of relief staff.

From a review of residents' care plans and personal emergency evacuation plans it was unclear if there was an adequate staff ratio on duty to ensure residents' assessed needs were met at all times. For example, a number of residents required two staff for personal care needs, while others required a one-to-one staff member at times in the day to support them, and another required the support of two staff in the community. When residents who required two staff for transfers or for personal care at night time, staff had to request support from other houses on the campus. In one house, there was an identified risk to residents due to the staffing level at night time. This risk had increased in the months prior to the inspection, due to the increasing care and support needs of the residents, and a high incidence of falls. The person in charge had escalated this risk to management prior to the inspection taking place. The provider had responded to this risk to by increasing resources where required. The provider reported that a full review of staffing was to be undertaken to ascertain each of the residents' assessed needs and to ensure that

this was achievable within the staffing complement available.

A sample of three Staff files were reviewed. These were found to contain all of the information required as per Schedule 2 of the regulations. There was evidence that a recent recruit had been through induction and had garda vetting in place prior to commencing in their role.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors reviewed the staff training matrix and found that staff training had improved since the last inspection. All staff had completed fire safety, manual handling and safeguarding. 93% of staff had completed training in managing behaviours of concern and food safety, with the remaining staff booked for refresher training in the weeks following the inspection. 64% of staff had completed training in epilepsy, and 64% had also completed training in a human-rights based approach to health and social care.

However, improvements were required in training which was specifically required to support residents' assessed needs in this centre. For example, there were 11 residents in the centre who were identified to be at risk of choking, many of whom had modified diets. There had been a recent choking incident which had required staff to perform the Heimlich manoeuvre. However, only 19% of the staff team completed training in feeding, eating, drinking and swallowing difficulties. 6.5% of staff had done first aid.

Some residents required specialist evacuation aids (ski sheets) to evacuate safely. 41% of staff had completed training on these prior to the inspection. The inspector saw a schedule for the remainder of staff to be trained in the weeks following the inspection.

The inspector saw a supervision schedule which was in place to ensure that all staff received supervision in line with the provider's policy. The person in charge, the clinical nurse manager and senior staff nurses were responsible for supervision of staff. All of the staff had completed at least one supervision session on the day of the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the management team on the campus had stabilised in the months prior to this inspection taking place, and that there was a clear management

structure and implementation of systems to ensure that there was good monitoring and oversight of residents' care and support.

The provider had carried out an annual review and six-monthly unannounced provider visits in line with regulatory requirements. The inspector reviewed these reports and found that the provider was self-identifying areas requiring improvement which included person-centred planning, staff training, fire safety and the maintenance of documentation. The inspector viewed minutes of monthly meetings between the person in charge and the person participating in management and found that these were comprehensive, and included a review of a compliance action log in place to ensure the timely progression of areas requiring action.

There was a schedule of audits in place at different intervals to monitor and oversee aspects of the service such as the residents' care plans, incidents and accidents, quality of life, finances, fire and medication. These were found to be identifying areas requiring improvement.

Team meetings took place in each house once a month and there was a set agenda in place. It was evident that incidents and accidents were discussed, and that there was a set agenda in place. Safety pauses took place each day at the handover. The inspector viewed a record of safety pauses for the two weeks prior to this inspection taking place. It was evident that a variety of topics were discussed such as safeguarding, incidents and accidents, updates on residents, rights, mealtimes and fire safety.

Judgment: Compliant

Regulation 3: Statement of purpose

The inspector reviewed the provider's statement of purpose which had been submitted with the application to renew the registration of this centre. The statement of purpose was found to contain information required by the regulations. It had been recently updated and was regularly reviewed.

Judgment: Compliant

Regulation 4: Written policies and procedures

Inspectors reviewed the provider's Schedule 5 policies and found that all of the required policies outlined in the regulations were in date and reviewed at regular intervals. They were available in each of the houses for staff to read and were reviewed in line with timeframes outlined in the regulations.

Judgment: Compliant

Quality and safety

The inspector found that residents' welfare was promoted in the centre. As outlined at the beginning of the report, it was evident that staff working with residents knew them well, were able to respond to interactions in a kind and caring manner, and that residents appeared to be comfortable and content in their homes. Improvements were required in fire precautions, and this is discussed under Regulation 28: Fire Precautions below.

A review of care plans showed that residents' had care interventions and plans developed where these were assessed as being required. Person-centred plans were being developed, and goals were being reviewed. The provider had identified this area as a priority for the centre for the year ahead. Residents were observed to be moving freely about their homes, to engage in activities of their choice within their homes, and some were observed to go out with the support of staff. Activity logs indicated that residents were getting out for drives, shopping for personal items, accessing the day service on-site and doing some chores. As outlined at the beginning of the report, this was sometimes a challenge due to difficulties in accessing transport and drivers on the campus.

Residents in the centre were supported to have best possible health through access to relevant health and social care professionals and through staff ensuring ongoing monitoring of each residents' health. Staff whom the inspector spoke with were found to be knowledgeable on the purpose of a hospital appointment attended, and the outcome. They supported a resident to tell inspectors about this appointment.

Positive behaviour support had improved since the last inspection, and residents who required specialist review from the clinical nurse specialist in positive behaviour support, had now received it. Additional training had been provided to staff. Restrictive practices were reviewed with input from the multidisciplinary team.

There had been peer-to-peer incidents occuring in the centre, and there were safeguarding plans in place to minimise the possibility of these events occuring, and to minimise any distress to be caused. Safeguarding was regularly discussed with both residents and staff, and compatibility assessments had also been completed to establish residents' will and preferences related to their living situations.

The provider had systems in place to ensure that risk was assessed, managed and regularly reviewed, including a system for responding to emergencies. While the provider had fire safety management systems in place in the centre, fire drills required attention to ensure that the provider could be assured that the safe evacuation of residents was possible with support from a reasonable number of staff on the campus.

Regulation 17: Premises

Overall, the inspector found that residents' homes were well suited to their needs, and that they met the requirements of Regulation 17. As outlined at the beginning of the report, each of the houses were nicely decorated, clean and warm. They all had the same layout, with large dining areas with a sitting room, a kitchen, a smaller sitting room, toilet, office, staff changing room and toilet, six resident bedrooms and two accessible bathrooms. The inspector carried out a walkabout with the person in charge of each house and found that they were largely in a good state of repair. There were some minor repairs required such as cupboards in residents' bedrooms being worn and peeling. However, these were already identified on the centre's maintenance log and had been escalated to management.

Judgment: Compliant

Regulation 20: Information for residents

The inspector carried out a review of residents' guides for each of the three houses in the designated centre and found that they met regulatory requirements.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector viewed the safety statement, a record of incidents and accidents, the risk log and risk assessments and found that the provider had systems in place to identify, assess, manage and review risk within the centre.

The risk log and assessments had been updated recently to reflect changes in residents' needs and incidents. Incidents and accidents were recorded in line with the provider's policy. Trending of incidents for each resident occured on a quarterly basis, and incidents and accidents were a standing agenda item on management meetings and at staff meetings. There was evidence of the person in charge escalating risks to management to ensure the ongoing health and safety of residents and staff following any adverse incidents.

Judgment: Compliant

Regulation 28: Fire precautions

A walkabout of all three houses was carried out in the company of the person in charge. The provider had installed fire doors with swing closers throughout the houses. One bedroom in each house had a hold-open device. While for some residents this did not pose any issues, for others it made getting in and out of their bedrooms difficult without staff support. Fire fighting equipment, smoke alarms and emergency lighting were in place, and the inspector observed a test being carried out in one of the houses on the first day of the inspection. Fire alarms were linked with all of the houses on the campus to alert them and to call for support, while there was a radio receiver, or a walky-talky system in place for staff to communicate in the event of an emergency. The inspector reviewed 17 personal emergency evacuation plans and found that these had been recently updated and were regularly reviewed.

Documentation and practice relating to fire drills required improvement and review to ensure that the provider was assured that the safe evacuation of residents was achievable by night-time, with the available resources on the campus. The inspector viewed a schedule and a record of all staff who had taken part in drills from the beginning of the year. This was monitored by the person in charge. Documentation for each of the drills recorded in two houses required more than the typical complement of staff available in the centre.

For example, the inspector viewed five drills for one house. These had taken place with support from five staff in two drills and between 10 and 12 in the other two drills. A meeting had been scheduled for issues identified in a drill with staff, and this identified that three staff would be needed to evacuate a resident via a ski sheet. In the second house, there were a number of residents who were at risk of falls and two who required evacuation via a ski sheet or a wheelchair. A record of five drills was also viewed and found that where drills had been carried out with four or five staff at night-time, the evacuation times were outside of what was identified as safe by the provider. While this drill had been done again, in line with policy, it had less residents and more staff, and was done when residents were alert and awake and therefore did not provide assurances to the provider that reasonable evacuation times were achievable with a realistic staffing complement available from the campus at night-time.

Judgment: Substantially compliant

Regulation 6: Health care

From a review of six care plans, and from speaking with the staff, it was evident to the inspector that residents were supported to have best possible health. They had access to a general practitioner and a range of health and social care professionals such as physiotherapy, occupational therapy, speech and language therapy,

dietetics and behaviour support. There was a health promotion officer now employed on the site to further enhance the health care services for residents such as immunisation, monitoring and overseeing health care and issues relating to infection prevention and control. This was reported to be a valuable resource, and enhancing the monitoring of health care.

Residents had access to National Screening Programmes such as retina screening, Breastcheck and bowel screening. Records were kept of each appointment attended, and any follow up actions required. Care interventions were in place for specific diagnoses or need identified, and these were well documented. Residents had records of monthly observations kept to ensure ongoing monitoring of their health. Hospital passports were in place to ensure that key information relating to the person, how they communicate, their support needs and relevant information was available to accompany residents to any health appointments.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support was identified as an area requiring review on the last inspection of the centre. A review of three residents' care plans showed that the provider had completed actions they committed to in their compliance plan. This included referrals being sent to relevant members of the multidisciplinary team. These three residents had had a number of inputs from the clinical nurse specialist in behaviour support, and they had behaviours of concern risk assessments in place. These assessments outlined control measures to proactively manage identified risks. Some residents no longer required a positive behaviour support plan, but continued to have access to services as they required it. Eighteen of the staff team had attended a bespoke session on promoting a restraint free environment.

The inspector reviewed the restrictive practice register and a sample of restrictive practice assessments and reviews in the above residents' care plans. Some of the restrictive practices in the centre were in place for health and safety reasons, and to manage risk. These included having a magnetic fob on the front doors, sharps locked, bed rails and lap belts. These had recently been reviewed with input from relevant members of the multidisciplinary team. Information relating to restrictive practices had been developed for residents and these were reviewed and found on residents' files.

Judgment: Compliant

Regulation 8: Protection

There had been 21 notifications relating to safeguarding made to the Office of the Chief Inspector in the twelve months prior to this inspection taking place. Many of these related to compatibility issues in two of the three houses. The inspector noted that where incidents had occured, these were recognised by staff as safeguarding incidents and reported in line with National Policy. Safeguarding plans were put in place and a safeguarding log was kept to monitor and oversee the status of each of these plans. Staff on duty on the first day of the inspection were able to describe what safeguarding plans were in place in the centre, and how they managed interactions and routines to ensure that residents remained safe and happy in their home.

The provider had identified compatibility as an issue and had put plans in place to ensure that residents' will and preference relating to their living situation were identified and acted upon. Since the last inspection, one resident had moved out into a community house, while another had been given a place in a house. The third resident had been referred to the provider's admissions, discharge and transfer committee for consideration. Safeguarding was a standing agenda item on staff meetings and was also discussed with residents.

A review of six of the residents' personal care plans found that residents' support needs and preferences in relation to their personal care was clearly documented to guide staff practice and to ensure that residents' right to autonomy, privacy and dignity were promoted and upheld during care routines.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Glen 2 OSV-0001439

Inspection ID: MON-0034771

Date of inspection: 05/06/2024 and 12/06/2024

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: The registered provider remains committed to recruiting staff to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents. • 1 WTE Staff Nurse position has been filled and commenced in post on 15.7.24 • Newly qualified nurse (1WTE) commencing 4.11.24 • 30 hours WTE care assistant post has been recruited and is currently onboarding with a plan to be in post by 31.10.24. • Advertisement currently in place for 1 WTE care assistant • Regular relief staff are assigned to the designated centre to support continuity of care. • The PIC has reviewed rosters and assigned twilight hours for one bungalow based on assessed needs. • A staffing review will be carried out by the provider to ensure that the resources adequately meet the assessed needs of the individuals living in the centre by 31.12.24.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has developed a plan to ensure that staff have access to appropriate training, including refresher training. • All staff have completed food safety training. • All staff are scheduled to attend managing behaviours of concern (MBOC) and refresher MBOC training by 31.12.24.	

• 21 staff are scheduled to complete feeding, eating, drinking, and swallowing difficulties on HSEland by 31.7.24.
• Bespoke training on "dysphagia, choking risk and risk management" has been scheduled with speech and language therapist and will be provided by the 20.8.24.
• 16 staff are scheduled to complete "Observing and Responding to seizures" on HSEland by 30.9.24.
• 13 staff are scheduled to complete module 1-4 on Human Rights on HSEland by 30.9.24.
• Basic Life Support training dates confirmed. The PIC will ensure all staff attend training in basic life support by 31.08.24

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The fire closure mechanism on two-bedroom doors have been replaced to support ease of access and three further doors have been scheduled to be replaced by the 31.8.24.
• All fire drill reports will record clearly the staff who were actively partaking in the evacuation drill. Where additional staff are present and not participating in the evacuation the fire drill records will reflect this.
• Meeting held with Quality & Risk Advisor, PPIM, PIC on 23/07/24 to review night fire evacuation processes, recent fire drills and plans to ensure safe evacuation.
• All PEEPs will be updated in line with fire evacuation review recommendations.
• Regular Fire drills will be completed to ensure all night staff are familiar with night evacuation procedures and are completed within target times by 31.08.24
• Changes to PEEPs and fire evacuation plan will be discussed at handover, included in Safety Pause and discussed at staff meetings.
• All staff have been scheduled to attend Albac / Fire Ski Skeet training with completion date by 31.08.24

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(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.	Substantially Compliant	Yellow	31/12/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and	Substantially Compliant	Yellow	31/08/2024

	fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			